DMC-ODS

... and assorted SUD topics

Tom Renfree & Paula Wilhelm

CIBHS Fiscal Leadership Institute
December 12, 2017
Who’s in the room?

• **How many are:**
  - New to SUD finance?
  - DMC-ODS opt-in counties?
  - Currently providing ODS services?
  - Part of the Partnership ODS model?
Session objectives:

What would you like to learn or discuss?
Agenda

1. ODS refresher
2. Key fiscal changes
3. FAQs and discussion
4. Other SUD “hot issues”
5. Q & A
# ODS refresher: expanded benefits

<table>
<thead>
<tr>
<th>Standard DMC Benefits (available to beneficiaries in all counties)</th>
<th>Pilot Benefits (only available to beneficiaries in pilot counties)</th>
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<tbody>
<tr>
<td>Outpatient Drug Free Treatment</td>
<td>Outpatient Services</td>
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<tr>
<td>Intensive Outpatient Treatment</td>
<td>Intensive Outpatient Services</td>
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<td>Naltrexone Treatment (oral for opioid dependence or with TAR for other)</td>
<td>Naltrexone Treatment (oral for opioid dependence or with TAR for other)</td>
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<tr>
<td>Narcotic Treatment Program (methadone)</td>
<td>Narcotic Treatment Program (methadone + additional medications)</td>
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<td>Perinatal Residential SUD Services (limited by IMD exclusion)</td>
<td>Residential Services (not restricted by IMD exclusion or limited to perinatal)</td>
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<td>Detoxification in a Hospital (with a TAR)</td>
<td>Withdrawal Management (at least one level)</td>
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<td>Recovery Services</td>
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<td>Case Management</td>
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<td>Physician Consultation</td>
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<td>Partial Hospitalization (optional)</td>
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<td>Additional Medication Assisted Treatment (optional)</td>
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ODS refresher: Pre-ODS delivery system

Community Health and Social Services
(Prevention, Screening, and Brief Intervention Services)

Self-Referrals
(Client, Family Member, etc.)

Withdrawal Management

Residential Treatment

Intensive Outpatient Services

Outpatient Services

Recovery Support Services

ODS refresher: ODS organized delivery system

Community Health and Social Services (Prevention, Screening, and Brief Intervention Services)

SUD Continuum of Care

- Withdrawal Management
- Residential Treatment
- Intensive Outpatient Services
- Outpatient Services
- Recovery Support Services

Intake, Assessment and Placement

Key fiscal changes under ODS

• County-specific interim rates
  ▪ Resources:
    ✓ ODS rate-setting workgroup calls: 2:00 p.m. on 2nd & 4th Thursdays
    ✓ Fiscal plan guide: DHCS IN 16-050
    ✓ Fiscal considerations FAQs: http://www.dhcs.ca.gov/provgovpart/Pages/FAQs_Fact_Sheets.aspx

• New CPE protocol
  ▪ Resources:
    ✓ Fiscal Provisions: DHCS IN 15-034

• Billing for expanded services
  ▪ Resources:
    ✓ Procedure Codes and Modifiers: DHCS IN 17-045
    ✓ Claiming webinar: http://www.dhcs.ca.gov/provgovpart/Pages/DMC_ODS_Webinars.aspx

▪ Different same-day billing rules
  ▪ Resources:
    ✓ DHCS IN 17-039 and same-day billing matrix
ODS rate-setting

DHCS same-day billing matrix

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# Billing & services comparison

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<th>Regular State Plan Services</th>
<th>Waiver Services</th>
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<tr>
<td><strong>Outpatient, intensive outpatient, residential, and narcotic</strong></td>
<td>County must provide outpatient, intensive outpatient, residential, and narcotic treatment.</td>
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<tr>
<td>treatment are available</td>
<td>Residential treatment includes several levels (3.1, 3.3, 3.5). County must provide at least one level initially and all levels with 3 years</td>
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<tr>
<td>Residential treatment is an optional service</td>
<td>- no bed capacity limit</td>
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<tr>
<td>- 16-bed capacity limit</td>
<td>- all populations allowed (men, youth, peri or non-peri)</td>
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<tr>
<td>- Perinatal beneficiaries only</td>
<td>- provider’s level designated by SUD Compliance.</td>
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<tr>
<td>Methadone is the only medication assisted treatment (MAT),</td>
<td>Additional MAT available in NTP programs and non-NTP programs:</td>
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<td>available only in narcotic treatment programs (NTPs)</td>
<td>- NTP MAT: Buprenorphine, Naloxone, Disulfiram</td>
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<tr>
<td>Withdrawal management: only available as fee for service</td>
<td>- non-NTP MAT: county identifies those they will provide</td>
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<tr>
<td>Case management, physician consultation, recovery services are</td>
<td>Withdrawal management includes several levels (1, 2, 3.2). County must provide at least one level</td>
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<td>not allowable services</td>
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<tr>
<td>Partial hospitalization and additional medication assisted</td>
<td>Partial hospitalization and additional MAT are optional services.</td>
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<td>treatment (MAT) are not allowable services</td>
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<td>Rates/Units of Service/Billing</td>
<td>Interim rates are set by the county, approved by DHCS. SMA does not apply.</td>
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<td>Rates are set by DHCS (state maximum allowance - SMA)</td>
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<td>Separate rates for ODF individual and ODF group counseling</td>
<td>Group and individual counseling will have same rate.</td>
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<td>Units of service (UOS) vary depending on service (i.e., ODF</td>
<td>UOS = 15 minutes for all services, except UOS = daily for partial hospitalization, withdrawal management, residential, and UOS = 10 minutes for NTP counseling</td>
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<td>group is 90 minutes; ODF individual is 50 minutes)</td>
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<td>No 'formula used to determine group minutes per beneficiary</td>
<td>Formula used to determine group counseling minutes for each beneficiary</td>
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<td>Fractional units of service are not allowed; county must pro-rate the cost</td>
<td>Fractional units are allowed.</td>
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<td>Multiple billing override code is needed for multiple services</td>
<td>No multiple billing override code, but some services are not allowed on the same day (see lockout table)</td>
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<td>in one day</td>
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<td>National Drug Code (NDC) not required on 837P</td>
<td>NDC is required on 837P</td>
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ODS FAQs

• Can ODS counties bill for services that do not take place at a certified DMC site?
• Can counties bill for services provided by registered AOD counselors who are not yet certified?
• Can providers that provide only detox bill for this as a stand-alone service under the DMC-ODS?
• The ICD-10 remission codes for claiming recovery services under the DMC-ODS are inconsistent with the DSM-V diagnoses required for treatment planning and documentation. Can we use DSM-V for billing?
• What code can I use to claim recovery services for a client without a prior dependence diagnosis (e.g., individuals coming-from self-help programs or incarceration)?
• Under the DMC-ODS waiver for a residential service claim, can counties submit claims for continuous multiple days of residential treatment services, or do we have to submit separate claims for each day?
• Can counties use SAPT block grant funds to pay for room & board for residential treatment clients?
• What about using SAPT dollars to fund services while Medi-Cal eligibility is verified or transferred?
• Can counties pay each other for services rendered to out-of-county beneficiaries?
• What happens if my county’s resident receives services from a site that has a direct contract with DHCS?
• Can ODS counties bill for early intervention services for youth who are at risk of developing an SUD?
What questions do you have for each other?
ODS resource pages

- **DHCS ODS homepage**

- **DMC-ODS STCs and CPE protocol**
  - [http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx)

- **DMC-ODS webinars**
  - [http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx)
    - Includes presentation on ODS claiming and extensive 3-part fiscal overview

- **Fact Sheets, FAQs, and Information Notices**
  - [http://www.dhcs.ca.gov/provgovpart/Pages/FAQs_Fact_Sheets.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/FAQs_Fact_Sheets.aspx)
    - Includes FAQs on billing and fiscal considerations

- **CIBHS waiver trainings homepage**
  - [https://www.cibhs.org/dmc-ods-waiver-trainings](https://www.cibhs.org/dmc-ods-waiver-trainings)

- **CBHDA committee pages**
  - [http://www.cbhda.org/member-info/committees/](http://www.cbhda.org/member-info/committees/)
    - SAPT
    - Medi-Cal Policy
    - Financial Services
SUD Hot Issues

• County of Responsibility transition
• AB 395
  ▪ 6 months for DMC claim submission!
• Final Rule & Parity implementation
  ▪ ODS counties = Prepaid Inpatient Health Plans
    ✓ Beneficiary informing, grievances & appeals, EQRO, QA and UM processes
  ▪ Statewide network adequacy standards (codified in AB 205)
  ▪ Parity: provider credentialing, continuity of care, informing
  ▪ CBHDA resource page: http://www.cbhda.org/member-info/committees/medi-cal-policy/federal-regulations-resources/
• Prop 64
  ▪ Portion of revenues to be dedicated to youth prevention, early intervention, & treatment services
• EPSDT and youth SUD services
  • Billing for youth residential in state plan counties: DHCS IN 16-063
Drum Medi-Cal County of Responsibility Flow Chart

Counties may use this tool as a companion to DHCS Information Notice (IN) 17-036: Drug Medi-Cal County of Responsibility Transition. *Please contact Paula at pwi@elm@cbhda.org with questions.

Referral scenarios

- Is the County of Service (CoS) a waiver county?
  - Yes: CoR = ODS WAIVER
  - No: CoR = STATE PLAN/NON-ODS

- Is the County of Responsibility (CoR) an ODS waiver county?
  - Yes: Is the County of Service (CoS) a state plan/non-ODS county?
    - Yes: 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 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: CoR provides non-federal share of Medi-Cal payments and receives FFP.

- 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.

*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.
AB 395: SUD Treatment Providers

• **AB 395 – Substance Use Treatment Providers** (Co-Sponsored/Support)

  ➢ **What it Does:** Requires Drug Medi-Cal claims from providers and counties to be submitted to the Department of Health Care Services (DHCS) within a six-month timeframe and updates laws governing medication-assisted treatment.

  ➢ **Background:** This bill was co-sponsored by CBHDA. The Drug Medi-Cal (DMC) program was realigned to counties in 2011, but is still subject to certain state regulations that restrict service provision. An example of such a restriction is a state-only requirement that claims for DMC services must be submitted to the DHCS not later than 30 days after the end of the month in which the service was provided. This short 30-day window for submitting claims is inconsistent with both federal Medicaid law and other Medi-Cal fee-for-service timeframes and has been an administrative burden for counties and providers. AB 395 will add a simple provision to the Welfare & Institutions Code requiring DMC claims from providers and counties to be submitted within a six-month timeframe, consistent with Medi-Cal fee-for-service requirements. AB 395 also authorizes narcotic treatment programs to utilize all federally-approved medications for the treatment of addiction, and strikes the 20-patient limit applied to office-based providers.
AB 205: Network Adequacy

- **What it Does:** Codifies key provisions of the Medicaid Managed Care Final Rule, including grievance and appeals systems and statewide network adequacy standards.

- **Background:** In May 2016 CMS published the extensive and detailed Medicaid Managed Care Final Rule. The Final Rule is the first significant update to managed care regulations in almost two decades and includes significant changes related to network adequacy requirements and beneficiary protections, including grievance and appeals systems. County Mental Health Plans and counties opting into the DMC Organized Delivery System waiver must comply with the Final Rule. The grievance and appeals requirements in the bill align with the Final Rule, including compliance with updated timelines for standard and expedited resolutions of grievances and appeals and state fair hearing processes. The bill also adopts network adequacy standards for time and distance and timely access proposed by DHCS in July 2017, but changes the methodology by which counties are categorized as rural, small, medium or large (see next slide).
## AB 205 and Final Rule network adequacy standards

### Table 1. California’s Final Network Standards

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Time and Distance</th>
<th>Timely Access for Non-Urgent1 Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder Outpatient Services</td>
<td>Based on county population size as follows: Rural Counties: 60 miles or 90 minutes from the beneficiary’s residence Small Counties: 60 miles or 90 minutes from the beneficiary’s residence Medium Counties: 30 miles or 60 minutes from the beneficiary’s residence Large Counties: 15 miles or 30 minutes from the beneficiary’s residence</td>
<td>Within 10 business days to appointment from request</td>
</tr>
</tbody>
</table>

### Substance Use Disorder Opioid Treatment Programs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Within 3 business days to appointment from request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Counties: 60 miles or 90 minutes from the beneficiary’s residence Small Counties: 45 miles or 75 minutes from the beneficiary’s residence Medium Counties: 30 miles or 60 minutes from the beneficiary’s residence Large Counties: 15 miles or 30 minutes from the beneficiary’s residence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### County Size Designation Changes: Population Size Methodology v. Population Density Methodology

<table>
<thead>
<tr>
<th></th>
<th>Population Size (DHCS proposed standard)</th>
<th>Population Density (new and final standard)</th>
<th>Counties with Changed Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural  (60 miles/90 minutes)</td>
<td>Small (45 miles/75 minutes)</td>
<td>Lake Amador Madera Nevada El Dorado Kings Yuba Sutter Napa</td>
<td></td>
</tr>
<tr>
<td>Small  (45 miles/75 minutes)</td>
<td>Medium (30 miles/60 minutes)</td>
<td>Placer Sonoma Stanislaus Ventura Marin San Joaquin Solano Santa Cruz</td>
<td></td>
</tr>
<tr>
<td>Small  (45 miles/75 minutes)</td>
<td>Dense (15 miles/30 minutes)</td>
<td>San Francisco</td>
<td></td>
</tr>
<tr>
<td>Medium (30 miles/60 minutes)</td>
<td>Dense (15 miles/30 minutes)</td>
<td>San Diego Santa Clara Contra Costa Sacramento San Mateo Alameda Orange</td>
<td></td>
</tr>
<tr>
<td>Medium (30 miles/60 minutes)</td>
<td>Small (45 miles/75 minutes)</td>
<td>San Bernardino</td>
<td></td>
</tr>
</tbody>
</table>

### Sources:
See also:
1) AB 205: [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB205](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB205)
**AB 205 Final Rule network adequacy standards: AB 205 text**

**Article 6.3. Medi-Cal Managed Care Plans**

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time and distance standards for the following services:

\[\ldots\]

4 (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary’s place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary’s place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary’s place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary’s place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary’s place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary’s place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary’s place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.
AB 205 Final Rule network adequacy standards: AB 205 text

[Reference to Knox-Keene standards for timeliness of urgent appointments]
(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any allowable exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

... 

[Timeliness of NTP appointments]
(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

... 

[Process for requesting alternative access standards]
(2) If a Medi-Cal managed care plan cannot meet the time and distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department. A request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time and distance standards, if known at that time.

(3) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan’s proposal, the department shall inform the Medi-Cal managed care plan of the department’s reason for rejecting the proposal. The department shall post any approved alternative access standards on its Internet Web site.
Other questions?
Contact Information

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
Appendices

ODS fiscal webinars
from DHCS & Harbage Consulting

Combined Content from DMC-ODS County Technical Assistance Webinars: Fiscal Provisions Parts I, II, and III
Overview of Presentation

- Overview of Fiscal Terms & Conditions
- County Fiscal Plan Requirements
- Cost Report
- Short Doyle 2 Claims & Coding Requirements
- DMC-ODS Health Care Procedure Coding System
- Interim Rates Development Strategy – County Example
- Resources & Contact Information
Overview of Fiscal Terms & Conditions
Fiscal Terms & Conditions

• **Certified Public Expenditure.** Counties will certify the total allowable expenditures incurred in providing DMC-ODS pilot services through county operated or contracted providers. The CPE protocol must be approved by CMS before FFP will be made available.

• **County-Specific Rates.** Counties will develop proposed county-specific interim rates for each covered service (except for NTP) subject to state approval.

• **2011 Realignment Provisions / BH Subaccount.** 2011 Realignment requirements related to the BH Subaccount will remain in place and the state will continue to assess and monitor county expenditures for the realigned programs.
Fiscal Terms & Conditions (cont.)

- **Federal Financial Participation (FFP).** FFP will be available to contracting pilot counties who certify the total allowable expenditures incurred in delivering covered services.

- **County-Operated Providers.** County-operated providers will be reimbursed based on actual costs.

- **Subcontracted Providers.** Subcontracted fee-for-service providers and managed care plans will be reimbursed based on actual expenditures.

- **CPE Protocol.** Approved & posted to DHCS website (http://www.dhcs.ca.gov/provgovpart/Documents/DMCAAttachmentA A.pdf)
CPE Protocol Critical Elements

- **Inflation Factor.** CMS has approved the State’s choice of using the Medicare Home Health Agency Market Basket Index for the DMC ODS inflation factor. The inflation factor is 2.4% for the 16/17 fiscal year.

- **Lower of Cost or Charge.** Cost settlement will be subject to the lower of cost or customary charge.

- **Cost Report.** CMS will approve modifications to the cost report worksheets that are used for the FY 16/17 settlement.
Key Elements of IN 15-034 (DMC-ODS Fiscal Provisions) – August 20, 2015

- **Federal Reimbursement Structure.** FFP will be available to counties subject to federal certified public expenditure requirements outlined in the Code of Federal Regulations and the Social Security Act.

- **Cost Reporting.** Each provider must submit annually a cost report that reflects the individual providers cost of serving Medi-Cal beneficiaries.

- **Interim Rate-Setting.** Counties may use their recently filed cost reports to develop proposed interim rates for federal cash flow purposes and may trend those rates by an applicable health care related index.

- **Reconciliation.** Final reconciliation will be performed annually by reconciling the interim payments made to the government entity (county) to the finalized cost report for the year in which the interim payments were made. Over and under payments of federal funds to the government entity (county) will be determined based on this reconciliation.
County Fiscal Plan Requirements
County Fiscal Plan Requirements

- **Annual Fiscal Plan.** Counties are required to complete and submit an Annual County Fiscal Plan following DHCS guidance.
- **DHCS Review and Approval.** DHCS will review and approve the plan annually.
- **Interim Rates.** Proposed interim rates must be developed for each required and selected optional service specified in the waiver.
- **Supporting Information.** Counties must provide supporting information consistent with state and federal guidance for each proposed rate.
- **Sources.** Appropriate sources of information include filed cost reports, approved medical inflation factors, detailed provider direct and indirect service cost estimates and verified charges made to other third party payers for similar programs.
County Fiscal Plan Requirements (cont.)

- **Residential Rates.** Proposed residential rates must include clear differentiation between treatment and non-treatment room and board costs.

- **Outpatient Rates.** Proposed outpatient treatment rates should include all assessment, treatment planning and treatment provision direct and indirect costs consistent with coverage and program requirements outlined in state and federal guidance.

- **Admin, QI, UR, etc.** County administrative, quality improvement, authorization, and utilization review activities may be claimed separately consistent with state and federal guidance.
Cost Report
Annual Cost Report Requirements

• **Provider Cost Report.** Each provider will submit an annual cost report that reflects the services rendered to Medi-Cal beneficiaries consistent with the authorities specified in the approved terms and conditions of the waiver.

• **County Cost Report.** Contracting counties will submit an annual cost report that summarizes the total directly delivered actual costs and contracted fee for service provider expenditures for the covered services.

• **Reconciliation.** These actual costs and expenditures will be reconciled to the interim payments made throughout the year to determine if a federal overpayment or under payment was made to the county.
Annual Cost Report Requirements (cont.)

• **New Forms.** DHCS will require the new cost report forms that were approved in State Plan Amendment 15-013.

• **DMC-ODS Version.** The DMC-ODS version of the new cost report forms will include the additional DMC-ODS services (e.g. case management and withdrawal management) and additional sections per each tab where applicable.

• **Cost Allocation Tab.** The most significant adjustment to the cost report forms will be the shift from using the state rate to the county interim rate as the amount entered on the cost allocation tab per each modality and service type.
Short Doyle 2 Claims & Coding Requirements
Short Doyle 2 Claims & Coding Requirements

- **Same Transaction.** DMC-ODS claims will be processed by Short Doyle 2 in the same manner as regular DMC claims using the 837P Transaction.

- **New Procedures Codes and Modifiers.** There will be several new procedure codes and modifiers (published in Information Notice 16-057, and the pending DMC-ODS Billing Manual).

- **Different Same-Day Billing Rules.** The rules for Same Day Billing are different (refer to MHSUDS Information Notice 16-007).
DMC-ODS Health Care Procedure Coding System
New procedure codes will be added for the DMC-ODS services:

- Non-perinatal Residential
- Partial Hospitalization
- Withdrawal Management
- Case Management
- Physician Consultation
- Recovery Services
- Additional Medication Assisted Treatment
# DMC-ODS Health Care Procedure Coding System (HCPCS) - Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DMC ODS Service</th>
<th>HCPCS Description</th>
<th>Units of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9008</td>
<td>Physician Consultation</td>
<td>Coordinated care fee, physician coordinated care oversight services</td>
<td>15 min.</td>
</tr>
<tr>
<td>H0004</td>
<td>Individual Counseling</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
<td>15 min.</td>
</tr>
<tr>
<td>H0005</td>
<td>Group Counseling</td>
<td>Alcohol and/or drug services; group counseling by a clinician</td>
<td>15 min.</td>
</tr>
<tr>
<td>H0006</td>
<td>Case Management</td>
<td>Alcohol and/or drug services; case management</td>
<td>15 min.</td>
</tr>
<tr>
<td>H0012</td>
<td>Residential Withdrawal Management</td>
<td>Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)</td>
<td>Daily</td>
</tr>
<tr>
<td>H0014</td>
<td>Ambulatory Withdrawal Management</td>
<td>Alcohol and/or drug services; ambulatory detoxification</td>
<td>Daily</td>
</tr>
<tr>
<td>H0015</td>
<td>Intensive Outpatient Treatment</td>
<td>Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education (billed in 15 minute increments)</td>
<td>15 min.</td>
</tr>
</tbody>
</table>
## DMC-ODS Health Care Procedure Coding System (HCPCS) - Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DMC ODS Service</th>
<th>HCPCS Description</th>
<th>Units of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0019</td>
<td>Residential</td>
<td>Behavioral health: long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
<td>Daily</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone Dosing</td>
<td>Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)</td>
<td>Daily</td>
</tr>
<tr>
<td>H2010</td>
<td>MAT (non-NTP)</td>
<td>Comprehensive medication services, per 15 minutes</td>
<td>15 min.</td>
</tr>
<tr>
<td>S0201</td>
<td>Partial Hospitalization</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
<td>Daily</td>
</tr>
<tr>
<td>S5000</td>
<td>MAT (NTP)</td>
<td>Prescription drug, generic</td>
<td>Daily</td>
</tr>
<tr>
<td>T1012</td>
<td>Recovery Services – Recovery Monitoring/Substance Abuse Assistance</td>
<td>Alcohol and/or substance abuse services, skills development</td>
<td>15 min.</td>
</tr>
</tbody>
</table>
DMC-ODS Health Care Procedure Coding System (HCPCS) - Modifiers

- **New Modifiers.** New modifiers will be needed to differentiate between:
  - The new services as they are delivered in the various modalities
  - The different ASAM Levels of Care
  - Adult and youth services

- **NDC.** The National Drug Code will be needed to differentiate between the various additional medications that will be offered
# DMC-ODS Health Care Procedure Coding System (HCPCS) - Modifiers

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Types of Service/Level of Care</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA</td>
<td>Youth Services</td>
<td>Child/adolescent program</td>
</tr>
<tr>
<td>HD</td>
<td>Perinatal Services</td>
<td>Pregnant/parenting women’s program</td>
</tr>
<tr>
<td>HG</td>
<td>ASAM OTP/Narcotic Treatment Program (NTP)</td>
<td>Opioid addiction treatment program</td>
</tr>
<tr>
<td>U1</td>
<td>ASAM 3.1 Residential</td>
<td>Medicaid level of care 1, as defined by each state</td>
</tr>
<tr>
<td>U2</td>
<td>ASAM 3.3 Residential</td>
<td>Medicaid level of care 2, as defined by each state</td>
</tr>
<tr>
<td>U3</td>
<td>ASAM 3.5 Residential</td>
<td>Medicaid level of care 3, as defined by each state</td>
</tr>
<tr>
<td>U4</td>
<td>ASAM 1-Withdrawal Management</td>
<td>Medicaid level of care 4, as defined by each state</td>
</tr>
<tr>
<td>U5</td>
<td>ASAM 2-Withdrawal Management</td>
<td>Medicaid level of care 5, as defined by each state</td>
</tr>
<tr>
<td>U6</td>
<td>ODS Recovery Services</td>
<td>Medicaid level of care 6, as defined by each state</td>
</tr>
<tr>
<td>U7</td>
<td>ODS ASAM 1 Outpatient Drug Free</td>
<td>Medicaid level of care 7, as defined by each state</td>
</tr>
<tr>
<td>UB</td>
<td>ODS ASAM 2.0 Intensive Outpatient Treatment</td>
<td>Medicaid level of care 8, as defined by each state</td>
</tr>
<tr>
<td>UA</td>
<td>ODS ASAM OTP/NTP</td>
<td>Medicaid level of care 10, as defined by each state</td>
</tr>
<tr>
<td>UB</td>
<td>ODS ASAM 2.5 Partial Hospitalization</td>
<td>Medicaid level of care 11, as defined by each state</td>
</tr>
<tr>
<td>NDC</td>
<td>MAT (NTP)</td>
<td>National Drug Code</td>
</tr>
</tbody>
</table>
Interim Rates Development Strategy – County Example
County “X” Interim Rate Strategy

Residential Treatment Rate:

15/16 contracted bed day UOS rate  (weighted average of contractors)

x Additional cost to operate the program as DMC – 8%

x 16/17 inflation-related UOS rate increase – 4.5%

x % of UOS cost that is treatment (not room & board) – 73%

= DMC-ODS Residential UOS Rate
Count “X” Interim Rate Strategy

Projected Units:

14/15 actual bed days provided
x % of clients in 15/16 who are Medi-Cal beneficiaries
x % projected increase in number of residential clients
x % projected increase in residential length of stay
x % fully operational residential services that will be implemented in 16/17

= Residential UOS projected to be delivered in 16/17
County “X” Interim Rate Strategy

Outpatient Treatment Rate:

15/16 contracted OP UOS rate (weighted average of contractor rates)

x Adjustment for how DMC counts billable hours vs. how County currently counts NNA claimable hours (e.g., 15-minute increments vs 50 minutes; FTF vs. non-FTF vs. indirect)

x Additional cost to operate the program as DMC – 8%

x 16/17 inflation-related UOS rate increase – 4.5%

= DMC-ODS Outpatient UOS Rate
Projected Units:

14/15 actual OP UOS provided
x % of clients in 15/16 who are Medi-Cal beneficiaries
x % projected increase in number of OP clients
x % fully operational OP services that will be implemented in 16/17

= Outpatient UOS projected to be delivered in 16/17
Resources & Contact Information
FAQs and Information Notices

- DMC-ODS Fiscal Considerations FAQ:
  http://www.dhcs.ca.gov/provgovpart/Pages/FAQs_Fact_Sheets.aspx

- DMC-ODS Information Notices:
  http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Information_Notices.aspx
California Department of Health Care Services

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Drug Medi-Cal Organized Delivery System Claiming

Technical Assistance Webinar for Counties
February 2, 2017
Overview of Presentation

• DMC-ODS Healthcare Common Procedure Coding System
• DMC Billing Manual & New DMC-ODS Waiver Chapter
• Questions and Discussion
DMC-ODS Healthcare Common Procedure Coding System (HCPCS)
Information Notice 17-002

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) AND MODIFIERS

– Supersedes IN 16-057

DMC ODS HCPCS and Modifiers

• Once a county has opted-in to the DMC-ODS Pilot, the old codes and modifiers will not be sufficient to get the claim approved in the Short-Doyle Medi-Cal system. New combinations of HCPCS codes and modifiers will need to be submitted on the 837P claim file.
• HG – Opioid addiction treatment program
  – We will continue to use the HG modifier on the OTP/NTP claims, unless the claim is for Recovery Services.

• HD – Pregnant/parenting women's program
  – We will continue to use the HD modifier to identify perinatal and post-partum women’s services.
HCPCS Modifiers – (cont.)

• HA – Child/adolescent program
  – We have included the HA modifier to distinguish between adult and child/youth services in the DMC-ODS. Any beneficiary under the age of 21 will need to have this modifier on every claim to assure correct claim adjudication.
U Codes – Level of Care

- U1 – 3.1 RES
- U2 – 3.3 RES
- U3 – 3.5 RES
- U4 – 1-WM
- U5 – 2-WM
- U6 – Recovery Services

- U7 - ODF
- U8 - IOT
- U9 – 3.2-WM
- UA – OTP/NTP
- UB – Partial Hospitalization
Recovery Services

• Recovery Services have some unique characteristics.
  – Recovery Services are available for each DMC-ODS level of care.
  – Recovery Services are available to beneficiaries that have completed treatment.
  – Recovery Services cannot be claimed in combination with any other treatment service.
Recovery Services (cont.)

• The components of Recovery Services include:
  – Individual counseling – H0004/U6
  – Group counseling – H0005/U6
  – Case management – H0006/U6
  – Recovery monitoring/substance abuse assistance – T1012/U6
National Drug Codes (NDC)

• Medication Assisted Treatment (MAT) with HCPCS S5000 and S5001 will need to use the NDC for the medication that is administered.
  – OTP/NTP MAT is required to provide buprenorphine, disulfiram, and naloxone to beneficiaries.
  – S5000/S5001 with the UA modifier and the correct NDC will be necessary for correct claim adjudication.
National Drug Codes (NDC) (con’t)

- Non-OTP/NTP MAT is optional for counties that choose to provide additional medications to beneficiaries.
  - The ODS county will set rates for these non-OTP/NTP medications.
  - S5000/S5001 with the appropriate U code modifier and the correct NDC will be necessary for correct claim adjudication.
Same Day Billing

• DMC-ODS Same Day Billing rules (Information Notice 16-007) have eliminated the need for the Multiple Billing Override code.
  – **Note:** Same Day Billing in more than one level of care will be restricted to combinations with OTP/NTP to allow for cases where methadone dosing is part of the necessary treatment for any beneficiary in any other level of care.
Short Doyle Medi-Cal Claiming

• In order to submit correctly coded claims for the DMC-ODS services beginning on the “Go Live” date and forward, each DMC-ODS county will need to use the new HCPCS code and modifier combinations that have been identified in IN 17-002.
DMC Billing Manual & New DMC-ODS Waiver Chapter
Overview

• The purpose of the DMC Billing Manual is to provide counties and direct providers with information on how to submit a claim for reimbursement for DMC services rendered.

• The DMC-ODS waiver chapter provides direction to counties that have an executed Intergovernmental Agreement with DHCS to administer waiver services.

• Updated DMC Billing Manual posted on the DHCS website:
Overview (cont.)

- Most federal and state regulations that pertain to DMC billing for regular state plan services are still applicable in the DMC-ODS.
- Only counties can opt-in to the waiver.
- Detailed guidance for DMC-ODS billing is outlined in Chapter 6 and related Information Notices.
New DMC-ODS Services

• Case Management
• Physician Consultation
• Withdrawal Management
• Medication Assisted Treatment
• Partial Hospitalization
## Services Comparison

<table>
<thead>
<tr>
<th>Regular State Plan Services</th>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient, intensive outpatient, residential, and narcotic treatment are available</td>
<td>County must provide outpatient, intensive outpatient, residential, and narcotic treatment</td>
</tr>
<tr>
<td>Residential treatment is an optional service</td>
<td>Residential treatment includes several levels (3.1, 3.3, 3.5). County must provide at least one level initially and all levels with 3 years</td>
</tr>
<tr>
<td>- 16-bed capacity limit</td>
<td>- no bed capacity limit</td>
</tr>
<tr>
<td>- Perinatal beneficiaries only</td>
<td>- all populations allowed (men, youth, peri or non-peri)</td>
</tr>
<tr>
<td>Methadone is the only medication assisted treatment (MAT), available only in narcotic treatment programs (NTPs)</td>
<td>Additional MAT available in NTP programs and non-NTP programs: - NTP MAT: Buprenorphine, Naloxone, Disulfiram - non-NTP MAT: county identifies those they will provide</td>
</tr>
<tr>
<td>Withdrawal management: only available as fee for service</td>
<td>Withdrawal management includes several levels (1, 2, 3.2). County must provide at least one level</td>
</tr>
<tr>
<td>Case management, physician consultation, recovery services are not allowable services</td>
<td>County must provide case management, physician consultation, and recovery services</td>
</tr>
<tr>
<td>Partial hospitalization and additional medication assisted treatment (MAT) are not allowable services</td>
<td>Partial hospitalization and additional MAT are optional services</td>
</tr>
<tr>
<td>Rates/Units of Service/Billing</td>
<td>Rates/Units of Service/Billing</td>
</tr>
<tr>
<td>Rates are set by DHCS (state maximum allowance - SMA)</td>
<td>(Interim) rates are set by the county, approved by DHCS. SMA does not apply.</td>
</tr>
<tr>
<td>Separate rates for ODF individual and ODF group counseling</td>
<td>Group and individual counseling will have same rate</td>
</tr>
<tr>
<td>Units of service (UOS) vary depending on service (i.e., ODF group is 90 minutes; ODF individual is 50 minutes)</td>
<td>UOS = 15 minutes for all services, except UOS = daily for partial hospitalization, withdrawal management, residential; and UOS = 10 minutes for NTP counseling</td>
</tr>
<tr>
<td>No formula used to determine group minutes per beneficiary</td>
<td>Formula used to determine group counseling minutes for each beneficiary</td>
</tr>
<tr>
<td>Fractional units of service are not allowed; county must pro-rate the cost</td>
<td>Fractional units are allowed.</td>
</tr>
<tr>
<td>Multiple billing override code is needed for multiple services in one day</td>
<td>No multiple billing override code, but some services are not allowed on the same day (see lockout table)</td>
</tr>
<tr>
<td>National Drug Code (NDC) not required on 837P</td>
<td>NDC is required on 837P</td>
</tr>
</tbody>
</table>
Questions and Discussion

For optimal sound quality, please ensure that you are dialed-in using your phone and that you have inputted your audio PIN.
California Department of Health Care Services

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DMC-ODS Resources

• For additional information, please see the DMC-ODS Frequently Asked Questions posted the DHCS website: http://www.dhcs.ca.gov/provgovpart/Pages/Fact-Sheets-and-FAQs.aspx?

• For questions, please contact dmcodswaiver@dhcs.ca.gov