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behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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- MEMORANDUM -

DATE: May 16, 2022

TO: Alameda County Behavioral Health Drug Medi-Cal Organized Delivery System Providers (DMC-ODS)

FROM: Torfeh Rejali, Quality Assurance (QA) Administrator *Torfeh Rejali*

SUBJECT: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026

This memorandum announces the roll out of CalAIM requirements related to the DMC-ODS systems of care and publication of policy titled "Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026" on the ACBH Provider Website. Specific CALAIM requirements related to Criteria for Beneficiary Access and Level of Care Determinations are clarified.

Background

California Advancing and Innovating Medi-Cal (CalAIM) is a statewide Department of Health Care Services (DHCS) initiative that aims to provide broad delivery system, program and payment reform across the Medi-Cal system. The goal of the initiative is to transform the Medi-Cal delivery system, moving it towards a population health approach that prioritizes prevention and whole person care. The vision is to "meet people where they are in life, address social drivers of health and break down the walls of health care."

Criteria for Beneficiary Access and Level of Care Determinations

On December 17, 2021, the Department of Health Care Services (DHCS) released BHIN 21-075, providing additional details related to updated access criteria, medical necessity, and levels of care determinations effective January 1, 2022. A policy titled "Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026" has been posted on the ACBH Provider Website. *It is recommended that DMC-ODS providers review the policy in detail. This memo is primarily focused on changes to Beneficiary Access and Level of Care determinations.*

In coordination with the Behavioral Health Collaborative, ACBH has been working to identify the impact of these new requirements on the day to day processes for the providers offering substance use disorder (SUD) services to Medi-Cal beneficiaries and required changes to Electronic Health Records. Below is a summary of the new State and County requirements relevant to Criteria for Beneficiary Access and Level of Care Determinations.

Main Highlights of the New Requirements

Covered Services

- Covered SUD prevention, screening, assessment, and outpatient treatment services are reimbursable Medi-Cal services when:
    a. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met.
    b. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan.
    c. The beneficiary has a co-occurring mental health condition.
- Clinically appropriate and covered DMC services provided during the assessment process are covered and reimbursable even if the assessment later determines that the beneficiary does not meet criteria for DMC.

Changes to Diagnosis

> ***COUNTY NOTE**: ACBH is working to update the diagnosis lists in Clinician Gateway and InSYST systems. Until that occurs, LPHAs (licensed and registered), working within their scope of practice, should continue to use diagnoses that are on the Included Diagnosis List, including Z03.89 only.*

- Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable without an established Substance Use Disorder (SUD) diagnosis for up to 30 days for adult or 60 days if the beneficiary is under 21 or homeless. Specific ICD-10 Z codes can be used for claim submission.
- If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.
- Beneficiaries under age 21, who do not meet criteria for a SUD diagnosis, are still eligible for DMC-ODS Early Intervention services under the EPSDT mandate.
- The flexibility related to diagnosis at initial assessment does not eliminate the requirement that all Medi-Cal claims include a CMS ICD-10 diagnosis code. The following options may be used during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:
    a. ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
    b. ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.
    c. In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHA and LMPHs may use any clinically appropriate ICD-10 codes. For example, codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Criteria for Beneficiary Access to Services

Initial Assessment and Services Provided DURING the Assessment Process:

- Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for:
    - Up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis (dx) for Substance-Related and Addictive Disorders (SUD) is established, **OR**
    - Up to 60 days for beneficiaries ages 12-20 years old or, if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.
- A full ASAM assessment or initial provisional referral tool for preliminary level of care recommendations is not required to *begin* services.
- The initial assessment shall be performed face-to-face, by telehealth or telephone by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

Services Provided AFTER Assessment:

- Beneficiaries 21 years old or older:

- Have at least one DSM SUD diagnosis, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, **OR**
- Have had at least one DSM SUD diagnosis prior to being incarcerated or during incarceration, determined by substance use history.

- Beneficiaries under 21 years of age:
  - Are eligible for DMC-ODS services without a SUD DSM diagnosis. ICD-10 Z codes should be used for claim submission.
  - County contracted providers are responsible for the provision of medically necessary DMC-ODS services pursuant to the EPSDT mandate. EPSDT entitles beneficiaries 21 and under to any medically necessary services coverable under Medicaid to correct or ameliorate identified conditions, even if they do not meet criteria for a SUD diagnosis. This includes risky substance use, substance misuse and early engagement services.
  - Providers are still expected to complete ASAM and offer the most appropriate level of care during and after assessment.

American Society of Addiction Medicine (ASAM) Criteria Assessments

- ASAM Criteria is used to determine placement into the appropriate level of care for all beneficiaries, and is separate and distinct from determining medical necessity.
- A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary to begin receiving covered and reimbursable SUD treatment services, an abbreviated ASAM screening tool may be used for initial screening, referral and access to clinically appropriate services.
- Levels 1 and 2.1 no longer require that a full ASAM is repeated based on strict timelines. Going forward, a full ASAM is required when a beneficiary's condition changes and as determined by clinical judgement, the beneficiary requires a different level of care to maintain recovery.
- The chart below shows the required ASAM frequency by level of care:

Level of Care	ASAM Requirements at Initial Assessment	ASAM Requirements Ongoing
Level 1 OS (Outpatient Services), OTP (Opioid Treatment Program) Level 2.1 IOS (Intensive Outpatient Services)	Full ASAM[1] within 30 days for adult or within 60 days if under 21 years old or homeless.	When beneficiary's condition changes.
Level 3.1 Residential – Clinically Managed Low-Intensity Residential Services Level 3.3 Residential - Clinically Managed Population – Specific High Intensity Residential Services	Full ASAM[1] within 5 days ***COUNTY NOTE**: Per UM prior authorization policy, a brief ASAM screening will continue to be completed by Portal prior to admission.*	When beneficiary's condition changes ***COUNTY NOTE**: As authorization for services is required for Residential level of care, ACBH will continue to require that a full ASAM be completed when requesting authorization after the first 5 days- for up to 30 days and*

[1] **Full ASAM**: ACBH is designing a new, streamlined note type that combines ALOC and Intake/Assessment.

Level 3.5 Residential - Clinically Managed High Intensity Residential Services		*whenever additional authorization is requested.*[2]
Level 3.2 - WM Residential - Clinically Managed Withdrawal Management Level 3.7 – WM Medically Monitored Intensive Withdrawal Management Services	A full ASAM is not required to admit to withdrawal management ***COUNTY NOTE****: Complete a brief ASAM (ALOC Portal Screener in CG) within 24 hours of admission. May complete only the clinically relevant ASAM Dimensions. To allow capturing of ASAM and timelines data, a completed brief ASAM is required even if the client leaves within 24 hours of admission.*	May use ASAM or other brief assessment tool to support appropriate transition ***COUNTY NOTE****: Complete all ASAM Dimensions (ALOC Portal Screener in CG) for transitions of care prior to discharge.*

Residential Services

- There will no longer be a cap on the number of days and courses of treatment for residential services. Authorization continues to be required for residential levels of care (e.g. ASAM 3.1, 3.3, or 3.5).
- The statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days. This is not a quantitative treatment limitation or hard "cap" on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need. Counties shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress.

Opioid Treatment Programs (OTP)/Narcotic Treatment Programs (NTP)

OTP/NTPs are required to follow both DMC-ODS and 9 CCR Div. 4, Ch. 4 regulations.

Action Required

The changes and increased flexibilities noted in this memo are effective immediately. Please begin working with your teams to communicate and implement these changes, as appropriate.

The County will be offering training opportunities in the near future and will notify providers via memo and the ACBH Provider website. Changes resulting from the CalAIM initiatives will continue to be discussed during monthly Brown Bag meetings. We welcome questions and opportunities for clarification of these significant changes. **Brown Bags are scheduled every third Thursday of the month from 12pm-1pm. The next Brown Bag meeting is scheduled for May 19, 2022.** If you do not have the meeting already on your calendar, below is the link and call-in information:

Link: https://global.gotomeeting.com/join/486928181

United States (Toll Free): 1 866 899 4679; United States: +1 (224) 501-3316
Access Code: 486-928-181

For questions, please contact QATA@acgov.org.

[2] ACBH is designing a new note type for requests beyond the first 30 days of residential services.