Behavioral Health Workgroup
Stakeholder Feedback on Issues in the DMC-ODS

Policy category	Policy proposal	DHCS policy response
Residential Treatment Length of Stay	Remove the 2-episode limitation on residential treatment	Remove limitation on 2 episodes from waiver; advocate to CMS for maximum of 90 days in 365 day period; same for adults and adolescents.
Residential Treatment Definition	Clarify statewide documentation standards (what is required, what frequency) . Clarify coverage of transportation	DHCS is clarifying documentation requirements in the interagency agreement. DHCS clarified that transportation for residential services is paid for in DMC-ODS; transportation for physical health services for residential clients is covered in Medi-Cal Managed Care.
	Allow residential treatment facilities to provide withdrawal management.	To be discussed further.
	Establish statewide standards for the minimum number of hours per week of billable clinical services that residential treatment programs must offer to receive DMC-ODS reimbursement	DHCS revised STC definition to match Alcohol and Other Drug (AOD) standards at 20 hours structured services with minimum five hours clinical weekly.
Recovery Services	Recovery services and case management TA/training would be helpful for counties and providers. Need to increase recovery services for justice-involved.	DHCS will look at adding TA/training for these services. In the STCs, clarification was added around the allowable services (group counseling, assessment, alumni groups, education sessions) and workforce guidance added around using peers. Clarification that beneficiaries in long-term MAT are eligible for recovery services. In the STCs, clarification is added for justice-involved individuals.
Telehealth	Add telehealth as a required benefit	Telehealth will remain an optional modality in DMC ODS
Medication Assisted	All SUD providers should offer MAT, either by referral or on-site.	All providers must provide or refer to MAT services. Counties may offer additional optional MAT services.

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Treatment	DHCS should develop strategies for increasing access to MAT in a variety of settings, including potential performance or evaluation measures related to MAT access	DHCS has extensive efforts in place through the federally funded MAT Expansion Project and other DHCS opioid related projects.
Physician Consultation Services	Add collaborative care codes in SUD and SMHS	Physician consultation services currently a benefit in DMC ODS (physicians, psychiatrists and addiction specialists; removed limitation that physician consultation services can only be billed by DMC providers) For SMHS: to be discussed further
Evidence-Based Practice Requirements	Add contingency management and DBT as required benefits in DMC ODS	Contingency management is added as an optional evidenced-based practice. Counties may require DBT, but DHCS did not add it to STCs.
DHCS Provider Appeals	Remove provider appeals process (some advocated to keep in place)	DHCS decided to remove this process from the STCs as it was not used.
ASAM criteria: MAT, incarceration or homelessness	Adjust ASAM criteria to account for incarceration and/or homelessness, and to direct people appropriately to MAT when indicated. Eliminate need for ASAM criteria for NTP services.	National ASAM criteria is under revision to address these problems. In the STCs, added clarification around medical necessity for the justice-involved. DHCS will continue to require ASAM assessment for all DMC ODS providers, to ensure that beneficiaries are assessed for all levels of care.
Screening, diagnosis and treatment	Allow treatment prior to diagnosis. Allow non-licensed clinicians to do assessments without oversight of licensed professionals.	DHCS proposes to revise medical necessity requirements in waiver: 1. Counties may use the brief ASAM screening tool (NOT the full assessment) to determine needs and initial place of care for triage calls. 2. If a beneficiary accesses lower levels of care directly (any service other than residential treatment), the provider is responsible to do a screening process (or an H&P) and start treatment immediately. SUD symptoms or diagnosis is sufficient to determine medical necessity for treatment. The county may NOT require a call to the triage line, nor prior authorization, nor an assessment done by county staff prior to starting treatment. The

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		only exception is residential care, where the county is entitled to do a full ASAM assessment to determine the need for higher level of care. The client should only be required to do one full ASAM assessment (if done by the county, the provider must accept the county results). 3. Providers treating beneficiaries in lower levels of care (all services other than residential) should complete an assessment early in treatment, and no later than 30 days. Counties shall not require an assessment done prior to treatment onset. 4. Care may be provided prior to a diagnosis. A diagnosis must be in place (at least provisional) prior to discharge from higher levels of care (residential and inpatient). Since the ASAM full assessment must be done within 30 days (unless a client refuses – client refusal should not lead to denial of treatment), a diagnosis (at minimum, provisional) should be in place after the assessment. 5. SUD providers may treat patients with MH and SUD diagnoses. DHCS will remove the requirement for one diagnosis to be primary. 6. ASAM assessments may be completed by non-licensed staff without review by an LHPA or medical director in these circumstances: a. An on-line, tool validated for use by nonlicensed staff is used (e.g., Continuum) OR b. The SUD diagnosis determined by the assessment is concordant with an assessment done by a licensed clinician within 12 months (e.g., an H&P at an NTP, or a previous diagnostic assessment by a clinician). If the assessment produces a different diagnosis, and the tool is not an on-line validated tool, then an unlicensed clinician cannot give a new diagnosis – the client should be clinically assessed by a licensed clinician to validate the new diagnosis. 7. Repeat ASAM assessments are not required at NTPs (after the initial 30 day assessments) unless a client's condition changes and requires residential care.

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		8. Repeat ASAM assessments shall not be required by counties more frequently than annually for lower levels of care.
Peer-Based Services	Define a scope of practice for peer-based services and allow reimbursement for peer-based services for MH and SUD.	DMC ODS added peers in the case management benefit. Additional peer support services to be discussed further.
Same-Day Billing	Adjust same-day billing restrictions to facilitate and incentivize transitions between levels of care by allowing claims to be processed in two different levels of care during a 48 hour period.	Same-day billing for same service will be allowed if at different addresses (to allow transitions of care)
Early and Periodic Screening, Diagnostic, and Treatment	Allow billing for Early and Periodic Screening, Diagnostic, and Treatment services for high-risk youth who may not meet the diagnostic criteria for a substance use disorder.	All beneficiaries (regardless of age) may receive treatment prior to diagnosis. Youth are entitled to any services needed to treat a condition, even if not meeting criteria for an SUD, including treatment for risky substance use.
HIV/ Hepatitis screening and treatment	Allow medication management of HIV and hep C treatment at SUD treatment facilities	HIV and hepatitis C testing and treatment may be incorporated into incidental medical services at residential services.
Group services	Remove cap on number of patients who can attend per group	Education sessions do not have a cap. Counseling sessions cap is in statute; DHCS does not propose changing it at this time.
Duplicative oversight leading to barriers to care or decrease in workforce capacity	For counties contracting with out-of-county providers: a. Counties should deem a provider compliant if the provider has passed a facility audit by the in-county DMC ODS plan. b. Counties should deem	DHCS is continuing to explore options to address these concerns. Counties may accept training from other sources with proof of completion and may currently review in-county audit reports to be in compliance with 438 requirements.

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	credentialing done by the in-county DMC ODS plan or through a national credentialing body. c. Counties should continue to do chart reviews as needed for their own beneficiaries (remotely is sufficient) d. Counties may not require staff to repeat training if the training on the same topic (e.g., evidence-based practice) has been completed on-line, through the provider, or through another county. Counties should provide funding for training if in excess of state requirements.	
Documentation	Counties should not impose documentation requirements that add administrative burden without clinical value: a. Require providers to do duplicate entry into county EHRs. b. Require providers to complete standardized treatment plan templates, treatment narratives, etc. Providers should use problem lists and progress notes to document assessments and individualized treatment plans. c. Require providers to send treatment plans and progress	The BH Quality Improvement Program (BH QIP) shall provide funding to help counties develop the ability to ingest electronic data files from providers containing client demographics and claiming information, and no longer require providers to do duplicate data entry. DHCS anticipates that some county documentation requirements will become less burdensome with implementation of new medical necessity changes and with payment reform. DHCS does not have the authority to prohibit counties from requirements above and beyond state requirements.

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	notes. d. Utilization review or prior authorization review should not be done on lower levels of care (other than outlier analysis)	
Disallowances	Excessive disallowances due to MH diagnosis or clinical chart documentation not following requirements.	DHCS would move away from disallowances based on clinical chart documentation alone, in the absence of fraud, waste or abuse.
Resolve COS/COR Issue	Providers and counties would like the county of service to be financially responsible from the time a beneficiary makes a change with the county staff to a new county of residence.	DHCS continues to explore options to resolve this issue.
Out of state providers	Consider a reciprocity agreement that would allow CA to grant streamlined DMC certification or otherwise bill Medi-Cal for Medicaid providers in neighboring states	DHCS requires all providers to complete the Medi-Cal application and cannot make exceptions for out-of-state providers.
Lack of infrastructure and resources for counties	Infrastructure and resource constraints are the key challenges now for early implementer counties and smaller counties considering opting in (i.e. workforce, building new facilities, etc.).	DHCS acknowledges these challenges.
Workforce training	DHCS should ensure MH professionals have sufficient training in SUD, and SUD professionals receive training in MH.	Thank you for your comment.
LHPA	LHPA should not be required to sign	This is not required under the STCs or contract. Counties may have

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oversight	progress notes for SUD counselors.	additional oversight requirements.
Tribal care	Ensure counties meet obligations regarding Indian Health Care Providers.	DHCS will provide clarification regarding county contractual requirements towards Indian Health Care Providers. DHCS will seek an allowance for specific cultural practices for Tribal 638 and Urban clinics.
NTP access	DHCS should include language asserting that a county may not limit access to NTP services by allowing waitlists, limiting and decreasing treatment capacity slots, or preventing programs from expanding by withholding letters of support for new clinic locations.	DHCS does not support any policies or actions that limit access to services for beneficiaries. Waitlists are not permitted in DMC ODS.
Expenditure Authority for IMD Services	Do not change the current reimbursement for IMD facilities including Free Standing Psychiatric treatment centers, Chemical Dependency Recovery Hospitals (CDRHs) and DHCS licensed residential facilities for residential treatment and withdrawal management.	DHCS is not changing this policy in the renewal. These services are currently allowed.