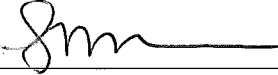


County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
POLICY:	Next Review Date: October 1, 2028
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY, OTHER COVERAGE REQUIREMENTS</u> SUPERCEDES: BHRS-88 DMC-ODS REQUIREMENTS FOR 2022-2026; BHRS-89 CRITERIA FOR ACCESS TO SMHS, MEDICAL NECESSITY, OTHER COVERAGE	Date Approved: October 15, 2025 By:  Todd Schirmer, PhD, CCHP Director of Behavioral Health and Recovery Services

POLICY: CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS

I. PURPOSE:

This policy and procedure outlines guidelines and criteria for accessing Integrated Behavioral Health Plan (IBHP) services, which includes Specialty Mental Health Services (SMHS) and Drug/Medi-Cal Organized Delivery System (DMC-ODS) services as described in the State/County IBHP Contract and Department of Health Care Services (DHCS) Behavioral Health Information Notices (BHIN) BHIN 21-073, BHIN 24-001, and any subsequently issued applicable BHINs. As outlined in the State/County IBHP Contract, in the event of a conflict between the terms of the Contract and a State or federal statute or regulation, or a BHIN, Marin IBHP shall adhere to the applicable statute, regulation, or BHIN.

II. BACKGROUND:

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care to ensure that all Medi-Cal beneficiaries receive coordinated services in support of improved health outcomes. The goal is to ensure access to the right care in the right place at the right time.

To achieve this aim, DHCS has clarified the responsibilities of IBHPs, including updating the criteria for access to SMHS, for both adults and beneficiaries under age 21, except for psychiatric inpatient hospital and psychiatric health facility services. BHIN 21-073 supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.2101 and other guidance published prior to January 1, 2022, regarding medical necessity criteria for MHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services), including components of BHIN 20-043. For substance use disorder services, Medi-Cal adult members whose county of residence participates in DMC-ODS, and Medi-Cal members under age 21 in all counties, are able to receive DMC-ODS services consistent with BHIN 24-001's medical necessity of services criteria, access criteria, assessment criteria, and level of care determination criteria.

III. POLICY:

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

A) Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

Furthermore, federal guidance from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health or substance use services need not be curative or restorative to ameliorate a mental health or substance use condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and are thus medically necessary and covered as EPSDT services.

Services provided to a member must be medically necessary and clinically appropriate to address the member's presenting condition (42 C.F.R. §§ 456.5 and 440.230 (b))

- B) County shall ensure that all required services covered under the IBHP Contract are available and accessible to members in accordance with the applicable state and federal time and distance for network providers¹.
- C) Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied for members meeting criteria for DMC-ODS services and members shall not be placed on wait lists.
- D) IBHP services shall be provided with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/IBHP County Contract.
- E) If the IBHP network is unable to provide medically necessary covered services, the IBHP county must adequately and in a timely manner cover these services out-of-network for as long as the County's network is unable to provide them².
- F) County shall provide prior authorization for residential and inpatient services--excluding Withdrawal Management (WM) Services--within 24 hours of the prior authorization request being submitted by the provider.

¹ 42 CFR 438.68 and W&I Code Section 14197 and any behavioral health information notices

² 42 CFR §438.206(b)(4)

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- G) County may not impose prior authorization or centralized DMC-ODS County-administered full ASAM assessment requirements prior to the provision of non-residential or non-inpatient assessment and treatment services, including WM Services.
- H) Medications for Addiction Treatment/Medication Assisted Treatment (MAT): County must demonstrate they either directly offer or have an effective referral process to MAT services for members with SUD diagnoses treatable with MAT. Additionally, under the “alternative sites” option, County may cover drug products costs for MAT when the medications are purchased and administered or dispensed in a non-clinical setting.
1. All medications and biological products utilized to treat SUDs, including long- acting injectables, continue to be available through the medical pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.
 2. Members needing or utilizing MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in a program.
 3. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a member who declines counseling services.
 4. If the DMC-ODS provider is not capable of continuing to treat the member, the provider must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm handoff to support ongoing engagement.
- I) DMC-ODS for members in the criminal justice system
1. Parole and Probation is not a barrier to DMC-ODS treatment.
 2. Members may receive recovery services immediately after incarceration regardless of whether they received SUD treatment during incarceration.
 3. CalAIM Justice Involved Re-Entry Initiative: As part of BH Links, DMC-ODS plans will be required, within 14 days prior to release (if known), and in coordination with the prerelease care manager, to ensure processes are in place for a BH Link between the correctional behavioral health provider, a DMC-ODS provider, and the member. DMCODS plans are required to implement all components of BH Links, including ability to receive referrals from correctional facilities in all counties, by October 1, 2024.
- J) Covered DMC-ODS Services
1. DMC-ODS services are provided by Drug Medi-Cal (DMC)-certified providers and are based on medical necessity.
 2. DMC-ODS services must be recommended by Licensed Practitioners of the Healing Arts (LPHAs), within the scope of their practice.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

3. DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services.
 - a. Early Intervention Services (ASAM Level 0.5)³
 - b. Outpatient Treatment Services (ASAM Level 1)
 - c. Intensive Outpatient Treatment Services (ASAM Level 2.1)
 - d. Partial Hospitalization Services (ASAM Level 2.5) - Optional
 - e. Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
 - f. Narcotic Treatment Program
 - g. Withdrawal Management Services (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM)
 - h. Medication for Addiction Treatment (also known as Medication Assisted Treatment – MAT)
 - i. Peer Support Specialist Services (effective July 2022)
 - j. Recovery Services
 - k. Care Coordination
 - l. Clinician Consultation (not a direct service to the member)
 - m. Contingency Management (optional)
 - n. Mobile Crisis Services
 - o. Traditional Health Care Practices

K) Indian Health Care Providers

1. American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted in to the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 23-027 for additional guidance. IHCPs include:

³ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral (SABIRT, also known as SBIRT) is covered by Fee-For-Service and managed care delivery systems, not DMC-ODS, for beneficiaries aged 11 years and older.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Review Date: October 1,2028 Date Approved: October 15, 2025

- a. Indian Health Service (IHS) facilities – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.
 - b. Tribal 638 Providers – Federally recognized Tribes or Tribal organizations that contract or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.
 - i. Tribal 638 providers enrolled in Medi-Cal as an Indian Health Services Memorandum of Agreement (IHS-MOA) provider must appear on the “List of American Indian Health Program Providers” set forth in APL 17-020, Attachment 1 in order to qualify for reimbursement as a Tribal 638 Provider under this BHIN.
 - ii. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC provider, must do so consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008.9 Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the “List of Tribal Federally Qualified Health Center Providers”
 - c. Urban Indian Organizations (UIO) – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of U.S. Code: Title 25, Chapter 18.
2. All American Indian and Alaska Native (AI/AN) Medi-Cal members whose county of responsibility is a DMC-ODS county may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the member’s county of responsibility and whether or not the IHCP is located in the member’s county of responsibility. DMC-ODS counties must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal members, even if the DMC-ODS county does not have a contract with the IHCP. DMC-ODS counties are not obligated to pay for services provided to non-AI/AN members by IHCPs that are not contracted with the DMC-ODS county⁴.
 3. In order to receive reimbursement from a county or the state for the provision of DMC-ODS services (whether or not the IHCP is contracted with the county), an IHCP must be enrolled as a DMC provider and certified by DHCS to provide those services. As required by 42 CFR 438.14, DMC-ODS Counties must demonstrate that there are

⁴ See BHIN 20-065 for additional information

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

sufficient IHCPs participating in the provider network to ensure timely access to DMC-ODS services. DMC-ODS Counties must adhere to all 42 CFR 438.14 requirements⁵.

4. Effective March 21, 2025, DMC-ODS counties shall provide coverage for traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations (Tribal Facilities) under the Indian Self-determination and Education Assistance Act, and facilities operated by urban Indian organizations (UIO facilities) under Title V of the Indian Health Care Improvement Act to Medi-Cal members who receive covered services delivered by or through these facilities and meet DMC-ODS access criteria, as described in DHCS BHIN 25-007.

L) Practice Requirements

1. DMC-ODS Counties shall ensure that providers implement at least two of the following evidenced-based treatment practices (EBPs) based on the timeline established in the DMC-ODS County implementation plan. DMC-ODS plans shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State will monitor the implementation of EBPs during reviews. The two EBPs are per provider, per service modality. The evidenced-based practices are:
 - a. Motivational Interviewing – A member-centered, empathic, but directive counseling strategy designed to explore and reduce a person’s ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on members’ past successes.
 - b. Cognitive-Behavioral Therapy – Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
 - c. Relapse Prevention – A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.
 - d. Trauma-Informed Treatment – Services must take into account an understanding of trauma, and place priority on trauma survivors’ safety, choice, and control.
 - e. Psycho-Education – Psycho-educational groups are designed to educate members about substance abuse and related behaviors and consequences.

⁵ See BHIN 20-065 for additional information

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

Psycho-educational groups provide information designed to have a direct application to members’ lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

M) All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria©

N) DHCS Level of Care Designation or ASAM Level of Care Certification^{6,7}

1. All Residential Treatment facilities under DMC-ODS require a DHCS Level of Care (LOC) designation and/or at least one residential ASAM Certification.
 - a. DHCS Level 3.1 – Clinically Managed Low-Intensity Residential Services
 - b. DHCS Level 3.2 – Clinically Managed Residential WM
 - c. DHCS Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
 - d. DHCS Level 3.5 – Clinically Managed High-Intensity Residential Services

O) DMC-ODS Provider Qualifications

1. County shall ensure that all covered services are provided by Drug Medi-Cal (DMC) certified providers.
2. County shall ensure that DMC-certified providers meet the following requirements:
 - a. Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
 - b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.
 - c. Provider shall sign an agreement with the DMC-ODS county or counties prior to rendering DMC-ODS services.

P) Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act⁸, County shall ensure that all

⁶ California Health and Safety Code Section 11834.015

⁷ Behavioral Health Information Notice 21-001

⁸ Social Security Act §1905 (ssa.gov)

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

members under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC-ODS limits or modifies the scope of the EPSDT mandate. DMC-ODS Counties are responsible for the provision of SUD services pursuant to the EPSDT mandate.

IV. AUTHORITY/RESPONSIBILITY:

- BHRS Director
- BHRS Division Directors
- BHRS Quality Management
- BHRS Program Managers/Supervisors/Contract Managers
- BHRS Service Providers

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

V. **PROCEDURE:**

For Specialty Mental Health Services

Criteria for Adult Members to Access the Specialty Mental Health Services Delivery System

For members 21 years of age or older, a county MHP shall provide covered SMHS for members who meet both of the following criteria, (1) and (2) below:

1. The members has one or both of the following:
 - a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
 - b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

2. The member's condition as described in paragraph (1) is due to either of the following:
 - a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders⁹ and the International Statistical Classification of Diseases and Related Health Problems.
 - b. A suspected mental disorder that has not yet been diagnosed.

Criteria for Members under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled members under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

1. The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department,¹⁰ involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

⁹ A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

¹⁰ MHPs are not required to implement a trauma screening tool until DHCS issues additional guidance regarding approved tool(s) for the purposes of SMHS access criteria.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

OR

2. The member meets both of the following requirements in a) and b), below:
 - a. The member has at least one of the following:
 - i. A significant impairment
 - ii. A reasonable probability of significant deterioration in an important area of life functioning
 - iii. A reasonable probability of not progressing developmentally as appropriate.
 - iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

- b. The member's condition as described in subparagraph (2) above is due to one of the following:
 - i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders¹¹ and the International Statistical Classification of Diseases and Related Health Problems.
 - ii. A suspected mental health disorder that has not yet been diagnosed.
 - iii. Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.¹²

If a member under age 21 meets the criteria as described in (1) above, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (2) above.

Additional Coverage Requirements and Clarifications

This criteria for a member to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

¹¹ A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for SMHS as described above.

¹² Welf. & Inst. Code, § 14184.402(d)

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.¹³
- The member has a co-occurring substance use disorder.

Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS-approved ICD-10 diagnosis code.¹⁴ In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS-approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes.

The portion of BHIN 20-043 that limits SMHS to a list of DHCS included ICD-10 diagnoses is superseded by BHIN 21-073, effective January 1, 2022 (except for psychiatric inpatient hospital and psychiatric health facility services.)

Non-Specialty Mental Health Services

Non-Specialty Mental Health Services (NSMHS) are delivered by Medi-Cal Managed Care Plans (MCP) and Medi-Cal Fee-for-Service (FFS) providers and include the following¹⁵:

- Mental health evaluation and treatment, including individual group and family Psychotherapy¹⁶
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies and supplements

MHPs also provide these types of services; however, the level of impairment is typically identified as "moderate to severe" versus the "mild to moderate" level of impairment that supports the provision of NSMHS.

BHIN 21-073 does not change the respective responsibilities of MHPs, Medi-Cal MCPs and the Medi-Cal FFS delivery systems. Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system. However, SMHS are reimbursable for beneficiaries with medical diagnoses if they also

¹³ Some SMHS may still require an individual plan of care, such as Targeted Case Management (42 C.F.R. § 440.169.). DHCS will issue forthcoming guidance regarding documentation.

¹⁴ The ICD 10 Tabular (October 1st thru September 30th) at <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

¹⁵ Welf. & Inst. Code, § 14184.402(b)(1)

¹⁶ Dyadic services will be provided effective 7/1/22.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

have mental health conditions and meet criteria for SMHS as described above. Coordination of care between the MHP and the MCP may be necessary to address member' needs.

Criteria for Beneficiaries to Access Non-Specialty Mental Health Services

MCPs are required to provide or arrange for the provision of NSMHS for the following populations:¹⁷

- Members 21 years of age and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;¹⁸
- Member under age 21, to the extent eligible for services through the Medicaid EPSDT benefit as described above, regardless of level of distress or impairment or the presence of a diagnosis;
- Members of any age with potential mental health disorders not yet diagnosed.

For Substance Use Disorder (DMC-ODS) Services

A) Initial Assessment and Services Provided During the Assessment Process¹⁹

- a. Medi-Cal members whose county of responsibility is a DMC-ODS county are able to receive covered and clinically appropriate DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.
- b. Except for residential treatment and withdrawal management, pursuant to Welfare and Institutions Code section 14184.402(f)(1)(A), an SUD diagnosis is not a prerequisite for access to covered DMC-ODS services. Covered and clinically appropriate DMC-ODS services are Medi-Cal reimbursable during the assessment process, whether or not a Diagnostic and Statistical Manual of Mental Disorder (DSM) diagnosis for Substance-Related and Addictive Disorders is immediately established. Specific level-of-care assessment and authorization policies remain in effect for Residential Treatment Services and Withdrawal Management Services, as described below.

¹⁷ Welf. & Inst. Code, § 14184.402(b)(2)

¹⁸ A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a member meets criteria for access to the NSMHS delivery system. However, MCPs must cover NSMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

¹⁹ Initial assessment and services provided during the assessment process is superseded by BHIN 23-001

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- c. Level of Care Determination: The ASAM Criteria shall be used to determine placement into the appropriate level of care for all members and is separate and distinct from determining medical necessity. Additional guidance on ASAM Level of Care determinations is as follows:
 - a. A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for members under 21; a brief screening ASAM Criteria tool is sufficient for these services.
 - b. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
 - c. A full ASAM assessment does not need to be repeated unless the member's condition changes.
 - d. These requirements for ASAM level of care assessments apply to NTP clients and settings.
- d. Residential treatment services
 - a. Residential and inpatient DMC-ODS services are subject to prior authorization. Member placement and level of care determinations shall ensure that members are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition.
 - b. Prior authorization for residential and inpatient services (excluding WM services) is required within 24 hours of the prior authorization request being submitted by the provider.
 - c. County shall review the DSM and ASAM Criteria© to ensure that the member meets the requirements for the service.
- e. Initial assessment for Narcotic Treatment Programs (NTPs)
 - a. History and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.
- f. Additional Coverage Requirements and Clarifications
 - a. Consistent with W&I Code section 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services when:

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- i. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS access criteria (see description below) are met; or
 - a. Note: Clinically appropriate and covered DMC-ODS services provided to members over 21 are reimbursable during the assessment process as described in the “Initial Assessment and Services Provided During the Assessment Process” subsection. In addition, DMC-ODS plan(s) shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment subsequently determines that the member does not meet the criteria listed under the “DMC-ODS Access Criteria for Members After Assessment” subsection.
 - ii. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
 - a. Note: DHCS guidance on documentation requirements that took effect as of January 1, 2024 can be found in BHIN 23-068. NTPs must comply with the NTP treatment plan components set forth in 42 CFR 8.12.
 - iii. The member has a co-occurring mental health condition. DMC-ODS plans shall not disallow reimbursement for covered DMC-ODS services provided to a member who has a co-occurring mental health condition if the member meets the criteria listed under the “DMC-ODS Access Criteria for Members After Assessment” subsection.
- b. This does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved International Classification of Diseases, Tenth Revision (ICD-10-CM) code.⁴ In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list, for example, codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.

B) DMC-ODS Access Criteria AFTER Assessment²⁰

²⁰ W&I Section 14059.5(a)

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

1. Members 21 years and older: To qualify for DMC-ODS services after the initial assessment process, members 21 and older must meet the following criteria:
 - a. At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
OR
 - b. At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

2. Members under the age of 21: To qualify for DMC-ODS services after the initial assessment process, members under 21 must meet the following criteria
 - a. Receive covered and “medically necessary” services. Services are considered “medically necessary” if the service is necessary to correct or ameliorate screened health conditions ((pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations²¹).
 - b. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. DMC-ODS plans are obligated to provide early intervention services under the outpatient modality to members under the age of 21 at risk of developing an SUD, regardless of whether they meet diagnostic criteria for SUD, and even if the member is not participating in the full array of outpatient treatment services.

C) Covered Services

Covered services are based on recommendations by an LPHA, within their scope of practice. Services shall be provided by DMC-certified providers and based on medical necessity.

DMC-ODS covered services may be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. Member choice must be preserved; therefore, members have the right to request and receive covered services in person. This requirement applies to the following DMC-ODS services and service components: (a) Early Intervention Services (b) Outpatient Treatment Services (c) Intensive Outpatient Treatment Services (d) Partial Hospitalization Services (e) Residential Treatment Services (f) Inpatient Services (g) Recovery Services (h) Care Coordination (i) Clinician Consultation.

²¹ Section 1396d(r) of Title 42 of the United States Code.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

1. ASAM Level 0.5 - Early Intervention Services

- a. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service (FFS) and Medi-Cal managed care delivery system for members less than 21 years of age.
- b. Early intervention services are covered DMC-ODS services for members under the age of 21. Any member under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services.11 A full assessment utilizing the ASAM criteria is not required for a DMC member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used in lieu of a full ASAM for purposes of assessing for SBIRT or Early Intervention Services. A full ASAM assessment shall be performed, and the member under the age of 21 shall receive a referral to the appropriate level of care indicated by the assessment if the member’s conditions or symptoms constitute diagnostic criteria for SUD.
- c. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.
- d. Nothing in this section limits or modifies the scope of the EPSDT mandate.

2. ASAM Level 1 - Outpatient Treatment Services

- a. Outpatient treatment services include the following:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for Opioid Use Disorder (OUD)
 - vii. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services
 - x. SUD Crisis Intervention Services
- b. Service hours:

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- i. Members aged 21 years and older: 9 hours a week
- ii. Member under the age of 21: 6 hours a week
- iii. Services may exceed the maximum based on individual medical necessity.

3. ASAM Level 2.1 – Intensive Outpatient Treatment Services

- i. Intensive Outpatient Services are provided in a structured programming environment.
- ii. Intensive outpatient treatment services include the following:
 - 1. Assessment
 - 2. Care Coordination
 - 3. Counseling (individual and group)
 - 4. Family Therapy
 - 5. Medication Services
 - 6. MAT for Opioid Use Disorder (OUD)
 - 7. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
 - 8. Patient Education
 - 9. Recovery Services
 - 10. SUD Crisis Intervention Services
- iii. Service hours:
 - 1. Members aged 21 years and older: Minimum of 9 hours with maximum of 19 hours a week
 - 2. Member under the age of 21: Minimum of 6 hours with maximum of 19 hours a week
- iv. Services may exceed the maximum based on individual medical necessity.

4. ASAM Level 2.5 - Partial Hospitalization Services (Optional DMC-ODS level)

- a. Partial Hospitalization Services are provided in a clinically intensive programming environment designed to address the treatment needs of members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Partial Hospitalization Services typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting.
- b. Service components include the following:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- v. Medication Services
- vi. MAT for opioid use disorder (OUD)
- vii. MAT for alcohol use disorder (AUD) and other non-opioid SUDs
- viii. Patient Education
- ix. Recovery Services
- x. SUD Crisis Intervention Services

c. Requires 20 or more hours of weekly intensive programming.

5. ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment

- a. Residential Treatment Services are provided in a short-term residential program through one of the following levels:
 - i. Level 3.1 - Clinically Managed Low-Intensity Residential Services
 - ii. Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
 - iii. Level 3.5 - Clinically Managed High Intensity Residential Services
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for OUD
 - vii. MAT for AUD and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services
 - x. SUD Crisis Intervention Services
- c. Services shall address functional deficits documented in the ASAM Criteria©
 - i. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
- d. A member shall live on the premises and be considered a “short-term resident” of the residential facility where the member receives services under this DMC-ODS level of care.
- e. Services may be provided in facilities of any size.
- f. Services are driven by the member’s care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
- g. Residential treatment services for adults under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).

- h. Residential providers licensed by a state agency other than DHCS must be DMC-Certified.
- i. DHCS Level of Care designation and/or ASAM Level of Care Certification:
 - i. All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
 - ii. Designation is required for facilities offering ASAM levels 3.1, 3.3, 3.5.
 - iii. All counties with residential facilities offering levels 3.1., 3.3, and 3.5, licensed by a state agency other than DHCS, shall have an ASAM Level of Care Certification for each of the levels of care provided at the facility under the DMC-ODS program by January 1, 2024.
- j. Length of Stay
 - i. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard “cap” on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary.
 - ii. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

6. ASAM Levels 3.7 Medically Monitored Inpatient Services & 4.0 - Medically Managed Intensive Inpatient Services

- a. County may voluntarily cover and receive reimbursement through DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals Freestanding Acute Psychiatric Hospitals (FAPHs) or Chemical Dependency Recovery Hospitals (CDRHs). Regardless of whether County covers these levels of care, the County must have a clearly defined referral mechanism and care coordination for these levels of care. Additional information can be found on the DHCS All-Plan Letter 18-001²² which clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program.
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services

²² DHCS All-Plan Letter 1801

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- vi. MAT for OUD
- vii. MAT for AUD and other non-opioid SUDs
- viii. Patient Education
- ix. Recovery Services
- x. SUD Crisis Intervention Services
- c. Services shall address functional deficits documented in the ASAM Criteria©
 - i. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
- d. A member shall live on the premises and considered a “short-term resident” of the inpatient facility where the member receives services under this DMC-ODS level of care.
 - i. Treatment services under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
- e. Services are driven by the member’s care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting
- f. Length of Stay
 - i. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard “cap” on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary.
 - ii. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

7. Narcotic Treatment Program

- a. Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

- b. NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including:
 - i. Methadone
 - ii. Buprenorphine (transmucosal and long-acting injectable)
 - iii. Naltrexone (oral and long-acting injectable)
 - iv. Disulfiram
 - v. Naloxone

- c. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the member to a provider capable of dispensing the medication.

- d. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - i. The NTP shall offer the member a minimum of fifty (50) minutes of counseling services per calendar month
 - ii. Counseling services may be provided in-person, by telehealth, or by telephone
 - iv. Family Therapy
 - v. Medical Psychotherapy
 - vi. Medication Services
 - vii. MAT for OUD
 - viii. MAT for AUD and other non-opioid SUDs
 - ix. Patient Education
 - x. Recovery Services
 - xi. SUD Crisis Intervention Services
 - xii. Medical evaluation for methadone treatment
 - a. Medical history
 - b. Laboratory tests
 - c. Physical exam
 - d. Medical evaluation must be conducted in-person

8. Withdrawal Management (WM)Services

- a. WM services are provided as a part of a continuum of care to members experiencing withdrawal in the following outpatient, residential, and inpatient

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

settings. Member shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.

- b. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.
 - i. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
 - ii. Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting).
 - iii. Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
 - i. This is considered a residential level of care and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria©.
 - ii. A DHCS level of care designation and/or an ASAM Level of Care Certification is required.
 - iv. Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).
 - v. Level 4.0-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).
- c. Service components for outpatient, residential, and inpatient settings:
 - a. Assessment
 - b. Care Coordination
 - c. Medication Services
 - d. MAT for OUD
 - e. MAT for AUD and other non-opioid SUDs
 - f. Observation
 - g. Recovery Services
- d. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
 - a. WM services are urgent and provided on a short-term basis.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- b. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate.
- c. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode.
 - i. Receiving program shall adhere to initial assessment timeliness requirements.
- e. WM services may be provided in an outpatient, residential, or inpatient setting.
 - a. For residential settings, each member shall reside at the facility.

9. Medications for Addiction Treatment (also known as Medication-Assisted Treatment or MAT)

- a. Medications for addiction treatment include all medications and biological products Food and Drug Administration (FDA) approved to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD.
 - i. Methadone
 - ii. Buprenorphine (transmucosal and long-acting injectable)
 - iii. Naltrexone (oral and long-acting injectable)
 - iv. Disulfiram
 - v. Naloxone
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. Patient Education
 - vii. Recovery Services
 - viii. SUD Crisis Intervention Services
 - ix. Withdrawal Management Services
- c. MAT may be provided in clinical or non-clinical settings.
- d. MAT may be delivered as a standalone service.
- e. Additional clarification on MAT – DMC-ODS MAT Policy
 - i. DMC -ODS counties shall ensure all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT service for the member with SUD diagnoses that are treatable with medication or biological products pursuant to the requirements set forth in BHIN 23-054.
 - a. Effective referral mechanism is defined as facilitating access to MAT off-site for members if not provided on-site

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- b. Providing a member, the contact information for a treatment program is not considered sufficient.
 - c. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the member shall be made whether or not the provider seeks reimbursement through DMC-ODS.
 - d. Counties shall monitor the referral process or provision of MAT services.
 - ii. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD).
 - iii. DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit.
 - a. This means county pays for cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan.
 - b. If the DMC-ODS county elect the above option could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities and non-clinical or community settings.
 - iv. DMC-ODS counties who *do not choose* to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.
 - v. All medications and biological produces utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit *without* prior authorization and can be delivered to provider offices by pharmacies.
 - vi. Members needing or using MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.
 - vii. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a member who declines counseling services.
 - viii. For members with a lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services).
 - ix. If the DMC-ODS provider is not capable of continuing to treat the member, the DMC-ODS provider must assist the member in choosing another MAT

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

provider, support continuity of care and facilitate a warm hand-off to ensure engagement.

10. Peer Support Services (Implemented as a County Option *Effective July 1, 2022*)

- a. Medi-Cal Peer Support Services are defined as “culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery.” Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or nonclinical setting.
- b. Medi-Cal Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services or levels of care described in this “Covered DMC-ODS Services” section, including inpatient and residential services.

11. Recovery Services

- a. Recovery services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level with emphasis on the member as the central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member’s SUD.
 - vi. Relapse Prevention, which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member’s SUD.
- c. Services may be provided based on the member’s self-assessment or provider assessment of relapse risk.
- d. Diagnosis of “remission” is not required to receive Recovery Services
- e. Services may be provided concurrently with MAT services, including NTP services.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- f. Services may be provided immediately after incarceration with a prior diagnosis of SUD.
- g. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

12. Care Coordination

- a. Care coordination was previously referred to as “case management” for the years 2015-2021.
- b. Care coordination shall be provided in conjunction with *all* levels of treatment. It may also be delivered and claimed as a standalone service.
- c. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level.
- d. Service components include one of more of the following:
 - i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
 - ii. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
 - iii. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- e. Services can be provided in clinical or non-clinical settings, including the community.
- f. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.²³

13. Clinician Consultation

- a. Clinician consultation is *not* a direct service provided to a member.
- b. Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
Clinician consultation:

²³ DMC-ODS counties shall have an executed memoranda of understanding to support care coordination

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

- a. Includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific members.
- b. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.
- c. County may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.

14. Contingency Management

- i. Contingency Management (CM) is an evidence-based, cost-effective behavioral treatment for SUD that provides motivational incentives to treat individuals and reinforces positive behavior change for an individual to reduce the use of stimulants. Participation in the Recovery Incentives Program is optional for DMC-ODS plans, and it is available as an opt-in benefit for all DMC-ODS plans through December 31, 2026.

15. Mobile Crisis Services

- i. Mobile Crisis services provide rapid response, individual assessment, and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Consistent with existing guidance and given the unique nature of behavioral health crises, mobile crisis services are covered and reimbursable prior to determination of a mental health or SUD diagnosis, or a determination that the member meets access criteria for SMHS, DMC and/or DMC-ODS services.
- ii. For additional guidance regarding Mobile Crisis Services, please refer to BHIN 23-025.

D. DMC-ODS Financing

- 1. January 1, 2022, through June 30, 2023
 - a. For claiming federal financial participation (FFP), County will certify the total allowable expenditure incurred in providing the DMC-ODS waiver services provided through county-operated providers (based on actual cost, consistent with cost allocation methodology if warranted), contractor fee-for-service providers, or contracted managed care plans (based on actual expenditures).
- 2. July 1, 2023, and ongoing

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

- a. DHCS will use intergovernmental transfers from all participating counties to finance the non-federal share of all DMC-ODS payments. County will receive a monthly allocation from the local revenue fund 2011 (2011 Realignment) that is restricted to providing Medi-Cal Specialty Mental Health Services, Drug Medi-Cal services, and other non-Medi-Cal SUD services. County shall first meet the needs of Medi-Cal members before spending these restricted funds on non-Medi-Cal services. County shall make monthly transfers to DHCS from these and any other funds eligible under federal law or federal Medicaid reimbursement to finance the non-federal share of all DMC-ODS payments.

E. Responsibilities of DMC-ODS Counties for DMC-ODS Benefits

- a) The responsibilities of DMC-ODS Counties for the DMC-ODS benefit shall be included in each DMC-ODS County’s intergovernmental agreement with DHCS and shall require the DMC-ODS Counties to comply with the following.

- a. Selective Provider Contracting Requirements for DMC-ODS Counties

- 1. DMC-ODS Counties select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of Indian Health Care Providers (IHCPs) as described above in the “Indian Health Care Providers” section.
- 2. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.

- b) Contract Denial and Appeal Process

- 1. Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.
- 2. Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision. Counties shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/County contract. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county’s protest procedure if a provider wishes to challenge the denial to DHCS. If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may appeal to DHCS as outlined in Enclosure 4.

- c) Residential and Inpatient Treatment Provider

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

1. DMC-ODS counties will be responsible for ensuring and verifying that DMC-ODS residential treatment providers licensed by a state agency other than DHCS obtain an ASAM LOC Certification effective January 1, 2024. By January 1, 2024, all providers delivering Residential Treatment services Levels 3.1, 3.3, or 3.5 billed to DMC-ODS must have either a DHCS LOC Designation and/or an ASAM LOC Certification.

d) Access

1. Each DMC-ODS County must ensure that all required services covered under the DMC-ODS are available and accessible to enrollees of the DMC-ODS in accordance with the applicable state and federal time and distance standards for network providers developed by the DHCS, including those set forth in 42 CFR 438.68, and W&I Section 14197 and any Information Notices issued pursuant to those requirements.
2. Access to medically necessary services, including all FDA-approved medications for OUD, cannot be denied for members meeting criteria for DMC-ODS services nor shall members be put on wait lists. DMC-ODS members shall receive services from DMC-certified providers. All DMC-ODS services shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/DMC-ODS County Intergovernmental Agreement.
3. If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS County must adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.

e) Authorization Policy for Residential/Inpatient Levels of Care

1. DMC-ODS Counties shall provide prior authorization for residential and inpatient services (excluding withdrawal management services) within 24 hours of the prior authorization request being submitted by the provider. DMC-ODS Counties will review the DSM and ASAM Criteria to ensure that the member meets the requirements for the service.
2. DHCS does not require DMC-ODS plans to obtain a complete assessment or diagnosis to authorize residential treatment. DMC-ODS plans must review sufficient information, including DSM and ASAM Criteria, to ensure that the member meets the requirements for the service, and must communicate authorization policies to network providers.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

f) Authorization Policy for Non-Residential/Inpatient Levels of Care

1. DMC-ODS Counties may not impose prior authorization or centralized DMC-ODS County-administered ASAM full assessments prior to provision of non-residential or non-inpatient assessment and treatment services, including withdrawal management services. Brief ASAM-based screening tools may be used when members call the DMC-ODS County's member access number to determine the appropriate location for treatment.

g) Member Access Number

1. All DMC-ODS Counties shall have a 24/7 toll free number for both prospective and current members to call to access DMC-ODS services. Oral interpretation services and Text Telephone Relay or Telecommunications Relay Service (TTY/TRS) services must be made available for members, as needed.

h) DMC-ODS County of Responsibility, County of Residence, Care Transitions and Continuity of Care Policy

1. The County of Responsibility field in MEDS and MEDSLITE is the official source for determining which county and/or corresponding DMC-ODS plan is responsible to pay claims and provide any necessary authorizations for medically necessary SUD services provided to an eligible member, unless or until an inter-county transfer (ICT) has been initiated to change the address of a member's residence to another county. If a member moves to a new county or is being released from prison, jail, or a youth correctional facility and initiates an ICT, the new county is responsible for DMC-ODS services as of the date that the county of residence field in MEDS and MEDSLITE is updated.
2. The DMC-ODS County is responsible for ensuring that its residents with SUD receive appropriate covered treatment services. If a member is able to access all needed covered services, then the DMC-ODS County is not obligated to subcontract with additional providers to provide more choices for that individual member. However, in accordance with 42 CFR §438.206(b)(4), if the DMC-ODS County's provider network is unable to provide needed services to a particular member, the DMC-ODS County shall adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

3. 42 CFR 438.62(b) requires that DHCS’ transition of care policy ensures continued access to services during a transition from State Plan DMC to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. As outlined in MHSUDS 18-051, the DMC-ODS county must allow the member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

4. Accordingly, the DMC-ODS County shall ensure that members receiving Narcotic Treatment Program (NTP) services and working in or travelling to another county (including a county that does not opt in to the DMC-ODS program) do not experience a disruption of NTP services. In accordance with 42 CFR 438.206, if the DMC-ODS county’s provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS county’s provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the member. If a member working in or travelling to another county is not able to receive medically necessary DMC-ODS services, including NTP services, without paying “out of pocket”, the DMC-ODS county of responsibility has failed to comply with the requirements contained in 42 CFR 438.206.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

VI. DEFINITIONS:

Adolescent: Refers to members under age 21.

Assessment: Consists of activities to evaluate or monitor the status of a member’s behavioral health and determine the appropriate level of care and course of treatment for that member. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards.²⁴ Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the “Other laboratory and X-ray services” benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the member’s needs, planned interventions and to address and monitor a member’s progress and restoration of a member to their best possible functional level.

Family Therapy: A rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member’s recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

²⁴ As described above, NTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies the purpose of determining medical necessity under the DMC-ODS

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

Group Counseling: Consists of contacts with multiple members at the same time. Group Counseling focuses on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.

Homelessness: The member meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.²⁵ Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Individual Counseling: Consists of contacts with a member. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Involvement in child welfare: The member has an open child welfare services case, or the member is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the member is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; orb) the child has a family maintenance case (pre-placement or post-reunification), including both court ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile justice involvement: The member (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion

²⁵ Available at: <https://nche.ed.gov/mckinney-vento-definition/>. Full text of the Act is available here: <http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter19/subchapter6/partB&edition=prelim>

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1, 2028
POLICY:	Date Approved: October 15, 2025
<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	

programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meets the "juvenile justice involvement" criteria.

Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit, and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

Medical Psychotherapy: A counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the member.

Medication Services: Includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or WM not included in the definitions of MAT for OUD or MAT for AUD services.

Medications for Addiction Treatment (also known as Medication Assisted Treatment (MAT)) for Opioid Use Disorders (OUD): Includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

MAT for OUD may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the "Levels of Care" section.

- "Patient Education", which is education for the member on addiction, treatment, recovery and associated health risks.
- Prescribing and monitoring for MAT for OUD, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD.

Non-Specialty Mental Health Services (NSMHS): NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

Specialty Mental Health Services (SMHS): Specialty mental health services include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC),

<u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Page 34 of 36
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County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Review Date: October 1, 2028 Date Approved: October 15, 2025

Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

SUD Crisis Intervention Services: Consists of contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

Withdrawal Management Services: Provided to members when medically necessary for maximum reduction of the SUD symptoms and restoration of the member to their best possible functional level.

- Observation, which is the process of monitoring the member's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the member's health status.

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-120
	Review Date: October 1,2028
POLICY: <u>CRITERIA FOR ACCESS TO INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) SERVICES, MEDICAL NECESSITY AND OTHER COVERAGE REQUIREMENTS</u>	Date Approved: October 15, 2025

VII. FORMS ATTACHMENTS:

ENCLOSURE 4

Provider Appeals Process

1. Following a county’s contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider’s solicitation for a contract.
2. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet member need and the provider can demonstrate it is capable of providing high quality services under current rates, and: A. It can demonstrate arbitrary or inappropriate county fiscal limitations; or B. It can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.
3. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county’s decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
4. A provider shall have 30 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.
5. The provider shall include the following documentation to DHCS for consideration of an appeal: A. County’s solicitation document; B. County’s response to the county’s solicitation document; C. County’s written decision not to contract D. Documentation submitted for purposes of the county protest; E. Decision from county protest; and F. Evidence supporting the basis of appeal.
6. The county shall have 10 working days from the date set forth on the provider’s proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation:
 - a. the qualification and selection procedures set forth in its solicitation documents; the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of members served in the county, including any anticipated change in need and the rationale for the change; and the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County’s solicitation procedures. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.