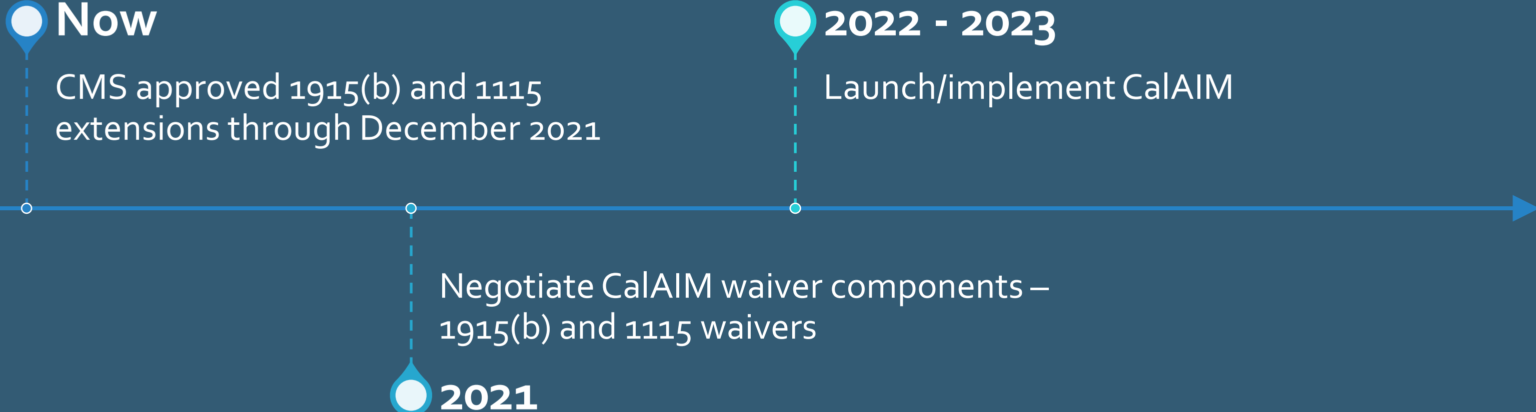
CALAIM: DMC-ODS RENEWAL

SAPT Committee

April 21, 2021

CALAIM: CURRENT TIMELINES



CALAIM BH PROPOSALS THAT IMPACT SMH *AND* DMC/DMC-ODS

- Payment reform
- Medical necessity
- MH/SUD Integration
- Peer Support Services
- SMI/SED IMD Waiver
- DMC-ODS Renewal
- Long-term plan for foster youth

CALAIM BEHAVIORAL HEALTH PROPOSALS

- Payment reform
- Medical necessity
- MH/SUD Integration
- Peer Support Services
- SMI/SED IMD Waiver
- DMC-ODS Renewal
- Long-term plan for foster youth

A NOTE ON WAIVER AUTHORITIES . . .

- Beginning in 2022, DHCS proposes to shift certain DMC-ODS program components/authorities into the 1915(b) managed care waiver
- 1115 waivers are demonstration waivers
  - Some pieces of DMC-ODS still require demonstration authority
  - E.g., payment for Adult Residential Treatment in “IMDs” and payment protocol overall, and new tribal provider types
- This change is not a problem!
  - DMC-ODS participation will still be optional by county.

PROPOSED DMC-ODS CHANGES UNDER CALAIM (ENACTED IN TWO PHASES)

- Residential Treatment LOS Limitations
- Recovery Services
- Evidence-Based Practice Requirements
- DHCS Provider Appeals Process
- MAT Access
- Medical Necessity
- NTPs and ASAM
- Clinician Consultation Services
- Tribal Services
- Early Intervention ?

PROPOSED TIMELINE

Phase One – Effective 1/1/2021

- Remove residential treatment length-of-stay (LOS) limitations
- Recovery services
- Medical necessity
  - Early intervention ?
- Expanding access to MAT

Phase Two – Effective 1/1/2022

- Tribal services
- EBP requirements
- DHCS provider appeals process
- Clinician consultation services
- Medical necessity (ASAM) for NTPs

DMC-ODS PHASE 1

Enacted via 2021 Extension

PHASE ONE PROVISIONS INCLUDED IN RECENT INFORMATION NOTICES FROM DHCS

Residential Treatment

- Update residential treatment definition to remove LOS limitations
- Remove distinction between adults and adolescents for these requirements, affirm EPSDT mandate applies

Recovery Services

- Clarify allowable components of recovery services
- When and how beneficiaries may access recovery services
- Affirms availability of recovery services to individuals receiving MAT

Access to MAT

- Keep “Additional MAT” services as an optional DMC-ODS benefit, but clarify that all providers must either directly offer, or have referral mechanisms to, MAT

Medical Necessity

- Services can be reimbursed prior to diagnosis (during assessment period)
- Dedicated criteria for treatment after incarceration, i.e., history of SUD prior to time in custody
- Affirms early intervention is reimbursable for youth under 21 who do not meet diagnostic criteria for SUDs

CMS APPROVED RESIDENTIAL TREATMENT LENGTH-OF-STAY REQUIREMENTS

- Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs.
- Annual reimbursement limitation on the number of residential stays has been removed and approved by CMS.
  - Applies to both adult and adolescent stays, removing discrepancies between the two
- Client's length of stay for residential treatment services shall be determined by a Licensed Practitioner of the Health Arts (LPHA) based on medical necessity
- Statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days or less.
- Counties shall adhere to LOS monitoring requirements set by EQRO.

CMS APPROVED RECOVERY SERVICES CLARIFICATIONS

Allowable components of recovery services

- Specify allowable services under this provision

When and how beneficiaries may access recovery services

- Clarifies beneficiaries may receive recovery services immediately after incarceration, whether or not they received SUD treatment while incarcerated
- Beneficiaries may receive recovery services based on a self assessment or provider assessment of relapse risk
- Clarifies recovery services may be provided in-person, by telephone, or by telehealth.

Availability of recovery services to individuals receiving MAT

- Clarifies that beneficiaries receiving MAT, including NTP services, may receive recovery services

CMS APPROVED MEDICAL NECESSITY POLICIES

- Clarifies plans may receive reimbursement for covered services for up to 30 days after first encounter with a beneficiary, whether or not a diagnosis has been established.
  - Plans may receive reimbursement for covered services for up to 60 days after the first encounter for specialized clients including individuals experiencing homelessness and individuals under 21.
- EPSDT services include early engagement services, educational services, and treatment for risky SUD.
- For all beneficiaries, medical necessity for ongoing DMC-ODS services must be determined by a LPHA via ASAM assessment
  - A full ASAM Criteria assessment is not required to begin receiving services
- To qualify for DMC-ODS services after initial assessment, adults must have at least one diagnosis or a history of diagnosis prior to incarceration

CMS APPROVED MAT ACCESS POLICIES

- DMC-ODS Counties must require all DMC-ODS providers to demonstrate they either directly offer or have referral mechanisms to MAT for qualifying beneficiaries
- Naltrexone is now a benefit in the DMC-ODS formulary for NTPs.
  - NTPs are required to offer and administer medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naltrexone, naloxone, and disulfiram.
- "Additional MAT" remains an optional DMC-ODS service that may be provided in an alternative (non-NTP) settings
  - Licensed prescribers in DMC-ODS programs can be reimbursed for the ordering, prescribing, administering, and monitoring of all FDA-approved MAT

DMC-ODS PHASE 2

Enacted via 2022 Renewal

REMAINING PROVISIONS TO BE IMPLEMENTED CONT.

PHASE TWO – 1/1/2022

- Tribal Services
  - Increase access to SUD treatment for American Indians and Alaskan Natives by reimbursing services delivered by culturally specific provider types, and adding evidence-based practices
- Evidence Based Practice (EBP) Requirements
  - Expand the current list of EBP to include contingency management.
- DHCS Provider Appeals Process
  - Remove process that currently allows a provider to appeal DHCS if they believe the county erroneously rejected the provider's solicitation for a contract. (Provision is redundant with provider appeal rights included in 42 CFR 438 requirements for network adequacy.)

REMAINING PROVISIONS TO BE IMPLEMENTED CONT.

PHASE TWO – 1/1/2022

- Clinician consultation services
  - Would change the name of the benefit from "physician consultation services" to "clinician consultation services" to now include other licensed clinicians such as Nurse Practitioners and Physician Assistants.
  - Proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers (?).
- Medical necessity for NTPs
  - Update and align the STCs with EBPs to allow a physician's history and physical to determine medical necessity for NTP services as required by federal licensing laws. Would also clarify requirements for the initial assessment and medical necessity determinations in other settings.

RESOURCES

- Revised CalAIM Proposal (3/23/2021)
- 1115 Waiver Proposal (04/06/2021)
- 1915(b) Waiver Proposal (04/06/2021)
- DHCS CalAIM Webpage
- DRAFT Information Notices attached to SAPT Agenda email (sent 4/20/2021)
- CBHDA Webinar Recordings
  - Includes "deep dives" on Medical Necessity and Payment Reform, Feb. 2021
- CBHDA CalAIM Resources

THANK YOU!

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