blue california
Promise Health Plan

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A. PURPOSE

I. To ensure that there is an efficient process of identifying, screening, referring, and coordinating all levels of behavioral health care services for members among health care providers, behavioral health providers, and county agencies, to facilitate seamless, continuous, and medically necessary care.

II. Background

a. Medicaid Mental Health Parity Final Rule (CMS-2333-F), Medi-Cal Specialty Mental Health Services Waiver, and Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit, states that MCPs must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.[1] MCPs must also provide medically necessary non-specialty mental health services to children under the age of 21.[1]

b. Medi-Cal Managed Care Health Plans (MCPs) are required to follow the No Wrong Door for Mental Health Services policy.[9] This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to

maintain treatment relationships with trusted providers without interruption.

c. Per the California Welfare and Institutions Code Section 14132.755, the Dyadic Care Services benefit is a family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventative care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health.

d. Pursuant to the Health and Safety Code (HSC) section 1374.13, and Welfare and Institutions Code (WIC) sections 14132.72, 14132.100, and 14132.725, the Telehealth Services Policy outlines the Covered Services offered through Telehealth modalities and the expectations related to the documentation for Telehealth.

B. DEFINITIONS

1. **Beneficiary** – a means an eligible beneficiary who has enrolled in the MCP.
2. **Behavioral Health Providers (BHP)** – independently licensed behavioral health providers.
3. **County Department of Mental Health (DMH)** – The county department of mental health services who is responsible for specialty mental health services.
4. **County Department of Public Health (DPH)** – The county department of public health services who is responsible for the substance use disorder services.
5. **Current Procedural Terminology (CPT)** – a uniform nomenclature for coding medical procedures and services.
6. **Diagnostic and Statistical Manual for Mental Disorders (DSM)** – the approved listing of diagnoses codes and descriptions used to identify mental disorders.
7. **Dyadic Care Services** – The dyadic services benefit is a family and caregiver focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified and is designed to support the implementation of comprehensive models of dyadic care that works within the pediatric clinic setting to identify and address caregiver and family risk factors for the benefit of the child. The benefit is designed to support implementation of comprehensive models of dyadic care, such as HealthySteps and Dulce.
8. **Emergency Services** – Professional services as described in Title 22, CCR, Section 538552, hospital emergency departments or emergency

physicians for medical screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the plan member. No prior authorization is required.[2]

9. **Health Care Common Procedure Coding System (HCPCS)** – a set of standardized codes used to identify products, supplies, and services.
10. **Home Health Agency Services** – Home Health Agency Services described in Title 22, CCR, Section 51337[5] when medically necessary to meet the physical health and MCP behavioral health care needs of homebound members. A homebound member is one who is essentially confined to home due to illness or injury and if ambulatory or otherwise mobile, is unable to be absent from their home, except on an infrequent basis or for periods of relatively short duration (Title 22, Section 51146).
11. **Hospital Outpatient Department Services** - Professional services and associated room charges for hospital outpatient department services consistent with medical necessity and The Plan's contract with its subcontractor and DHCS.
12. **Local Mental Health Plan (LMHP)** – Los Angeles County Department of Mental Health also referred to in this policy as the County Mental Health Plan (CMHP).
13. **Medi-Cal Managed Care Plan (MCP)** – Refers to The Plan
14. **Member** – means an eligible beneficiary who has enrolled in the MCP.
15. **Nursing Facility Services** – room, board, and all medically necessary medical and other covered services provided to a The Plan member in a nursing facility, in accordance with the terms of The Plan's contract for coverage of long-term care.
16. **Outpatient Laboratory and Radiological Services** – All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a member's mental health condition.
17. Pharmaceutical Services – includes Prescribed Drugs (excluding anti-psychotic drugs, which are covered by Medi-Cal FFS).[1]
18. **Psychiatric Inpatient Hospital Services** - initial health history and physical examination required on admission and any consultations related to medically necessary services.
    a. The Plan is not responsible for room and board charges for psychiatric inpatient hospital stays by members.
19. **Social Determinants of Health (SDOH)** – are the conditions in the environments where people are born, live, learn, work, play worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: economic

stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

20. **Specialty Mental Health Services (SMHS)** – means the following mental health services covered by MHPs:
    a. Outpatient Services:
        i. Mental health services (assessments, plan development, therapy, rehabilitation, and collateral).
        ii. Medication support services.
        iii. Day treatment intensive services.
        iv. Day rehabilitation services.
        v. Crisis intervention services.
        vi. Crisis stabilization services.
        vii. Targeted case management services.
        viii. Therapeutic behavioral services.
    b. Residential services:
        i. Adult residential treatment services.
        ii. Crisis residential treatment services.
    c. Inpatient services:
        i. Acute psychiatric inpatient hospital services.
        ii. Psychiatric inpatient hospital professional services.
        iii. Psychiatric health facility services.
21. **Synchronous Interaction** – "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.
22. **Telehealth** – "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.
23. **Transportation Services** – includes non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F).[4]

C. POLICY

I. Blue Shield of California Promise Health Plan (The Plan) shall provide medically necessary outpatient mental health services that are covered under the Medi-Cal Managed Care Plan (MCP).

II. Primary Care Physicians (PCP) are responsible for providing mental health services that are within the scope of their practice.

III. Services that are beyond the scope of the PCP but are within The Plan's benefit responsibility shall be provided by The Plan's contracted network of licensed mental health providers.

IV. Dyadic Care Services include Dyadic behavioral health (DBH) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

V. Services that would not require an in-person presence of the Member for any reason are available to be engaged via telehealth in accordance with requirements set forth in section 5 of this policy.

VI. Services that qualify as specialty mental health (SMH) services shall be referred to the County Mental Health Plan (CMHP), which maintains responsibility for specialty mental health services. Medi-Cal members can be referred for SMH Services by a licensed clinician or through the Managed Behavioral Health Organization.

VII. The Plan shall cover and ensure the provision of primary medical care and other services unrelated to the specialty mental health treatment and coordinate care between the primary care provider and the CMHP providers as clinically indicated.

VIII. Communication and coordination of mental health services is done through the following process elements:

a. Screening
b. Assessment
c. Referral
d. Evaluation
e. Care Coordination
f. Case Management

D. PROCEDURE

I. Access

a. There are multiple entry paths for The Plan's members to access behavioral health care services. Referrals may be requested by, but not limited to primary care physicians (PCPs), specialty providers, County Departments, Community Based Organizations, case managers, and member self-referrals.
b. In accordance with APL 22-005 No Wrong Door for Mental health Services Policy and the requirements for parity in mental health and substance use disorder benefits in 42 CFR section 438.900, et seq, at any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider with The Plan's provider network without a referral from a PCP or prior authorization.

c. In accordance with APL 22-029, Dyadic Care Services benefit is designed to support the implementation of comprehensive models of dyadic care that works within the pediatric clinical setting to identify and address caregiver and family risk factors for the benefit of the child.
d. In accordance with APL 23-007 Telehealth Services Policy, members can request to access services via audio-only or video modality. Members who receive these services are eligible to receive the same services via in-person.
e. The Plan will not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements in 42 CFR section 438.900, et seq.
f. The Plan has a toll free 800 number that is available 24/7 for general inquiries, member eligibility verification, business hour service authorization requests and after-hour service authorization requests.
g. After-hour requests are coordinated by cross-connecting callers to the afterhours The Plan on-call nurses. The nurses have 24-hour access to The Plan physicians for assistance in making many medically necessity determinations that are beyond the nursing scope of practice. The after-hour nurses are educated and trained in coordinating behavioral health service referrals for all levels of mental health treatment to the appropriate provider network for behavioral health care.
h. As defined by the Medical Management section of the Medi-Cal Provider Manual, Non-Specialty Mental Health Services may be provided by licensed Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, Psychiatrists and Physicians.
i. As defined in the Psychiatric and Psychological Services section of the Medi-Cal Provider Manual, Non-specialty Mental Health services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician.
j. For Dyadic Services, appropriately trained nonclinical staff, including Community Health Workers (CHW), are not precluded from screening Members for issues related to SDOH or performing nonclinical support tasks as a component of the DBH visit, as long as the screening is not separately billed. Under the supervision of a supervising Provider from one of the provider types listed above, CHWs who meet the qualifications listed in the Community Worker (CHW) preventative Services section of the Provider Manual can assist a dyad to gain access to needed services to support their health, through the CHW benefit for health navigation services described in APL 22-016, or any superseding APL.

II. Dyadic Care Services
a. Member Eligibility Criteria

i. Children (members ages 20 or below) and their parent(s)/caregiver(s) are eligible for DBH well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in Title 42 of the United States Code (USC), Section 1396d(r). Under EPSDT standards, a diagnosis is not required to qualify for services.
ii. The family is eligible to receive Dyadic Care Services so long as child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

III. Covered Services

a. The DBH well-child visits do not need a particular recommendation or referral and will be offered as an appropriate service option even if the member does not request them. No authorization is required.
b. The benefit is available through telehealth or in-person with location in any setting including, but not limited to, pediatric primary care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no service location limitations.
c. Covered Dyadic Services are behavioral health services for children (members ages 20 or below) and/or their parent(s) or caregiver(s), and include:
    i. DBH Well-Child Visits
    ii. Dyadic Comprehensive Community Supports Services
    iii. Dyadic Psychoeducational Services
    iv. Dyadic Family Training and Counseling for Child Development
d. Dyadic Parent or Caregiver Services: dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (Member ages 20 or below) as appropriate:
    i. Brief Emotional/Behavioral Assessment
    ii. ACEs Screening
    iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
    iv. Depression Screening
    v. Health Behavioral Assessments and Interventions
    vi. Psychiatric Diagnostic Evaluation
    vii. Tobacco Cessation Counseling
e. Family Therapy
    i. Family therapy is a type of psychotherapy covered under Medi-Cal NSMHS benefit, including for Members ages 20 or below who are at risk for behavioral health concerns.

ii. Family therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.
iii. All family members do not need to be present for each service. For example, parents or caregivers can qualify for family therapy without their infant present, if necessary. The primary purpose of family therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).
iv. This includes:
    1. Members ages 20 or below with a diagnosis of a mental health disorder;
    2. Members ages 20 or below with persistent mental health symptoms in the absence of a mental health disorder;
    3. Members ages 20 or below with a history of at least one of the following risk factors:
        (i) Neonatal or pediatric intensive care unit hospitalization
        (ii) Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment)
        (iii) Death of a parent or caregiver
        (iv) Foster home placement
        (v) Food insecurity, housing instability
        (vi) Maltreatment
        (vii) Severe and persistent bullying
        (viii) Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability; or
    4. Members ages 20 or below who have a parent(s) or caregiver(s) with one or more of the following risk factors:
        (i) A serious illness or disability
        (ii) A history of incarceration
        (iii) Depression or other mood disorder
        (iv) Post-Traumatic Stress Disorder or other anxiety disorder
        (v) Psychotic disorder under treatment
        (vi) Substance use disorder
        (vii) Job loss
        (viii) A history of intimate partner violence or interpersonal violence
        (ix) Is a teen parent
v. The Plan will provide family therapy without regard to the five-visit limitation for Members ages 20 or below with risk factors for mental health disorders or parents/caregivers with related risk factors listed above.
vi. As defined in the Non-Specialty Mental Health Psychiatric and Psychological Services portion of the Medi-Cal Provider Manual, reimbursable family therapy models under the policy include, but are not limited to, Child-Parent

Psychotherapy, Triple P Positive Parenting Program, and Parent Child Interaction Therapy.

IV. Telehealth Services

a. Reimbursable Services

i. Covered Services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.

ii. The Member has provided verbal or written consent

iii. The Medical Record documentation substantiates that the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in the Medi-Cal provider manual.

iv. The Covered Services provided via Telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.

v. The appropriateness of the Telehealth modality was assessed to the Member's level of acuity at the time of the service.

vi. Covered services furnished through video synchronous interaction or audio-only synchronous interaction includes one of the following:

1. Members are offered the same services via in-person, face-to-face contact.
2. A referral is arranged, and a facilitation of, in-person care in which the member is not required to independently contact a different Provider to arrange for that care.

vii. Member Consent

1. Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth.
2. A Member's consent to receive Covered Services via Telehealth prior to the initial delivery of the services are documented in the Member's Medical Record and are made available to the Plan and DHCS upon request.
3. In addition to documenting consent prior to initial delivery of Covered Services via Telehealth, Members will be informed of the following:
   (i) The Member's right to access Covered Services delivered via Telehealth in-person.
   (ii) That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future.
   (iii) The availability of Non-Medical Transportation to in-person visits.
   (iv) The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

viii. Establishing New Patients via Telehealth

1. Members may be established as new patients via:
   (i) Synchronous video Telehealth visits.
   (ii) Audio-only synchronous interaction if one of more of the following criteria are met:
      1. The visit is related to a mental health condition which are considered sensitive services as defined in Civil Code section 56.06(n), obtained by a Member at or above the minimum age specified for consenting to the service specified in the section.
      2. The Member requests an audio-only modality.
      3. The Member attests they do not have access to video.
2. Federally Qualified Health Centers (FQHCs), including Tribal FQHCs, and Rural Health Clinics (RHCs), Rural Health Clinics (RHCs), as defined in BPC section 2290.5(a), if the visit meets all of the following conditions:
   (i) The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the Covered Service is performed.
   (ii) The individual who creates the patient's Medical Records at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
   (iii) The Provider determines that the billing Provider is able to meet the applicable standard of care.
   (iv) A Member who receives Covered Services via Telehealth must otherwise be eligible to receive in-person services from that Provider.

V. Screening and Referrals by the Managed Care Plan

a. In the event a member, or a person on behalf of the member under age 21, who is not currently receiving mental health services, contacts The Plan seeking mental health services, the member will be screened using the DHCS Approved Adult or Youth Screening Tool. This tool is to be used to guide a referral by The Plan to the appropriate Medi-Cal mental health delivery system (i.e., MCP or MHP).
   i. Tools:
      1. The Adult Screening Tool will be used for members aged 21 and older.
      2. The Youth Screening Tool will be used for members under age 21.
   ii. Screening for initial system of care assessment referral:
      1. Utilizing the screening tool in the primary language of the member, the scoring of the tool will determine whether the member is referred to their MCP or the MHP for assessment and medically necessary services.
   iii. Coordination of Services within MCP
      1. When the screening tool indicates that the member would be best assessed within The Plan's scope of responsibilities, the member will be given a referral to an in-network licensed mental health provider.
   iv. Coordination of Services to the MHP

1. When the screening tool indicates that the member would be best assessed within the MHP's scope of responsibilities, the member will be warm transferred to the MHP's access line and the tool will be shared with the MHP.

b. The completion of the tool is not considered an assessment. Once a member is referred to the MCP or MHP, they must receive an assessment from a Provider in that system to determine medical necessary mental health services.
c. The Adult and Youth screening tools are not required to be used when members contact mental health providers directly to seek mental health services. The Plan allows contracted mental health providers who are contacted directly by Members seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental health Services Policy described in APL 22-005, No Wrong Door for Mental Health Services Policy, or subsequent updates.[9]

VI. Screening and Referrals by a Primary Care Physician

a. The Plan's Primary Care Physicians are required to screen members for mental health needs and provide referrals as needed. Members with a positive screening
b. for depression or other behavioral health screening result may be further assessed either by the PCP or by a referral to a network mental health provider. The member may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the MCP network.
c. The Plan has a direct network of mental health providers for services that are beyond the scope of the PCP and are within The Plan's Behavioral Health Benefit responsibilities. Their customer service department will assist the member in identifying their behavioral health care needs and coordinate access to the appropriate level of service.

VII. Non-Specialty Mental Health Services (NSMHS)

a. The Plan covers the following NSMHS, which does not require a prior authorization, and that are provided by the following licensed mental health professionals acting within the scope of their license: Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs), licensed psychologists, Psychiatric Physician Assistants (PAs), Psychiatric Nurse Practitioners (NPs) and psychiatrists. Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers and psychology assistants may render services under a supervising licensed clinician.
    i. Mental health evaluation and treatment, including Individual, group and family psychotherapy
    ii. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition
    iii. Outpatient services for the purposes of monitoring drug therapy
    iv. Outpatient laboratory, drugs, supplies, and supplements

1. Drugs does not include medications covered under the Medi-Cal RX Contract Drug List (https://medi-calrx.dhcs.ca.gov/home/cdl)

v. Psychiatric consultation

b. The Plan will provide or arrange for the provision of the NSMHS listed above for the following populations:
   i. Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, and defined by the current Diagnostic and Statistical Manual of Mental Disorders.
      1. Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulate use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for recipients with any of these other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above).
   ii. Members who are under the age of 21, to the extent they are eligible for services through Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis; and
      1. Search Section 1396d(r)(5) of Title 42 of the U.S.C. (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) and that are necessary to correct or ameliorate a condition, including a behavioral health condition, discovered by a screening service, whether or not such services are covered under the State Plan), through the U.S.C. site http://uscode.house.gov/.
   iii. Members of any age with potential mental health disorders not yet diagnosed.

c. In addition to the above, The Plan provides:
   i. Psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.
   ii. Up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.
   iii. Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies.

d. Consistent with state law, clinically appropriate and covered NSMHS are covered by The Plan even when:
   i. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
   ii. Services are not included in an individual treatment plan;

iii. The member has a co-occurring mental health condition and substance use disorder (SUD); or
iv. NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

VIII. Alcohol and Substance Use Disorder Screening, Referral, and Services

a. The Plan will provide covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventative Services Task force grade A and B recommendations for adults as outlined in The Plan's Policy & Procedure 10.26.5 Alcohol Misuse Screening and Counseling.[11] The Plan will provide or arrange for the provision of:
   i. Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
      1. Minors 16 years of age or older has the right to consent to receive medications and treatments for opiod use disorder, including buprenorphine, without parent or guardian consent.
   ii. Emergency services necessary to stabilize the member.

IX. Emergency Services

a. The Plan is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services includes facility and professional services and facility charges claimed by emergency departments. No prior authorization is required.[2]

X. Care Management and Care Coordination

a. The Plan provides medical case management and all medically necessary Medi-Cal covered physical health care services for a member receiving SMHS. The Plan will coordinate with the MHP. The Plan continue to manage the member's mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside of The Plan's provider network.
b. For members receiving NSMHS, The Plan provides care coordination and case management, and all medically necessary Medi-Cal covered physical health care services.[13]

XI. Specialty Mental Health Services[1]

a. The County Mental Health Plan is responsible in covering outpatient services when there is significant impairment in functioning, and inpatient services in the event of emergency and inpatient services are needed.
b. Outpatient
    i. An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria:
        1. Has an included mental health diagnosis[8]
        2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function;
        3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning.
        4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and
        5. The condition would not be responsive to physical health care based treatment.
        6. Note: for beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels to correct or ameliorate a mental health condition or impairment.[8]
    ii. These services include:
        1. Mental Health Services:
            (i) Assessment
            (ii) Plan Development
            (iii) Therapy
            (iv) Rehabilitation
            (v) Collateral
        2. Medication Support Services
        3. Day Treatment Intensive
        4. Day Rehabilitation
        5. Crisis Residential Treatment
        6. Crisis Intervention
        7. Crisis Stabilization
        8. Targeted Case Managed
        9. Intensive Care Coordination
        10. Intensive Home-Based Services
        11. Therapeutic Foster Care
        12. Therapeutic Behavioral Services
c. Drug Medi-Cal Organized Delivery System (DMC-ODS)
    i. Clinically appropriate and covered SMHS are covered by MHPs whether or not the member has a co-occurring SUD. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties,

respectively whether or not the member has a co-occurring mental health condition.

d. Inpatient
   i. A beneficiary is eligible for services if he or she meets the following medical necessity criteria:
      1. An included diagnosis;
      2. Cannot be safely treated at a lower level of care;
      3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder:
         (i) Symptoms or behaviors which represent a current danger to self or others, or significant property destruction;
         (ii) Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter;
         (iii) Symptoms or behaviors which present a severe risk to the beneficiary's physical health;
         (iv) Symptoms or behaviors which represent a recent, significant deterioration in ability to function;
         (v) Psychiatric evaluations or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and;
         (vi) Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.
   ii. These services include:
      1. Acute psychiatric inpatient hospital services
      2. Psychiatric Health Facility Services
      3. Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

XII. Managed Care Responsibilities

a. In addition to covering the NSMHS mentioned above, the Plan will be responsible for continued communication with specialty mental health provider for coordination of care where required.
b. All behavioral health services shall be provided in a culturally and linguistically appropriate manner.
c. When required, The Plan's Case Management Department will assist in coordinating services between the member's Primary Care Physician, direct mental health provider and the CMHP provider. All requests for Protected Health Information (PHI) must be conducted in strict adherence to prevailing HIPAA confidentiality laws including the completion beneficiary release of information forms that allow treatment history, active treatment, and health information.
d. The number of visits for mental health is not limited so long as the MCP beneficiary meets medical necessity criteria.
e. Data sharing agreements that address the coordination of information related to mental health services and Substance Brief Intervention services will be obtained with CMHP for SMHS and the county department responsible for substance

abuse treatment. The data is to be exchanged with County Mental Health Plans and Drug Medi-Cal Organized Delivery system in accordance with the applicable laws and regulations, and that the MOUs with those entities will delineate the technical requirements specific to each entity. In the event that the MOU does not include the technical specificity, a Desk Level Procedure document will be maintained by the parties responsible for the data exchange. Additional detail about this general procedure can be found in our Policy and Procedure 10.26.8 Behavioral Health Data Exchange.

XIII. Transition of Care

a. The Plan will use the DHCS approved Transition of Care Tool to facilitate transitions of care to MHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change.
b. The determination to transition services to and/or add services from the MHP delivery system will be made by a clinician via a patient-centered shared decision-making process.
c. Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool will be filled out by a clinician or a non-clinician.
    i. Members will be engaged in the process and consent will be obtained in accordance with accepted standards of clinical practice.
d. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.
e. The Transition of Care Tool will be documented in the Care Management system, in the order of the tool approved by DHCS, which will include the contents of the tool, including the specific wording and other fields that are on the tool.
f. Additional information will not be added to the form but may be added to the records as an attachment. This may include documentation such as medical history reviews, care plans, and medication lists.
g. Following the administration of the Transition of Care Tool, the member will be referred to the MHP, or directly to an MHP provider delivering SMHS if agreed with the MHP.
    i. The Plan will coordinate member care services with the MHP to facilitate care transitions or addition of services, including the following:
        1. Ensuring that the referral process has been completed
        2. Ensuring that the Member has been connected with a Provider in the new system
        3. Ensuring that the new Provider accepts the care of the member and medically necessary services have been made available to the Member

XIV. Concurrent NSMHS and SMHS

a. Members May concurrently receive NSMHS from The Plan direct network provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative.
b. When a member meets criteria for both NSMHS and SMHS, the member would receive services based on the individual clinical need and established therapeutic relationships.

c. The Plan will not deny or disallow reimbursement for NSMHS provided to a member on the bases of the member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

XV. Dispute Resolution Process

a. Disputes between The Plan and the local Medi-Cal mental health plan regarding this policy will be resolved pursuant to Title 9, CCR, Section 1850.505.[3] Any decision rendered by DHCS and the California Department of Mental Health regarding a dispute between The Plan and the Local Medi-Cal mental health plan concerning provision of mental health services or Covered services required not be subject to the dispute procedures specified in the LA Care Contract Exhibit E, Attachment 2, Provision 18 regarding Disputes. The Plan will follow the Policy & Procedure 10.26.6 Resolving Mental Health Disputes with Mental Health Plan.[10]

E. MONITORING

I. At minimum, The Plan monitors quarterly the following, but is not limited to utilization of services, network access, appeals and grievances to identify any opportunities for improvement or administer a corrective action plan.

F. REFERENCES & ATTACHMENTS

1.	APL 22-006 (Supersedes APL 17-018)
2.	Title 22, CCR, Section 53855
3.	Title 9, CCR, Section 1810.247 & 1840.374, 1850.505
4.	Medicaid Mental Health Parity Final Rule (CMS-2333-F)
5.	Title 22, CCR, Section 51337
6.	Title 22, CCR, Section 51146
7.	Title 22, CCR, Section 52323
8.	Title 9, Section 18030.2015 for adults and Section 1830.210 for those under age 21
9.	APL 22-005 No Wrong Door for Mental Health Services Policy
10.	Policy & Procedure 10.26.6 Resolving Mental Health Disputes with Mental Health Plan
11.	Policy & Procedure 10.26.5 Alcohol Misuse Screening and Counseling
12.	Policy & Procedure 10.26.8 Behavioral Health Data Exchange
13.	WIC 14184.402 (f)(1)
14.	APL 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services
15.	APL 22-029 Dyadic Care Services and Family Therapy Benefits
16.	APL 22-016 Community Health Care Workers

17.	APL 23-007 (Supersedes APL 19-009) Telehealth Services Policy
18.	Policy and Procedure 10.26.14 Dyadic Care Services

G. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)
03/2024	Moved to new template. Revised in accordance with AB 816.
08/2023	Revised in accordance with the APL 23-007 and guidance from Compliance.
03/2023	Revised in accordance with the APL 22-029 and guidance from Compliance.
02/2023	Revised in accordance with feedback/guidance from Compliance and the following: APL 22-028 WIC 14184.402(f)(1)
08/2022	Revised in accordance with APL 22-005 and APL 22-006
04/2022	Revised in accordance with APL 21-014
06/2019	Moved Policy on to BSC Promise Template
02/2018	Revised in accordance with APL 17-018, Title 22, Title 9, and Medicaid Mental Health Parity Final Rule (replaced a combination of old behavioral health utilization management policy and procedures)