State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 14, 2021

Behavioral Health Information Notice No: 21-019

TO:

California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal Organized Delivery System – Updated Policy on Medical Necessity and Level of Care

PURPOSE: To provide clarification on medical necessity determination and level of care placement as part of California's Advancing and Innovating Medi-Cal (CalAIM)

BACKGROUND:
The Department of Health Care Services (DHCS) received approval on August 13, 2015, from the Centers for Medicare & Medicaid Services (CMS) to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. Authority for the DMC-ODS waiver was reauthorized as part of the state's Medi-Cal 2020 1115 waiver for a five-year term from January 2016 to December 2020. Prior to the expiration date, DHCS received a one-year waiver extension on December 29, 2020, that extends DMC-ODS through December 31, 2021.

CMS has approved several policy changes/clarifications in key areas effective retroactively to January 1, 2021, and continuing through the duration of the extension

period. These changes and clarifications are specified in amendments to the special terms and conditions of the DMC-ODS waiver. DHCS is currently preparing a new waiver request that, if approved by CMS, would authorize the DMC-ODS waiver through December 2026.

This information notice clarifies the policy related to access to treatment during the initial assessment period, medical necessity determination, and level of care placement.

POLICY:

Reimbursement for Treatment during Assessment Period

Within non-residential treatment settings, DMC-ODS services are reimbursable for up to 30 days following the first visit with an Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor, whether or not a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. Sixty days to complete American Society of Addiction Medicine (ASAM) assessment is also permitted for beneficiaries under 21, as described below. If a client withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders and later returns, the time period starts over.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid mandate entitles beneficiaries under the age of 21 to any medically necessary services coverable under a Medicaid state plan to correct or ameliorate identified conditions, even if they do not meet criteria for a substance use disorder (SUD) diagnosis. This includes treatment for risky substance use and early engagement services. Individual and group counseling and educational services are examples of early intervention services covered under EPSDT. DMC-ODS plans and/or providers are still expected to complete an ASAM assessment for youth as described below and offer the level of care and services that are clinically appropriate both during assessment and after assessment is completed. Nothing in the DMC-ODS overrides any EPSDT requirements.

Medical Necessity

To qualify for DMC-ODS services *after* the initial assessment, beneficiaries 21 years of age and older must meet one of the following criteria:

1) Have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; OR

2) Have had at least one diagnosis from the current 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, as determined by substance use history.

Beneficiaries under the age of 21 are eligible to receive Medicaid services pursuant to the EPSDT mandate. Under the EPSDT mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct or ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements. Counties are responsible for the provision of medically necessary DMC-ODS services pursuant to the EPSDT mandate. Beneficiaries under age 21 are eligible for DMC-ODS services without a diagnosis from the DSM for Substance-Related and Addictive Disorders.

A brief ASAM screening may be used to identify the most appropriate services prior to completion of a comprehensive assessment and diagnosis. For beneficiaries of any age, medical necessity for the DMC-ODS service(s) shall be determined by an LPHA based upon an assessment of the client. The DMC-ODS initial assessment shall be performed either face-to-face or via synchronous telehealth ("synchronous telehealth" is defined here as live video) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the client 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 medical necessity determination. The consultation between the LPHA and the registered or certified counselor can be conducted in-person, by synchronous video, or by telephone/audio only.

Level of Care

The ASAM Criteria assessment shall be used for all beneficiaries to determine placement into the appropriate level of care. For beneficiaries 21 and over, the ASAM Criteria assessment shall be completed within 30 days of the client's first visit with an LPHA or registered/certified counselor. For beneficiaries under 21, the ASAM Criteria assessment shall be completed within 60 days of the client's first visit with an LPHA or registered/certified counselor. If a client withdraws from treatment prior completing the ASAM Criteria assessment and later returns, the time period starts over. A full ASAM Criteria assessment shall not be required to begin receiving DMC-ODS services. The ASAM Criteria Assessment does not need to be repeated unless the client's condition changes. ASAM Criteria Assessment is required before a county DMC-ODS plan authorizes a residential treatment level of care.

These changes are effective as of January 1, 2021.

If you have questions, please contact countysupport@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, PsyD, LCSW, Chief
Medi-Cal Behavioral Health Division