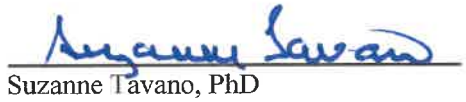
Contra Costa County Health Services Department **Behavioral Health Services Division** **Mental Health Services** **Alcohol and Other Drugs Services**	POLICY NO. 501 Effective As Of: July 1, 2022 Next Review Date: July 31, 2025 Policy Expires On: July 31, 2026
POLICY: **NO WRONG DOOR FOR BEHAVIORAL HEALTH SERVICES (CALAIM INITIATIVE)**	By:  Suzanne Tavano, PhD Behavioral Health Director

POLICY: NO WRONG DOOR FOR BEHAVIORAL HEALTH SERVICES (CALAIM INITIATIVE)

I. PURPOSE:

The purpose of this policy is to ensure that Medi-Cal beneficiaries receive timely behavioral health services without delay regardless of the delivery system where they seek care, and that beneficiaries are able to maintain treatment relationships with trusted providers without interruption.

Corresponding guidance to Medi-Cal Managed Care Health Plans (MCPs) is contained in All Plan Letter (APL) 22-005.

II. REFERENCES:

- 42 CFR, Section 1396d
- 42 CCR, Section 53855
- California Welfare and Institutions Code (WIC), Sections 14059.5, 14184.402
- California Department of Health Care Services (DHCS), Behavioral Health Information Notice (BHIN) 21-073
- DHCS, BHIN 22-011
- DHCS, All Plan Letter 21-014
- DHCS, All Plan Letter 22-005

III. DEFINITIONS:

- **Drug Medi-Cal (DMC):** Drug Medi-Cal is a treatment funding source for eligible Medi- Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.

- **Drug Medi-Cal Organized Delivery System (DMC-ODS):** The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

- **Fee-For-Service (FFS) Medi-Cal Delivery System:** Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

- **Managed Care Plan (MCP):** MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

- **Mental Health Plan (MHP):** MHP means an entity that enters into a contract with DHCS to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

- **Non-Specialty Mental Health Services (NSMHS):** NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

- **Specialty Mental Health Services (SMHS):** Specialty mental health services include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

IV. POLICY:

It is the policy of Behavioral Health Services Division (BHSD) to provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, and treatment services. These services are covered and reimbursable even when:

- Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;

- The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or

- NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

V. AUTHORITY/RESPONSIBILITY:

Behavioral Health Director
Behavioral Health Deputy Director
Mental Health Program Chiefs
Mental Health Program Managers
Alcohol and Other Drug Services Program Chief
Alcohol and Other Drug Program Managers
Access Line Program Manager

VI. PROCEDURE:

A. SMHS provided during the assessment period prior to determination of a diagnosis or prior to determination of whether SMHS access criteria are met.

1. Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS.

2. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does not meet criteria for SMHS or meets the criteria for NSMHS.

3. Likewise, MCPs must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the beneficiary does not meet criteria for NSMHS or meets the criteria for SMHS.

4. MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

   a. ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision

of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

b. ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

c. In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS-approved ICD-10 diagnosis code list, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

B. Co-occurring substance use disorders.

1. Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria on the basis of the beneficiary having a co- occurring SUD, when all other Medi-Cal and service requirements are met.

2. 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 beneficiary has a co-occurring mental health condition.

3. Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the beneficiary has a cooccurring SUD.

4. Similarly, clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

C. Concurrent NSMHS and SMHS.

1. Beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships.

2. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary on the basis of the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

3. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary on the basis of the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

4. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a beneficiary- centered shared decision-making process.

    a. Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).

b. Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from a FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

D. DHCS is developing a set of statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and care transitions for the SMHS, NSMHS and FFS systems.