BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE: **No Wrong Door for Mental Health Services**

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References: BHIN 22-011

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Purpose:
This policy stipulates that Medi-Cal beneficiaries shall receive timely mental health services without delay regardless of the delivery system where they seek care, and those beneficiaries are able to maintain treatment relationships with trusted providers without interruption.

Scope:
This policy applies to the San Francisco Mental Health Plan (MHP) and the SF Drug Medi-Cal Organized Delivery System (DMC-ODS). Additionally, this policy covers requirements for Medi-Cal Managed Care Health Plans (MCPs) working with SFDPH-BHS for delivering behavioral health services to their members.

Background: With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes. CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care. In alignment with the goals of CalAIM this policy reflects how BHS ensures that beneficiaries have access to the right care in the right place at the right time.

Policy:
Consistent with Welfare & Institutions Code 14184.402(f), clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and Specialty Mental Health Services (SMHS) prevention, screening, assessment, and treatment services are covered and reimbursable Medi-Cal services even when:

1) Services are provided prior to determination of a diagnosis or prior to determination of whether NSMHS or SMHS criteria are met;
2) The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

Procedure:

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

   Likewise, Managed Care Plans (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.

2. Co-occurring substance use disorder clinically appropriate and covered SMHS delivered by Mental Health Plan (MHP) providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring Substance Use Disorder (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. Similarly, clinically appropriate and covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition.

   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 co-occurring SUD. 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.

3. Concurrent NSMHS and SMHS 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. 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. 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.

Any concurrent NSMHS and SMHS for adults and 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 patient-centered shared decision-making process.

- 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).
- 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.

Contact Person:
Managed Care Director

Attachment(s):
Attachment 1: Medi-Cal Managed Care Health Plan Responsibilities
Attachment 2: FAQ CalAIM No Wrong Door

Distribution:
BHS Policies and Procedures are distributed by BHS Quality Management, Office of Regulatory Affairs.

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ATTACHMENT 1

MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES

Per forthcoming DHCS guidance, Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services, and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies and supplements.

MCPs must provide or arrange for the provision of the NSMHS listed above for the following populations:

- 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, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
- Members who are under the age of 21, to the extent they are eligible for services through the 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,
- Members of any age with potential mental health disorders not yet diagnosed.

In accordance with Welfare and Institutions (W&I) Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.). The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state’s Medicaid State Plan. Consistent with federal guidance from the Centers for Medicare & Medicaid Services, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition.6 Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services.

MCPs must also cover and pay 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.

MCPs must provide covered substance use disorder (SUD) services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, MCPs must provide or arrange for the provision of:

• Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and 7
• Emergency services necessary to stabilize the member.

The NSMHS and SUD services described above are covered services via the fee-for-service (FFS) delivery system for Medi-Cal beneficiaries who are not enrolled in a MCP.

MHPs are required to provide or arrange for the provision of medically necessary SMHS for beneficiaries in their counties who meet access criteria for SMHS as described in BHIN 21-073.