Referral scenarios

**Is the County of Responsibility (CoR) an ODS waiver county?**

- **YES, CoR = ODS WAIVER**
  - **CoR and CoS are ODS counties:**
    - **Option 1:** CoR may enter into a contract with the out-of-county provider.
    - **Option 2:** If the CoR does not wish to contract with the out-of-county provider, the CoS may refer the beneficiary back to the CoR for care coordination and referral to a provider within the ODS. Because an ODS county operates as a managed care plan, the ODS county is unavailable to provide DMC services – with the exception of state plan NTP services - to beneficiaries from other counties, i.e., claims submitted by ODS counties for non-NTP services provided to out-of-county beneficiaries will not be allowed. Under DMC-ODS selective contracting provisions, providers in an ODS county do not have the option to bypass the county and contract directly with the state.

- **NO, CoR = STATE PLAN/NON-ODS**
  - **Is the County of Service (CoS) a state plan/non-ODS county?**
    - **YES**
      - **CoR and CoS are state plan counties:**
        - **Option 1:** CoR may enter into a contract with the out-of-county provider.
        - **Option 2:** The CoS and CoR may enter into an MOU with each other to allow the exchange of behavioral health subaccount funds. The CoS could then continue to pay the provider and submit claims, while the CoR reimburses the CoS for the non-federal share of cost.
        - **Option 3:** A provider in a state plan (or non-DMC) county may seek a direct contract with the state for state plan services. The state will then pay the provider and invoice the CoR for the non-federal share of cost. A county may attempt to refer a beneficiary back to a state plan county for in-county services, but the state plan county is not an ODS and may or may not have a single process for intake, coordination, and referrals. Counties may wish to consider establishing MOUs to minimize disruption of services, as noted below.
    - **NO**

**Outcome**

**CoR = ODS and CoS = state plan:**

- **Option 1:** CoR may enter into a contract with the out-of-county provider.
- **Option 2:** If the CoR does not wish to contract with the out-of-county provider, the CoS may refer the beneficiary back to the CoR for care coordination and referral to a provider within the ODS.
- **Option 3:** The CoS and CoR may enter into an MOU with each other to allow the exchange of behavioral health subaccount funds. The CoS could then continue to pay the provider and submit claims, while the CoR reimburses the CoS for the non-federal share of cost.

**CoR = state plan and CoS = ODS:**

- **Option 1:** CoR may enter into a contract with the out-of-county provider, or must otherwise ensure its beneficiary has access to state plan services. Because an ODS county operates as a managed care plan, the ODS county is unavailable to provide DMC services – with the exception of state plan NTP services - to beneficiaries from other counties. I.e., claims submitted by ODS counties for non-NTP services provided to out-of-county beneficiaries will not be allowed. Under DMC-ODS selective contracting provisions, providers in an ODS county do not have the option to bypass the county and contract directly with the state.

**CoR provides non-federal share of Medi-Cal payments and receives FFP.**

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*No county is obligated to contract with a given provider or render payment for services for out-of-county beneficiaries. Counties may wish to establish MOUs with neighboring counties to outline notification and referral protocols that minimize disruption of services for beneficiaries who do seek services outside their counties of residence and/or are undergoing Medi-Cal transfers.
Adolescent SUD Treatment

Where does EPSDT come in?

Medically necessary SUD services for Medi-Cal eligible youth under 21 years of age are guaranteed under EPSDT, but delivered and billed through the Drug Medi-Cal delivery system (subject to certain authorization and documentation requirements).

- When co-occurring disorders are treated strictly through specialty mental health, DMC regulations do not apply.
- If specialized SUD treatment is medically necessary and delivered through a DMC-certified program rather than through specialty mental health, DMC regulations and/or 1115 Waiver STCs do come into play. But EPSDT rules take precedence. This leads to two possible scenarios:
Adolescent SUD Treatment (cont.)

- **State Plan county**: Residential SUD treatment for non-perinatal populations is not a covered State Plan benefit. But under EPSDT the adolescent is entitled to this service, assuming that medical necessity criteria and rules for authorization are met. Services can be billed through Short-Doyle using perinatal residential billing codes with a modifier. Length of stay depends on medical necessity and proper authorization.

- **ODS county**: Youth residential stays of longer than 30 days (plus one continuous 30-day extension per year) are not covered under the STCs. However, if a longer stay is medically necessary and properly authorized, the EPSDT entitlement takes precedence, much as it does in the State Plan scenario.
Adolescent SUD Treatment (cont.)

How is medical necessity determined for youth?

• EPSDT broadens the definition of medical necessity for youth, and makes the full SUD benefit package available to all individuals up to age 21 without any caps or limitations, assuming medical necessity is established.

• Medical necessity can only be determined after a full ASAM assessment (including the ASAM adolescent treatment criteria), which includes an assessment for an SUD diagnosis from the DSM. Screenings do not include sufficient information to determine medical necessity.

• In order to meet medical necessity criteria, youth and young adults under the age of 21 must meet at least one of the following criteria:
  - Have at least one diagnosis from the current DSM, and meet the ASAM criteria for medically-necessary services; OR
  - Be assessed to be “at-risk” for developing a substance use disorder.
Adolescent SUD Treatment (cont.)

What is the definition of “at risk” for youth up to age 21?

• Youth or young adults under the age of 21 may be determined to be “at risk” if they meet the following criteria:
  1. If the substance use does NOT meet the minimum criteria for a substance use disorder from the DSM-5; **AND**
  2. Determined to be at-risk of developing a substance use disorder based on reports of experimental or early-phase substance use, associated biopsychosocial risk factors, and information gathered from the full ASAM assessment and At-Risk Determination Tool.

• The “at-risk” designation must be determined either by an LPHA, or by a counselor (registered or certified) with signature approval from an LPHA.

Important to remember: **Federal EPSDT requirements supersede state Medi-Cal requirements, and the DMC-ODS Waiver does not override EPSDT.**
Contact Information

Kirsten Barlow, Executive Director
kbarlow@cbhda.org

Mary Ader, Deputy Director, Legislative Affairs
mader@cbhda.org

Tom Renfree, Deputy Director, Substance Use Disorder Services
trenfree@cbhda.org

Paula Wilhelm, Senior Policy Analyst
pwilhelm@cbhda.org

County Behavioral Health Directors Association of California
www.cbhda.org