MEDICAID MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT
COMPLIANCE PLAN

October 2, 2017
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# TABLE OF CONTENTS

1. EXECUTIVE SUMMARY ........................................................................................................................................... 5
   1.1 Medicaid Mental Health Parity Final Rule Background .................................................................................. 5
   1.2 Compliance Plan Overview ............................................................................................................................... 6

2. CALIFORNIA’S SERVICE DELIVERY SYSTEMS ........................................................................................................ 7
   2.1 Managed Care Plans ........................................................................................................................................... 7
   2.2 Mental Health Plans ........................................................................................................................................... 9
   2.3 Substance Use Disorder Services ..................................................................................................................... 11
   2.4 Waiver Services ................................................................................................................................................ 13
   2.5 Pharmacy Services .......................................................................................................................................... 13

3. PARITY ANALYSIS APPROACH .................................................................................................................................. 16
   3.1 Benefits Definition, Classification, and Mapping .............................................................................................. 16
      3.1.1 Defining Benefit Types ............................................................................................................................. 16
      3.1.2 Defining Classifications and Mapping Benefits to Classifications ......................................................... 17
   3.2 State-Level Policy Review .................................................................................................................................... 18
   3.3 Surveys and Technical Assistance .................................................................................................................. 18
      3.3.1 Medi-Cal Managed Care Plan Survey ....................................................................................................... 19
      3.3.2 County Mental Health Plan, DMC, and DMC-ODS Counties Survey ....................................................... 19
   3.4 Deep Dive Sessions ........................................................................................................................................... 19

4. PARITY ANALYSIS OUTCOMES ................................................................................................................................ 20
   4.1 Financial Requirements (FRS) ........................................................................................................................ 20
      4.1.1 Share of Cost ............................................................................................................................................... 21
      4.1.2 Cost-Sharing .............................................................................................................................................. 21
      4.1.3 Other Financial Requirements ............................................................................................................... 21
   4.2 Quantitative Treatment Limitations (QTL) ....................................................................................................... 22
      4.2.1 Specialty Mental Health Discharge Planning Targeted Case Management ............................................. 22
      4.2.2 DMC-ODS Residential Services .............................................................................................................. 22
      4.2.3 DMC Narcotic Treatment Program ......................................................................................................... 23
      4.2.4 Medication Supply Limits ....................................................................................................................... 23
      4.2.5 Alcohol Misuse Screening and Counseling Limits .................................................................................. 24
   4.3 Non-Quantitative Treatment Limitations (NQTL) .......................................................................................... 25
      4.3.1 Medical Management Standards ........................................................................................................... 26
      4.3.2 Non-Specialty Mental Health (Mild to Moderate Mental Health Services) ............................................ 30
      4.3.3 Reimbursement Structures ...................................................................................................................... 31
      4.3.4 Alcohol Misuse Screening and Counseling Provider Training .............................................................. 31
      4.3.5 Network Adequacy .................................................................................................................................. 32
      4.3.6 Provider Credentialing ............................................................................................................................ 32
      4.3.7 Failure First, Step Therapy, and Prescription Drug Network Tiers ......................................................... 33
      4.3.8 Continuity of Care .................................................................................................................................. 33
      4.3.9 Home and Community Based (HCBS) Waiver Services ...................................................................... 34
      4.3.10 Transportation ..................................................................................................................................... 35
      4.3.11 Federally Qualified Health Centers (FQHC) Same Day Billing ......................................................... 35
   4.4 Information Requirements ................................................................................................................................ 36

5. COMPLIANCE ACTION PLAN .................................................................................................................................. 37
   5.1 Contract Amendment and Deliverables .......................................................................................................... 37
      5.1.1 MCP Contract .......................................................................................................................................... 37
1. EXECUTIVE SUMMARY

1.1 Medicaid Mental Health Parity Final Rule Background

On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Parity Final Rule\(^1\) (Parity Rule) to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid and applied parity requirements to the coverage provided by Medicaid managed care organizations (MCOs), Alternative Benefit Plans (ABPs), and the Children’s Health Insurance Programs (CHIP). Specifically, the Parity Rule included the following requirements:

- Aggregate lifetime and annual dollar limits;
- Financial requirements (FR);
- Quantitative treatment limitations (QTLs);
- Non-quantitative treatment limitations (NQTLs); and
- Information requirements.

A key objective of the Parity Rule is to ensure that restrictions or limits on mental health and substance use disorder services are not more substantively applied as compared to medical surgical services. Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary’s lifetime or on an annual basis. These limits cannot be applied to mental health or substance use disorder (MH/SUD) benefits unless the limits apply to at least one third of all medical/surgical (M/S) benefits. In addition, such limits must either be applied to both medical/surgical and mental health and substance use disorder benefits as a whole or the limits applicable to mental health or substance use disorder benefits must be no more restrictive than those applicable to medical/surgical benefits. FRs and QTLs applied to MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL that applies to substantially all medical/surgical benefits in that classification.

A non-quantitative treatment limitation (NQTL) may not apply to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.

Further, the Parity Rule added requirements to make certain information pertaining to mental health and substance use disorder benefits available, specifically the criteria for medical necessity determinations and reason for denial of reimbursement or payment.

Certain parity requirements also apply to the Alternative Benefit Plan (ABP). The Parity Compliance Toolkit\(^2\) provides that an ABP that provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits is deemed compliant with parity requirements for beneficiaries entitled to EPSDT benefits.


Parity requirements apply when a beneficiary is enrolled in a Managed Care Organization (MCO). At such point, the beneficiary’s entire benefit package is subject to parity standards regardless of delivery system, which includes the medical/surgical benefits and non-specialty mental health benefits through the Medi-Cal managed care plans (MCP) and fee-for-service (FFS), pharmacy benefits through the MCP and FFS, specialty mental health benefits through the county mental health plans (MHP), substance use disorder benefits through the Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, and waiver services. California’s delivery system structures are described in greater detail in Section 2 below.

In California where some mental health and substance use disorder services for MCP enrollees are provided through a combination of MCPs and MHPs, the State has the responsibility of undertaking the parity analysis within the plans and across the delivery systems to determine if the benefits and any financial requirements or treatment limitations are consistent with the Parity Rule.

1.2 Compliance Plan Overview

The purpose of this Compliance Plan is to describe the comprehensive parity analysis that the California Department of Health Care Services (DHCS) has undertaken, resulting outcomes of the parity analysis, and solutions to rectify the findings. The Parity Compliance Toolkit outlined key steps in the parity analysis process. DHCS ensures required compliance with the Parity Rule by addressing such steps as described within this document.

This Compliance Plan is divided into six (6) sections:

- **Section 1** is the Compliance Plan overview that provides the background of the Parity Rule requirements and purpose of the Compliance Plan.
- **Section 2** provides the background on California’s service delivery, which provide context on the intricacy of the parity analysis.
- **Section 3** describes the State’s approach to conducting the comprehensive parity analysis.
- **Section 4** discusses the outcomes of the parity analysis.
- **Section 5** provides system-level changes that DHCS implemented and/or is in the process of operationalizing to come into compliance with the identified parity issues.
- **Section 6** describes the ongoing monitoring at the State and plan level when parity reassessment is required.
2. California’s Service Delivery Systems

The California Department of Health Care Services (DHCS) is the single state agency responsible for the administration of the State’s Medicaid program, called Medi-Cal. DHCS administers programs to support the vital health care needs of nearly 14 million Californians, about one-third of the State’s population.

DHCS contracts with MCPs for the provision of medical/surgical services, pharmacy benefits, preventative substance use disorder services, and non-specialty mental health services delivered in the primary care setting to beneficiaries with mild to moderate mental health functional impairment.

In California, specialty mental health and substance use disorder services are carved-out of the Managed Care Organization (MCO) delivery system through CMS-approved Medicaid Waivers. DHCS administers specialty mental health services (SMHS) through county mental health plans (MHPs) that are responsible for the provision, or arrangement of, specialty mental health services.

DHCS administers the DMC, DMC-ODS, and Substance Abuse Prevention and Treatment Block Grant (SABG) programs through a community-based system for SUD services through counties or through direct contracts with service providers. MCPs refer beneficiaries to MHPs for SMHS and/or SUD services. MHPs and MCPs have developed memoranda of understanding (MOUs) that include agreements for coordinating beneficiary care.

As a result of the carve-outs, DHCS examined each of the delivery system’s governing laws, State Plan, Waiver requirements, funding methodologies, administrative requirements, contractual agreements, and other complexities. Moreover, CMS required states to demonstrate parity within long-term care services and supports.

2.1 Managed Care Plans

Service Delivery

DHCS administers health care services through two delivery systems – managed care and fee-for-service (FFS). Medi-Cal managed care plans are required to offer services in an amount no less than what is offered to beneficiaries under Medi-Cal FFS. MCPs provide State Plan services in accordance with State statutes and regulations, Medi-Cal Provider Manual, DHCS Medi-Cal contract, and All Plan Letters (APLs).

Approximately 80 percent of Medi-Cal beneficiaries receive health care services through a MCP. In California, there are six models of managed care within the 58 counties:

- County Organized Health Systems (COHS)
- Two-Plan
- Geographic Managed Care (GMC)
- Regional
- Imperial
- San Benito

Attachment A in the Appendix illustrates the plan models by county.

Senior Care Action Network (SCAN) Health Plan is a Medicare Advantage Special Needs Plan that contracts with DHCS to provide services for the dual eligible Medicare/Medi-Cal population subset in certain geographic areas. Since CMS has defined SCAN as a MCO per the Medicaid Managed Care Final Rule, SCAN is included in areas where there is applicability to MCPs for parity.
MCPs cover most acute, primary and specialty care, pharmacy, and some long-term services and supports, although coverage of certain benefits can vary by plan models and individual plans in certain circumstances. Managed long-term services and supports (MLTSS) covered by MCPs include long-term health care facilities (i.e., Skilled Nursing Facilities/Nursing Facilities (SNF/NF), subacute facilities, and Intermediate Care Facilities), Multipurpose Senior Services Program (MSSP), and In-Home Supportive Services. MCPs also cover Community-Based Adult Services (CBAS) under the auspice of California’s Section 1115 Waiver, Medi-Cal 2020. California provides additional long-term care services under Home and Community-Based Services (HCBS) Waivers. These are discussed in the Waiver Services section.

Starting on January 1, 2014, California expanded its benefits for Medi-Cal beneficiaries with mental health conditions who do not meet the SMHS medical necessity criteria, and carved these benefits into managed care, thus providing access to a limited scope of primary care-based, non-emergency mental health and substance use disorder services through the MCPs. Pursuant to the State Plan, MCPs provide non-specialty mental health services included in the essential health benefits package.\(^3\)

Outpatient non-specialty mental health services include:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purpose of monitoring drug therapy;
- Outpatient laboratory, drugs, supplies and supplements (excluding antipsychotics); and
- Psychiatric consultation.

MCPs do not provide specialty mental health or substance use disorder services, but are responsible for referral and coordination with the local county office for these services. DHCS ensures that all contracts with MCPs include a process for screening, referral, and coordination with MHPs, as set forth in Welfare and Institutions Code Section 14681\(^4\). Further, memoranda of understanding (MOU) are in place between MCPs and MHPs to coordinate physical and mental health care, provide for a dispute resolution process, describe the Department’s responsibility for reviewing the disputes, and outline the provision of medically necessary services pending resolution of dispute.

MCPs are responsible for providing substance use disorder preventative services, which include Alcohol Misuse Screening and Counseling (AMSC) for misuse of alcohol, tobacco cessation services and office visits associated with alcohol and substance use disorder services when provided by a network provider acting within their scope of practice. MCPs are required to provide United States Preventative Services Taskforce (USPSTF) recommended covered tobacco cessation services, including: initial and annual assessment of tobacco use; FDA-approved tobacco cessation medications; individual, group and telephone counseling for beneficiaries who use tobacco products; services for pregnant tobacco users; and prevention services of tobacco use in children and adolescents.

**Governing Laws and Authority**

MCPs in California are governed by many different statutes and regulations set forth by both the Federal and State government, which include the Code of Federal Regulations (CFR), California Code of Regulations (CCR), California Health and Safety Code (H&S), California Welfare and Institutions Code (W&IC), and Knox-Keene

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\(^3\) Welfare & Institutions Code Sections 14132.03 and 14189.

Health Care Service Plan Act of 1975 (Knox Keene). DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements, whichever is more prescriptive.

DHCS operates its Medicaid managed care program under the authority of the Section 1115 Waiver. The waiver authority was granted under the Bridge to Reform Demonstration, which was renewed on December 30, 2015 as Medi-Cal 2020. The Section 1115 Waiver allowed California to phase in coverage in individual counties through the mandatory enrollment of the population into Medi-Cal managed care plans.

**Funding Mechanism**

DHCS pays MCPs monthly actuarially sound capitation rates as defined in 42 CFR 438.6(c) and 42 CFR 438.4 and those rates are developed in accordance with standards specified in 42 CFR 438.5 per beneficiary in addition to potential supplemental capitation for specific services. Capitation rates generally are flat fees that are paid for each member that covers all included costs of health care for a defined population group. The capitation rates are calculated based on methods that are determined in part by CMS, which oversee the Medicaid program. In turn, MCPs negotiate rates and contract with providers to ensure services are rendered.

**2.2 Mental Health Plans**

**Service Delivery**

California’s specialty mental health services (SMHS) are provided under the 1915(b) Freedom of Choice Waiver. The 1915(b) SMHS Waiver provides California with the opportunity to deliver Rehabilitative Mental Health Services to children and adults through a managed care delivery system, with MHPs designated as Prepaid Inpatient Health Plans. DHCS contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiary’s mental health treatment needs and goals as documented in the beneficiary’s treatment plan. The county MHPs provide outpatient SMHS in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries. The SMHS covered under the 1915(b) SMHS Waiver are defined in California’s Medicaid State Plan and include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges. These services are as follows:

- Mental Health Services;
- Medication Support Services;

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5 MCPs pay providers in a variety of ways, which may include some form of capitation, FFS, or other types of arrangements.

6 Rehabilitative Mental Health Services are services recommended by a physician or other licensed mental health professional within the scope of his or her practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary’s functional level. Rehabilitative Mental Health Services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention. Rehabilitative Mental Health Services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past. Rehabilitative Mental Health Services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. (Medi-Cal State Plan, Supplement 3)

7 SMHS medical necessity criteria is outlined in Title 9 CCR Chapter 11, Sections 1820.205, 1830.205, and 1830.210.
• Day Treatment Intensive;  
• Day Rehabilitation;  
• Crisis Intervention;  
• Crisis Stabilization;  
• Adult Residential Treatment;  
• Crisis Residential Treatment Services;  
• Psychiatric Inpatient Hospital Services;  
• Targeted Case Management; and  
• EPSDT Services.

**Governing Laws and Authority**

MHPs in California are governed by many different statutes and regulations set forth by both the Federal and State government. State governance include the California Code of Regulations (CCR) and California Welfare and Institutions Code (W&IC). MHPs are classified as Prepaid Inpatient Health Plans (PIHP) under the Federal Medicaid Managed Care regulations, and as such, are also governed by Title 42 and the Code of Federal Regulations (CFR) part 438. DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements.

The State’s enabling legislation for the 1915(b) Waiver is set forth in Welfare and Institutions Code Sections 14680-14685.1 and 14700-14726.

**Funding Mechanism**
The 1915(b) Waiver program is administered locally by each county’s MHP, and each county’s MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries. MHPs are not paid on a capitated basis, but rather, are reimbursed through a claims-based FFS payment structure based on their actual expenditures for services. MHPs negotiate rates and contract with providers to ensure services are rendered. California funds SMHS through multiple dedicated revenue sources. In addition to FFP, these sources include 1991 Realignment, 2011 Realignment, Mental Health Services Act, SAMHSA Block Grants and locally-generated matching funds for 1991 Realignment, or other local revenues. Attachment B in the Appendix illustrates the map of California’s counties by mental health regions.

2.3 Substance Use Disorder Services

Service Delivery

Beneficiaries enrolled in Medi-Cal receive substance use disorder services through DMC, which is a carve-out of the MCPs’ benefits. Treatment is offered on demand (i.e., no referral necessary) for all Medi-Cal beneficiaries when medically necessary.

For SUD services, California’s State Plan authorizes the DMC program to provide the following five treatment modalities:

- Outpatient Drug Free Treatment (group and/or individual counseling);
- Intensive Outpatient Treatment;
- Residential Treatment (limited to pregnant and perinatal clients);
- Naltrexone Treatment; and
- Narcotic Replacement Therapy (methadone).

The DMC system establishes a structure for providing State Plan SUD services. In addition, SABG funding supports a significant portion of California’s SUD treatment services. The SABG includes funding for outpatient and residential treatment designed to augment the DMC program’s SUD services. SABG-funded providers are required to adhere to a hierarchy of priority populations and all beneficiaries must indicate active substance use

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8 1991 Realignment was a legislatively-driven effort initiated in 1991 that approved a half-cent increase in state sales tax and dedicated a portion of vehicle license fees to fund local community mental health services.

9 2011 Realignment codified the Behavioral Health Services Subaccount that currently funds SMHS, DMC, residential perinatal drug services and treatment, drug court operations, and other non-DMC programs. See AB 109 (Chapter 15, Statutes of 2011) and SB 1020 (Statutes of 2012) for more information.

10 MHSA revenues, established by Proposition 63, which passed in 2004 and is generated through a 1% surtax on personal income over $1 million, are allocated directly to counties and have helped to significantly fund rehabilitative and preventive mental health services to underserved populations.

11 A portion of local revenue generated from property taxes, patient fees, and some payments from private insurance companies is used to fund mental health services, referred to as a Maintenance of Effort (MOE).

12 Title 42, USC §300x-21(b) authorizes the use of SABG funds only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse, and for related activities contained in 42 USC §300x-24, which applies to tuberculosis and human immunodeficiency services.
within the previous 12-months to be eligible for SABG funded treatment services. This also includes individuals who were incarcerated and reported using while incarcerated.

The current DMC delivery system places emphasis on state-wideness, resulting in SUD treatment facilities spread unevenly across California. Challenges arising from this approach include difficulty targeting the needs of specific populations and issues with ensuring quality across providers. To address these challenges, in 2015 CMS approved the DMC-ODS waiver amendment to the Medi-Cal 2020 Demonstration Waiver13.

By opting into the DMC-ODS and executing the DMC-ODS Intergovernmental Agreement, the county agrees to provide or arrange for the provision of DMC-ODS services through a PIHP. The county makes DMC-ODS services available as a Medi-Cal benefit for all individuals who reside within its county borders, have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a substance use disorder, and meet the medical necessity to receive that particular service based on American Society of Addiction Medicine (ASAM) criteria for SUD treatment services. The county may make these DMC-ODS services available by selectively contracting with DMC certified providers, a managed care plan, or offer county-operated services.

DMC-ODS services include:

- Outpatient drug free services;
- Intensive outpatient services;
- Withdrawal management (detoxification) services;
- Narcotic replacement therapy;
- Medication-assisted treatment;
- Residential treatment services; and
- Recovery services

**Governing Laws and Authority**

The statutes that govern the DMC Program are established in Welfare and Institutions Code Section 14021, 14124, and 14043.38, as well as Health and Safety Code Sections 11750-11975. The primary regulations that govern DMC are contained in the California Code of Regulations Title 22, Sections 51341.1 (program requirements), 51490.1 (claim submission requirements), and 51516.1 (reimbursement rates and requirements). Other regulations pertaining to the DMC program are in Title 9 CCR Section 9533. DMC-ODS counties are also governed by the Code of Federal Regulations (CFR). DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements.

DHCS operates DMC under the State Plan and the California Code of Regulations Title 9 and 22. The DMC-ODS Waiver is under the authority of the Section 1115 Waiver entitled Medi-Cal 2020.

**Funding Mechanism**

The DMC-ODS Pilot program is authorized and financed under the authority of the State’s Section 1115 Waiver. Funding for SUD services in DMC and DMC-ODS is allocated to the counties from State and Federal funding, and is also supplemented by county and local funding, the Substance Abuse Prevention and Treatment Block Grant, discretionary grants, and the Behavioral Health Subaccount that was codified by the 2011 County Realignment (Senate Bill 1020). Similar to the SMHS, SUD services are reimbursed through the claims-based FFS

payment structure based on the county’s actual expenditures. DMC-ODS counties pay providers the agreed-upon rates between the county and its providers. Counties receive quarterly payments of one-fourth of their annual allocation of SABG funding.

2.4 Waiver Services

Service Delivery

In addition to MCP-covered MLTSS services, California provides long-term care services through Home and Community Based Services (HCBS) waivers. The Social Security Act lists specific services that may be provided in HCBS programs, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. The array of services, which are approved by CMS through the Waiver application, differ significantly in the populations they serve, their size and complexities, and their statutory and regulatory structures, among other differences. HCBS Waivers allow states flexibility to offer different types of services to individuals with chronic disabilities in community-based settings as an alternative to Institutionalized care.

California currently administers seven (7) 1915(c) HCBS Waivers:

- Multipurpose Senior Services Program (MSSP) Waiver
- HIV/AIDS Waiver
- Developmental Disabilities (DD) Waiver
- Assisted Living Waiver (ALW)
- Nursing Facility/Acute Hospital (NF/AH) Waiver
- In-Home Operations (IHO) Waiver
- Pediatric Palliative Care (PPC) Waiver

Governing Laws and Authority

DHCS is the Single State Agency responsible for the administration of CMS approved Waiver services. The Federal government authorized the 1915(c) HCBS Waiver programs under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, codified in section 1915(c) of the Social Security Act. Governing State statutes are established in Welfare and Institutions Code Section 14137.

Funding Mechanism

LTSS benefits provided by MCPs are included in their capitation rate. LTSS benefits provided under the HCBS Waivers and 1915(i) State Plan are paid for under the FFS structure.

2.5 Pharmacy Services

Service Delivery

DHCS refers to drugs as capitated or carved-out. A drug that is capitated is covered by MCPs and included in their capitation rates. When dispensed, the pharmacy bills the MCP for the covered drug, not Medi-Cal FFS. A complete list of carved-out or non-capitated drugs is maintained by the DHCS Pharmacy Benefits Division and is
distributed to the MCPs on a regular basis. This list is also posted in the Medi-Cal Provider Manual\textsuperscript{14} and providers are notified of any updates via Provider Bulletins.

A carved-out drug is a drug that is not covered by the MCPs and is not included in the MCPs’ capitation rates. Although a MCP provider may write a prescription for a carved-out drug, when dispensed, the pharmacy provider bills Medi-Cal FFS rather than the MCP. Certain categories of drugs are currently carved-out, or non-capitated, unless otherwise specified in the MCP’s contract with DHCS, or in the Medi-Cal Provider Manual. Drugs are carved-out by categories or classes as well as by ingredients and by the generic name, not by individual brand name, dose form, or indications for treatment.

Medi-Cal FFS has selected certain categories of medications and carved them out from the calculation of MCP capitation. The selection of carved-out drugs is determined based on the general cost factor of the class of drugs in the aggregate, the introduction of new and costly medications into the class, and the degree of difficulty in determining a capitation rate that would appropriately compensate the MCPs accordingly. The classes of selected drugs that are carved-out include:

- Drugs to treat HIV/AIDS (these medications are exempt from the 6 Rx limit)
- Alcohol and opioid detoxification and dependency treatment drugs
- Blood factors
- Psychiatric (antipsychotic) drugs
- Erectile dysfunction (ED) drugs when indicated for the treatment of ED

**Governing Laws**

The laws governing California’s prescription drug program are Section 1927(K) that defines Covered Outpatient Drugs (COD) and Section 1927(d) of the Social Security Act that allows state Medicaid programs to apply prior authorization and/or imposition of utilization limitations with respect to all drugs. These governing laws provide the prior authorization process that outlines requirements for response timeframes of a phone response within 24 hours of request for prior authorization and a 72-hour supply of a covered prescription drug in emergency situations. It further provides guidelines for utilization restrictions, which include, but are not limited to, the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals. Utilization control methods utilized by the State are further described in Section 4.2.7.

**Payment Mechanism**

Like other MCP services, payment for capitated drugs is negotiated by the health plans.

FFS provider reimbursement is statutorily set at the lowest of: acquisition cost of the drug plus a professional dispensing fee, the Federal Upper Limit, the Maximum Allowable Ingredient Cost, or the usual and customary price charge by the provider to the general public.

**Authority**

The authority to include pharmacy benefits in the State’s Medicaid program is established in the Social Security Act. Prescription drugs are an optional benefit. Therefore, the State Plan is the source that documents that

\textsuperscript{14} Medi-Cal Provider Manual: \url{http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp}
prescription drugs will be included in the California Medicaid program, and it provides the parameters of the types of prescription drug services covered.
3. Parity Analysis Approach

DHCS conducted a mandatory assessment of Medicaid benefits across the delivery systems to ensure the State’s compliance with the Parity Rule. DHCS adhered to the Parity Compliance Toolkit that outlined key steps to conducting the parity analysis and examined benefits across delivery systems for parity compliance:

- Medi-Cal managed care plans
- Mental health plans
- Drug Medi-Cal
- Drug Medi-Cal Organized Delivery System
- Waivers
- FFS

To gain perspectives on current practices across delivery systems, as well as to identify parity concerns, DHCS utilized three methods to collect information. These methods included: (1) a survey administered to the MCPs, MHPs, DMC-ODS Counties, and counties providing SUD services through DMC to better understand operations at the local level, (2) review of policies and guidance at the State level, and (3) rigorous Department-wide deep dive discussions to draw comparisons between the delivery systems.

The scope of the parity analysis included benefits mapping and classification; identification, analysis, and determination of FRs, QTLs, and NQTLs; and review of notice and disclosure requirements in the four classifications of benefits by benefit package. The following sections provide greater detail on the extent of review in these areas.

3.1 Benefits Definition, Classification, and Mapping

3.1.1 Defining Benefit Types

In order to determine whether mental health and substance use disorder benefits are provided in parity with medical/surgical benefits, it was essential to identify which benefits are considered mental health and substance use disorder benefits and which are medical/surgical benefits for the purpose of this parity analysis. DHCS utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM), a generally recognized independent standard of current medical practice, as a basis for defining benefits as mental health and substance use disorder services. DHCS referred to the Parity Rule for the definitions for mental health and substance use disorder benefits and developed the following benefits definitions:

<table>
<thead>
<tr>
<th>Table 1. Benefits Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Type</strong></td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
</tbody>
</table>
Table 1. Benefits Definitions

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder</td>
<td>A Substance Use Disorder is the recurrent use of alcohol and/or drugs that has caused clinically and functionally significant impairment in life activities. SUD treatment services are services, inpatient and outpatient, provided to treat a beneficiary enrolled in Medi-Cal who has at least one diagnosis for an SUD based on the criteria established by the Diagnostic and Statistical Manual of Mental Disorders (DSM). SUD treatment services are outpatient drug free, intensive outpatient, withdrawal management (detoxification), narcotic replacement therapy, medication-assisted treatment, residential treatment, and recovery services.</td>
</tr>
</tbody>
</table>

3.1.2 Defining Classifications and Mapping Benefits to Classifications

The Parity Rule specifies that financial requirements and treatment limitations apply by benefit classification. Moreover, in order to conduct the parity analysis, each medical/surgical, mental health, and substance use disorder benefit must be mapped to one of four classifications of benefits: Inpatient, Outpatient, Prescription Drugs, and Emergency Care. Further, when mental health and substance use disorder benefits are provided in any one classification in a benefit package, then mental health or substance use disorder benefits must also be provided in every classification in which medical/surgical benefits are provided for that benefit package.

DHCS assigned each service to one of four classifications. This required the State to compare medical/surgical services to mental health services and medical/surgical services to substance use disorder services per benefit classification. For example, comparing inpatient medical/surgical services to inpatient mental health services, as well as inpatient medical/surgical services to inpatient substance use disorder services.

DHCS selected the setting as the basis of organizing the services into the benefit classifications. The basis of the setting helped to better align and organize available services by benefits classification. Inpatient settings that included hospital settings, acute care settings, and psychiatric health facilities all provide beneficiaries access to an array of inpatient services. Settings for outpatient services include outpatient clinics, and outpatient hospitals, and community-based settings. Prescription drug services included all medications and associated supplies, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment. Lastly, emergency care includes all covered medications or items delivered in an emergency department setting other than an inpatient setting.

For purposes of mapping benefits in each classification during the parity analysis, DHCS utilized the following classification definitions:
Table 2. Classification Definitions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>All covered services furnished in a hospital, acute care setting, or psychiatric health facility.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>All covered services in an outpatient clinic, outpatient hospital, or community-based setting.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.</td>
</tr>
</tbody>
</table>

Please refer to Attachment C in the Appendix for the Medi-Cal benefits mapped to the four classifications.

Once the four classifications were defined and all medical/surgical, mental health, and substance use disorder benefits were mapped to a classification, DHCS moved on to the next part of the parity analysis, which entailed the statewide policy review for identification of financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations applied to specific benefits in each classification.

3.2 State-Level Policy Review

Parity compliance requires an analysis of financial requirements (FR), quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL) imposed on mental health and substance use disorder benefits to ensure they are no more restrictive than those that apply to medical/surgical benefits in the same classification. To review potential state-imposed FRs, QTLs, and NQTLs in each classification, DHCS organized a Mental Health Parity Workgroup (Workgroup) that included the applicable programs from within the Department: Managed Care Quality and Monitoring Division (MCQMD), Mental Health and Substance Use Disorder Services (MHSUDS), Pharmacy Benefits Division (PBD), Benefits Division (BD), Long Term Care Division (LTCD), and the Office of Legal Services (OLS). This Workgroup was comprised of program, clinical, and executive staff, and included legal representation to ensure that there was a multidisciplinary approach to the parity analysis.

The Workgroup reviewed State policies and guidance within the Medicaid State Plan, waiver programs, State and Federal statutes and regulations, All Plan Letters (APL) and County Information Notices, DHCS contracts with the MCPs and MHPs, Medi-Cal Provider Manual, and the DMC and SMHS Billing Manual for potential FRs, QTLs, and NQTLs. This provided DHCS with a standard of State and Federal guidance by which to gauge local level policies when they are more restrictive than State requirements. Established requirements and limitations within State policies set the floor for minimum standards that must be met. It is these requirements and limitations by which comparisons were drawn between delivery systems.

3.3 Surveys and Technical Assistance

To obtain knowledge and information on local level policies, processes, and standards, DHCS administered plan surveys to MCPs, MHPs, DMC, and DMC-ODS counties. DHCS sought input from the California Department of Managed Health Care (DMHC) on their commercial plan experience with MHPAEA compliance. The DMHC
regulates and monitors licensed private health plans in California under the Knox-Keene Health Care Services Plan Act (Knox-Keene), which includes monitoring compliance with MHPAEA. DHCS adapted the MHPAEA survey administered by DMHC and reviewed the guidance in the Toolkit to develop its own surveys for the MCPs and MHPs. DHCS also completed the survey from the State’s perspective on pharmacy services since the State carves out high-cost medications and some antipsychotics to FFS.

3.3.1 Medi-Cal Managed Care Plan Survey

On January 9, 2017, DHCS administered a survey to the 22 MCPs, which focused on the following areas: authorization and referral process, pharmacy and drug formulary, provider network, credentialing and contracting, case management and care coordination, treatment restriction and/or exclusions, and financial requirements. Please refer to Attachment D in the Appendix for the MCP survey template.

DHCS requested each MCP respond to the survey on current FRs, QTLs and NQTLs within each benefit classification. Following the issuance of the survey, DHCS conducted a webinar on January 9, 2017 to encourage MCP engagement, respond to questions, and provide assistance with completing the survey. Additionally, DHCS conducted technical assistance calls with each individual plan between January 9, 2017 and January 20, 2017 to provide further guidance and assistance with survey questions.

The Department also requested policies and procedures for each question that applied to the plan. The survey responses were analyzed for parity concerns. Once the initial results were analyzed, a follow-up survey was sent out to gather additional information on a case-by-case basis.

3.3.2 County Mental Health Plan, DMC, and DMC-ODS Counties Survey

DHCS administered a similar survey to the 56 MHP, DMC, and DMC-ODS counties on January 20, 2017. The survey was tailored to better align with the SMHS delivery system. It focused on gaining information about potential FRs, QTLs and NQTLs in eight areas: authorization and referral process; medication prescribing, authorization, and monitoring practices; progressive therapy/step therapy; provider network credentialing and contracting; case management and care coordination; client treatment plans; financial requirements; and, disclosure requirements. MHPs and DMC-ODS counties were required to complete the survey and submit supporting documentation (i.e., plan policies and procedures).

DHCS conducted a webinar on January 20, 2017 to provide MHPs, DMC, and DMC-ODS counties with an introduction to the parity requirements and an overview of the parity survey. DHCS also held a technical assistance call with the MHPs, DMC, and DMC-ODS counties on January 26, 2017 to provide further guidance and assistance with completion of the survey questions. Throughout the survey response period, DHCS provided technical assistance and guidance to MHPs, DMC, and DMC-ODS counties requesting additional support.

DHCS analyzed the survey responses and supporting documentation to identify potential areas of concern and engaged in focused deep dive reviews through its Workgroup.

Please refer to Attachment E in the Appendix for the MHP and DMC-ODS counties survey template.

3.4 Deep Dive Sessions

The Workgroup utilized dedicated deep dive sessions to get a better understanding of each program’s policies and limitations. Between March and June 2017, the Workgroup met two to three times weekly in person to
discuss existing policies and operations for considering comparability and stringency across the programs. These face-to-face meetings were critical to identifying potential parity concerns, as well as determining the State’s compliance and steps for resolution. The Workgroup continues to meet weekly in order to ensure regular communication and provide implementation progress updates with the entire team.

4. Parity Analysis Outcomes

The Workgroup utilized the findings from the surveys, State-level policy review, and deep dive meetings to identify the areas where there were potential parity concerns by FRs, QTLs, and NQTLs. A summary of the parity concerns resulting from the parity analysis are outlined in the table below. The results of the parity analysis are described in greater detail within this section.

<table>
<thead>
<tr>
<th>Table 3. Summary of Parity Concerns</th>
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<tbody>
<tr>
<td>• Share of cost statutes (FR)</td>
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<tr>
<td>• AMSC quantitative limits on screenings and brief interventions (QTL)</td>
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<tr>
<td>• Authorization processing and timeframes (NQTL)</td>
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<tr>
<td>• Non-specialty mental health prior authorization processes (NQTL)</td>
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<td>• AMSC provider training requirements (NQTL)</td>
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<tr>
<td>• Statewide credentialing policy (NQTL)</td>
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<tr>
<td>• Statewide continuity of care policy (NQTL)</td>
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<tr>
<td>• Transportation policy for non-MCP covered services (NQTL)</td>
</tr>
<tr>
<td>• Statewide Network Adequacy Proposal (NQTL)</td>
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<tr>
<td>• Standardized Notice of Action (NQTL)</td>
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</tbody>
</table>

4.1 Financial Requirements (FRs)

The parity regulations describe financial requirements as fees charged to beneficiaries for services, including copayments, deductibles and co-insurance. The regulations provide that no financial requirement be applied to mental health or substance use disorder benefits “in any classification that is more restrictive than the predominant financial requirement … of that type applied to substantially all medical/surgical benefits in the same classification ….” (42 C.F.R. § 438.910(b)(1)). Generally, the purpose of this requirement is to prevent beneficiaries from being charged more for mental health or substance use disorder services than for medical/surgical services, which would create a barrier to beneficiaries accessing those services.

The Workgroup evaluated the financial requirements applicable to mental health and substance use disorder benefits to ensure that they are no more restrictive than the financial requirements that apply to medical/surgical benefits in the same classification. The State complies with these financial requirements because no financial requirements apply to mental health or substance use disorder services. For this reason, DHCS did not need to perform the two-part test for FRs (i.e., Substantially All, Predominant Level).
4.1.1 Share of Cost

Share of cost (SOC) is the amount a beneficiary is required to pay, or obligates to pay, towards their medical expenses in a particular month before services can be billed to Medi-Cal. SOC is structured similarly to a private insurance plan’s out-of-pocket deductible, but on a monthly, rather than annual basis. The beneficiary’s SOC is calculated by the county during the eligibility process, and is based on the beneficiary’s countable income. Medi-Cal eligibility rules, including income requirements for the various Medi-Cal programs are established by Federal and State law.

The Workgroup found during the State-level policy review that each of the MCP, MHP, and SUD contracts have provisions that indicate that income is used to determine program eligibility, among other factors. SOC, which is based on income, is applied consistently across California’s delivery systems.

In addition to providing SMHS through a MHP, counties are required to provide community mental health services (which are not Medi-Cal reimbursable) to their residents. Historically, counties have charged residents fees, based on ability to pay, for community mental health services. Current share of cost statutes pertaining to Uniform Method of Determining Ability to Pay (UMDAP) requires counties to charge beneficiaries for SMHS (Welfare & Institutions Code sections 5709 and 5710). However, this is inconsistent with current practice; county MHPs do not charge any fees to Medi-Cal beneficiaries. The Department intends to amend Welfare & Institutions Code sections 5709 and 5710 to conform with current practice.

4.1.2 Cost-Sharing

Cost sharing is prohibited by regulation. California Code of Regulations, title 22, section 51341.1, subsection (h), paragraph (7) that states in part, “Providers shall not charge fees to beneficiaries for access to DMC substance use disorder services or for admission to a DMC treatment slot.” DHCS SUD County Monitoring Unit through its annual monitoring process, which includes a review of compliance with DMC or DMC-ODS contract terms and conditions, will continue to verify that counties do not collect any type of cost sharing from SUD treatment beneficiaries. In addition, DHCS contacted counties to ensure that cost-sharing practices for Medi-Cal beneficiaries are discontinued immediately.

4.1.3 Other Financial Requirements

Copayments
DHCS does not require beneficiaries to pay a copay to receive Medi-Cal services, including specialty mental health or SUD services. The Workgroup determined that there are no compliance steps needed for this requirement.

Coinsurance, Deductibles, and Out-of-Pocket Maximums
There are no coinsurance requirements, deductibles, or out-of-pocket maximums in the Medi-Cal program. The Workgroup determined that there are no compliance steps needed for these requirements.

Aggregate Lifetime and Annual Dollar Limits
Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary’s lifetime or on an annual basis. These limits cannot be applied to mental health or substance use disorder benefits unless the limits apply to at least one third of all medical/surgical benefits. In addition, such limits must either be applied to both medical/surgical and mental health and substance use disorder benefits as a whole or the limits applicable to mental health or substance use disorder
benefits must be no more restrictive than those applicable to medical/surgical benefits. The Medi-Cal program
does not place aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits;
therefore, the Workgroup determined that there are no compliance steps needed for these requirements.

4.2 Quantitative Treatment Limitations (QTL)

Quantitative treatment limitations (QTLs) are limits on the scope or duration of a benefit that are expressed
numerically, such as limits on the number of covered visits, days of coverage or frequency of covered treatment.
The general parity rule is that no QTL may apply to mental health or substance use disorder benefits in a
classification if the QTL is more restrictive than the predominant treatment limitation of that type that applies to
substantially all medical/surgical benefits in the same classification. The Workgroup reviewed State regulations
and policies for MCPs, MHPs, and counties providing substance use disorder services and evaluated for potential
QTLs discussed below.

4.2.1 Specialty Mental Health Discharge Planning Targeted Case Management

MHPs provide targeted case management (TCM) services for purposes of discharge planning. This specialty
mental health TCM service is provided solely for the purpose of coordinating placement of the beneficiary on
discharge from the hospital, psychiatric health facility or psychiatric nursing facility, during the 30 calendar days
immediately prior to the day of discharge, for a maximum of three (3) nonconsecutive periods of 30 calendar
days or less per continuous stay in the facility. The TCM service is billed separately than the inpatient stay.
Further, the beneficiary can receive additional TCM services upon discharge. The Workgroup concluded that the
QTL does not limit the benefit, but rather, defines the timeframe for when the service can be billed. As such, the
Workgroup determined that there is not a QTL issue with the SMH Discharge Planning TCM service.

4.2.2 DMC-ODS Residential Services

4.2.2.1 DMC-ODS Residential Treatment Services

DMC-ODS residential treatment is a non-institutional, 24-hour, short-term residential program that provides
rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical
Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the results of
a clinical assessment for determining the most appropriate level of care based on American Society of Addiction
Medicine (ASAM) criteria. Residential treatment services are provided in a continuum of care as per the five (5)
levels of ASAM residential treatment levels. Residential treatment services are required in all counties that
contract to participate in the DMC-ODS Program.

Counties that opt into DMC-ODS provide residential treatment services pursuant to the limitations and
requirements set forth in the Medi-Cal 2020 Demonstration Waiver and the DMC-ODS Intergovernmental
Agreement15 with the State. Section (X)(134) of the Medi-Cal 2020 Demonstration Waiver and Part III(H) of the
DMC-ODS Intergovernmental Agreement require counties that opt into the DMC-ODS provide residential
treatment services in accordance with the following limitations:

15 Executed DMC-ODS contracts: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-
System.aspx
• Adults – up to two 90-day periods with a one-time 30-day extension in a 365-day period;
• Adolescents – up to two 30-day periods, with a one-time 30-day extension in a 365-day period; and
• Perinatal beneficiaries for the duration of their pregnancy and 60 days postpartum.

The DMC-ODS residential benefit is only authorized when delivered according to the quantitative limitations set forth in the Medi-Cal 2020 Demonstration Waiver and accompanying expenditure authority. This expenditure authority is the exclusive basis upon which DHCS can claim Federal financial participation for the benefit notwithstanding the Institutions for Mental Diseases (IMD) prohibition in Medicaid. Authorizing the counties to provide DMC-ODS residential services without these quantitative limitations would exceed the expenditure authority and thus preclude provision of the DMC-ODS residential benefit by virtue of the Federal statutory IMD prohibition. Because these quantitative limitations are a prerequisite for providing the benefit itself in Medi-Cal, it is not appropriate to evaluate parity compliance in this specific DMC-ODS context. For this reason, the Workgroup determined that there are no QTL concerns with DMC-ODS residential treatment services.

4.2.2.2 Residential Treatment Services for Adolescents

Residential treatment services for adolescents are provided through DMC-ODS and may be authorized for up to 30 days in one continuous period. There is a limitation on reimbursement for two non-continuous 30-day regimens in any one-year period (365 days), and one extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period (365 days). However, the Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate overrides these quantitative limitations. Thus, the Workgroup determined that there are no QTL concerns with residential services for adolescents.

4.2.3 DMC Narcotic Treatment Program

The Narcotic Treatment Program (NTP) component of California’s substance use disorder program through DMC includes a 200 minutes per month limit on narcotic treatment counseling. Additionally, NTP beneficiaries must have medical necessity reevaluated by the Medical Director or Licensed Practitioner of the Healing Arts at least annually to determine that those services are still clinically appropriate for that individual.

In December 2013, DHCS submitted State Plan Amendment (SPA) 13-038 with the goal of providing additional substance use disorder services under the DMC program effective January 1, 2014. SPA 13-038 added language based upon an agreement with CMS that allowed the soft limit of 200 minutes per month to be exceeded and reimbursed in cases of medical necessity. As described in the Medical Management Standards below, DHCS applies the overarching principles of medical necessity equally to mental health and substance use disorder services as to medical/surgical services, thereby not presenting a QTL parity concern.

4.2.4 Medication Supply Limits

Medi-Cal FFS pharmacy benefits policy currently allows six (6) prescription medications to be filled per beneficiary per month without prior authorization. This limitation applies to all prescriptions, regardless of the drug type or category, except in the following cases:

• Nursing facility patients
• Adult and pediatric subacute care patients
• Family planning drugs (for example, oral contraceptives)
• Claims that must be submitted on paper (claims with required attachments)
• Claims for newborns, where the baby uses the mother’s identification number
• Some Managed Care Plans (verify with specific plan)
• Drugs for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, as identified by a specific symbol in the Contract Drugs List.
• Cancer drugs, as identified by a specific symbol in the Contract Drugs List.

Section 1927 of the Social Security Act allows state Medicaid programs to apply prior authorization and/or may impose limitations with respect to all drugs. Restrictions include, but are not limited to, the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this Act. Accordingly, out of concern regarding the risk of over-medication, misuse of medication, as well as fraud and abuse potential involved in the dispensing of medications, Medi-Cal FFS has imposed a limit of six (6) prescriptions filled per beneficiary per month without prior authorization.

Carved-out drugs are determined on various factors, including the:

• General cost factor of the class of drugs in the aggregate
• Introduction of new and costly medications into the class, and
• Degree of difficulty in determining a capitation rate that would appropriately compensate the MCPs accordingly

DHCS currently carves out the following classes of drugs:

• Drugs to treat HIV/AIDS (these medications are exempt from the 6 prescription limit)
• Alcohol and opioid detoxification and dependency treatment drugs
• Blood factors
• Psychiatric (antipsychotic) drugs

Carved-out drugs claims are submitted to Medi-Cal FFS for reimbursement and are thus subject to the six (6) prescription utilization control. This limitation is applied across all carved-out prescriptions in the FFS system, not just mental health and substance use disorder prescriptions. Although there is a potential that mental health and substance use disorder medications could exceed six prescriptions per member per month, the probability of over six carved-out prescriptions for an individual member per month is extremely low. Additionally, each MCP is able to establish utilization controls on all medications, including non-carved out mental health drugs. Plan utilization controls may be equally or more restrictive than the six prescription limit in FFS. Therefore, the FFS utilization control does not create an issue of parity for the mental health or SUD drugs due to the six (6) prescription limit or any other FFS utilization control restriction.

4.2.5 Alcohol Misuse Screening and Counseling Limits

On January 1, 2014, California began offering the Alcohol Misuse Screening and Counseling (AMSC) benefit (formerly known as Screening, Brief Intervention, and Referral to Treatment) to adult Medi-Cal beneficiaries under the Affordable Care Act, which required that preventive services be offered to all Medi-Cal beneficiaries 18 years and older in primary care settings. Medi-Cal-funded primary care practitioners must provide AMSC, which includes a brief behavioral counseling intervention provided by a health care professional to include feedback and advice aimed to reduce alcohol misuse and/or make appropriate referrals to mental health and/or
alcohol use disorder services. DHCS issued APL 14-004 to provide policy guidance to the MCPs and added the benefit to the Medi-Cal Provider Manual.

DHCS classified AMSC as a substance use disorder benefit, thereby drawing the comparison of QTLs with other medical/surgical preventative services. The Medi-Cal Provider Manual and APL 14-004 provides for one (1) full screen and three (3) brief interventions per year to be provided and reimbursed. This limit is based on recommendation from the United States Preventative Services Task Force (USPSTF) that three brief interventions are the most effective at reducing alcohol abuse in adults when conducted in the primary care setting. The USPSTF is an independent panel of experts in primary care and prevention that systematically review the evidence of effectiveness of, and develops recommendations for, clinical preventive services.

After providing the brief intervention and upon identifying a possible alcohol use disorder, MCPs are required to refer the beneficiary to the county alcohol and drug program for evaluation and treatment. The referral to treatment process consists of assisting a patient with accessing specialized alcohol abuse treatment and selecting treatment facilities, which allows the beneficiary access to a higher level of care. However, despite the referral to a higher level of care, the Workgroup determined that the AMSC limitation is still a QTL.

The Workgroup reviewed the current AMSC process and were concerned that although the beneficiary has access to a continuum of care, the limitations posed issues with appropriateness of needed services. The Workgroup was concerned about the potential for the beneficiary to not be allowed to return to the lower level of care after review by the county program determines that the beneficiary does not meet medical necessity for the higher level of care. Additionally, the Workgroup was concerned that after going through the continuum of care, the beneficiary may be in need of the lower level of care within the same year. Lastly, after referral to a higher level of treatment beyond the primary care setting, due to the quantitative limit, the primary care provider would not be able to provide additional services beyond the one (1) screening and three (3) brief interventions.

Therefore, the Workgroup determined that DHCS would need to clarify policy to state that limitations can be exceeded due to medical necessity. In order to operationalize this policy, DHCS will clarify in the APL and Medi-Cal Provider Manual that additional AMSC services beyond the one (1) screening and three (3) brief interventions can be provided on the basis of medical necessity. This clarification would help to ensure that beneficiaries have access to needed AMSC services in the primary care setting when medically necessary. This change would also align with other Medicaid benefits with quantitative limits (i.e., optional benefits) which can be exceeded if medically necessary. This is further explained in the Medical Necessity section.

4.3 Non-Quantitative Treatment Limitations (NQTL)

NQTLs are non-numerical limits on the scope or duration of benefits. The general parity rule is that NQTLs must not be imposed on mental health and substance use disorder benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification. For this reason, the Workgroup approached the NQTL analysis differently from the review of financial requirements and QTLs. The NQTL analysis required that the Workgroup review survey findings and local-level policies and procedures to determine how State-issued policy and federal guidance was implemented and operationalized in practice.
As described in the Parity Toolkit, the NQTL analysis does not focus on whether the final result is the same; instead, compliance is based upon parity in application of the underlying processes, strategies, evidentiary standards, or other factors, both in writing and in operation. The Workgroup evaluated each potential NQTL through the lens of two approaches: (1) comparability of the benefit structure by benefit classification and (2) stringency in which the limit is applied.

Although the Parity Rule provided an illustrative, non-exhaustive list of NQTLs, the Workgroup broadened its scope of review to other policies if there were potential disparity in processes among delivery systems. The following is a discussion of the NQTLs that the Workgroup determined required further analysis.

4.3.1 Medical Management Standards

4.3.1.1 Medical Necessity

Medical necessity is a medical management standard that can potentially limit or exclude benefits on the basis of medical necessity or medical appropriateness. In California, medical necessity is defined in State statutes.\(^{16}\) The Workgroup analyzed the application of medical necessity by evaluating the comparability and stringency between medical/surgical and mental health benefits and between medical/surgical and substance use disorder benefits. As part of the NQTL review, the Workgroup requested policies and procedures from the MCPs, MHPs, DMC, and DMC-ODS counties to verify that evidence-based clinical guidelines were being used consistently. MCPs, MHPs, DMC, and DMC-ODS counties, and consequently each of their network providers, must base their medical necessity determinations in accordance with the generally recognized clinically appropriate standards of care.

Further, the Workgroup evaluated how soft limits were applied by delivery system and determined that all Medicaid services that are eligible to exceed the quantitative limits set forth in the State Plan, Alternative Benefit Plan, and Medi-Cal Provider Manual are permitted to exceed the stated limit if it medically necessary, regardless of the type of service. The Workgroup ascertained that this principle is applied consistently irrespective whether the service is intended to treat a medical/surgical, mental health, or substance use disorder condition.

The Parity Rule also imposes information requirements with respect to medical necessity. The availability of criteria for medical necessity determinations and the reason for denial of coverage for mental health and substance use disorder benefits are further discussed in this document in the Information Requirements section.

4.3.1.2 Authorizations

Authorization of services may take place prospectively, prior to the service being rendered; concurrently, while the services are being rendered; or retrospectively, after the services have already been rendered. The Workgroup reviewed authorization policies and procedures to ensure consistent application of authorization decisions across medical/surgical, mental health, and substance use disorder services by benefit classification. In

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\(^{16}\) Medical necessity definitions: Medical/surgical services – Title 22 CCR Section 51303(a) and the DHCS-MCP Contract; SMHS – Title 9 Sections 1810, 1820.205 1830.205, and 1820.210 (for EPSDT); DMC – Title 22 CCR Section 51303.1 and Section 51341.1(h)(1)(A)(v)(a-b); DMC-ODS requires at least one diagnosis from the DSM Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders and must meet the ASAM Criteria definition of medical necessity for services.
reviewing for comparability and stringency across delivery systems, the Workgroup considered the following factors as part of the NQTL analysis:

- Definition of authorizations in each program
- Circumstances in which authorizations are applied
- Authorization process
- Requirements and timeframes
- Consequences/penalties when requirements are not met
- Benefits that are subject to the authorization requirements
- Frequency and appropriateness of reviews
- Triggers for reassessment

Through the Workgroup’s review of State and local policies, it was determined that both MCPs and MHPs utilize clinical standards along with regulatory guidance from DHCS to authorize and reimburse medically necessary services delivered by providers to beneficiaries. However, existing State statutes and regulations establish different standards for MCPs and MHPs. State statutes governing the MCPs are more prescriptive than Federal guidelines, while State regulations governing the MHPs align with the Federal requirements in the Medicaid Managed Care Final Rule17 regulations. As such, the Workgroup utilized the more restrictive State statutes governing the MCPs as the threshold for determining standardization across delivery systems.

California Health and Safety Code Section 1367.0118 describes the following key policy elements that the plan must have:

- Written policies and procedures, reviewed and approved by DHCS, on authorization processes, including the manner in which plans approve, modify, delay or deny based on medical necessity
- Defined criteria and guidelines for purposes of authorizing services based on medical necessity
- Disclose authorization policies and procedures to providers and beneficiaries upon request
- Employed or designed medical director that holds an unrestricted license in the state of California to practice medicine
- Telephone access for providers to request authorizations
- A quality assurance program that specifically looks at authorizations
- Communicate the decision of the review request to the provider
- A licensed physician or licensed health care professional deny or modify requests for authorizations
- Communications to the beneficiary regarding decisions must be in writing and initially to the providers via telephone or facsimile, which must include the reason of the plan decision, the description of the criteria or guidelines used, and the clinical reasons decision including medical necessity
- Notification to the beneficiary and provider must be provided in writing if the authorization review timelines cannot be met, which would include the additional information that is needed to make the determination, the additional expert that needs to be consulted and the additional exams or tests that are required

The systemic changes for the SMHS delivery system described within this section are in response to the adaptation of the key policy elements described above. To further comport with the aforementioned policy

elements, DHCS will communicate and enforce the following overarching authorization principles through the parity contract amendment and State policy guidance:

**Overarching Authorization Principles Applicable to MCPs and MHPs**

A plan shall disclose the utilization management or utilization review policies and procedures that the plan, its contracting provider groups, or any entity that the plan contracts with, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits provided by the plan. These policies and procedures shall ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration: service type; appropriate service usage, cost and effectiveness of service and service alternatives; contraindications to service and service alternatives; potential fraud, waste and abuse; patient and medical safety; and other clinically relevant factors. The policies and procedures shall be consistently applied to medical/surgical, mental health and substance use disorder benefits. The plan shall notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

**Prior Authorization**

Prior authorization policies for MCPs are specifically defined in State statutes. Statutes prescribe authorization timeframes and require that the list of services that require prior authorization be provided to providers and beneficiaries. In addition, State and federal requirements, as per the Medicaid Managed Care Final Rule, dictate notice content and process requirements for decisions that deny, modify, or terminate mental health or substance use disorder benefits.

The Workgroup identified an area of concern in the SMHS delivery system with respect to processing timeframes to respond to prior authorization requests. State statutes require that MCPs respond to prior authorization requests within five (5) business days. MHP timeframes allow for 14 calendar days per Federal regulations, which is more restrictive from the beneficiary’s perspective as compared to medical/surgical service requests. The Workgroup concluded that there were no parity concerns with prior authorization timeframes for substance use disorder services since DMC-ODS counties must respond to prior authorization requests by providers for residential treatment services within 24 hours, which is less restrictive than the five (5) business days utilized in MCPs.

Additionally, the Workgroup identified some key differences with regard to the method in which MCPs and MHPs utilized the prior authorization process and the requirement to provide a defined list of services that need prior authorization. Prior authorization requirements for MCPs are clearly delineated in State statutes. Specifically, MCPs are required to identify and list services that require prior authorization. The MCPs are also required to make this list available to providers and beneficiaries. Conversely, while the MHPs were required, per the MHP contract and Title 9 regulations, to have in place procedures for authorization of services and notification to beneficiaries, it was allowable for MHPs to authorize services retrospectively. For outpatient SMHS, the State guidance on authorizations did not specify whether authorizations should be done prior to service delivery, concurrently, or retrospectively. State regulations governing the MHPs (CCR title 9, chapter 11, sections 1830.215 and 1820.220) permit, but do not mandate, prior authorization of outpatient specialty mental health services although requirements for retrospective authorization of inpatient psychiatric hospital services
are explicitly outlined. For reasons that regulatory and State guidance was silent on prior and concurrent review of authorizations and was more explicit in allowing retrospective review, MHPs did not consistently utilize prior authorizations in the same manner as MCPs.

In order to address the disparity between the requirements for MCPs and MHPs, DHCS will adopt new requirements for prior authorization of SMHS, including the identification of services requiring prior authorization and timeframes for making authorization decisions. To align the prior authorization timeframes between MCPs and MHPs, DHCS will adopt the review timeframe of five (5) business days for MHPs. DHCS will amend the MHP contract and issue further guidance regarding circumstances and timeframes in which authorizations are required for specific SMHS. As this constitutes a significant shift in local operations related to authorization of services, DHCS will work with the county MHPs to rollout the implementation of the authorization procedures.

Nevertheless, the Workgroup identified no parity concerns with prior authorization processes for substance use disorder services. According to Section 134 of the Medi-Cal 2020 Demonstration Waiver and Part III(F)(3)(i – x) of the DMC-ODS Intergovernmental Agreement, prior authorization is only required for residential treatment services. Additionally, counties must develop written processes and procedures for processing initial and continuing authorization of services. Counties are required to use DSM and ASAM criteria to confirm that the services are medically necessary. Furthermore, the services that require prior authorization are listed in the DMC-ODS Waiver and county contract, and is made available to beneficiaries and providers through the county. There are no prior authorization requirements for SUD services in State Plan DMC counties. DMC services are provided based on medical necessity and at least one SUD diagnosis from the DSM.

**Concurrent Authorization**

The purpose of concurrent review for authorization requests is to ensure the appropriateness of inpatient and outpatient admissions and determine the level of care and length of stay based upon medical necessity. MCPs utilize concurrent review after the first day of post-stabilization admission to review for medical necessity. Just as for prior authorization, the timeframe and processing requirements for concurrent review of authorizations are outlined in State statutes.

The Workgroup identified an area of concern in the SMHS delivery system with respect to concurrent authorization timeframes and processes. As an example, the Workgroup had concerns with the existing authorization policies and procedures for psychiatric inpatient hospital services. The State guidance required initial authorization by the MHP’s Point of Authorization or by the hospital’s Utilization Review Committee\(^\text{19}\) (URC). If the initial authorization was determined by the hospital’s URC, MHPs were further permitted to conduct retrospective authorization of services. Specifically, the regulations required hospitals to request authorization from a beneficiary’s MHP prior to a planned admission or within 14 calendar days after the following: discharge, ninety-nine (99) calendar days of continuous service to a beneficiary, if the hospital stay exceeded that period of time, or the date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending) (CCR, title 9, chapter 11, section 1820.220(b).)

\(^{19}\) Hospitals are required to comply with Federal requirements for utilization control, including certification of need for care, evaluation and medical review, plans of care and utilization review plan, as well as requiring each hospital to establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care. (CCR, title 9, chapter 11, sections 1820.210 and 1820.230)
Although State regulations allow for the use of concurrent review, the Workgroup determined that due to the ambiguity of State guidance, MHPs are not consistently conducting concurrent authorization review. Since MHPs are mainly conducting retrospective authorization reviews, a payment adjustment to the provider could occur for services already rendered if it is determined that the services were not medically necessary. In contrast, authorizations approved by the MCPs are considered assured payment to providers.

The second concern that the Workgroup had with concurrent authorization review is regarding the processes and timeframe for authorization. The regulations require the hospital’s URC to approve or deny the payment authorization no later than the third working day from the day of admission. In an effort to bridge the parity concerns, DHCS will align the requirements for MHP authorizations of psychiatric inpatient hospital services with the concurrent authorization review requirements used by MCPs for inpatient hospital services. Similar to MCPs, MHPs will be expected to conduct concurrent review of treatment authorizations until discharge and complete the review within five (5) business days upon receipt of request. DHCS will ensure consistency in the required timeframes for concurrent review of inpatient hospital services by amending the contract and regulatory guidance for SMHS.

The Workgroup identified no parity concerns with concurrent review processes and timeframes for substance use disorder services. According to Section 134 of the Medi-Cal 2020 Demonstration Waiver and Part III(H)(iv)(b-c) of the DMC-ODS Intergovernmental Agreement, concurrent authorization is required only in residential treatment services for adults and adolescents to receive up to an additional 30 days of residential services who previously received prior authorization for up to 90 days of residential treatment services. Adults and adolescents who received authorization for residential treatment services may receive one 30-day extension per 365-day period, as long as services are determined to be medically necessary during the concurrent authorization process. In addition, the Workgroup has not identified any services in State Plan DMC that require concurrent authorization.

**Retrospective Authorization**

As mentioned in the *Prior Authorization* section above, the Workgroup determined that retrospective review is the main form of authorization review used by MHPs, as prior authorization and concurrent review are less common. To meet parity compliance, DHCS will issue guidance and clarify requirements for authorization of SMHS, as described with subsection 4.3.1.2.

The Workgroup did not identify any parity concerns with retrospective review for substance use disorder services. Retrospective reviews are not conducted in DMC or DMC-ODS; rather, services are provided according to medical necessity, and in the case of residential services, services must also meet prior authorization requirements. DHCS conducts post-service post-payment utilization reviews at DMC provider sites to determine compliance with standards of care and other DMC requirements. At the conclusion of each review, DHCS issues a written report detailing any deficiencies found and identifying recovery for any payments made for units of service that are found to be out of compliance.

**4.3.2 Non-Specialty Mental Health (Mild to Moderate Mental Health Services)**

After an analysis of the MCP survey results and review of policies and procedures, the Workgroup concluded that there were inconsistencies in processes within the MCPs. The Workgroup identified variances with the MCPs’ prior authorization processes between medical/surgical and non-specialty mental health services. Prior authorization processes appeared to vary from plan to plan; some MCPs required prior authorization to obtain an initial mental health assessment by a primary care provider or mental health provider. The Workgroup’s
review of State issued guidance via APL 13-021 revealed that prior authorization requirements were ambiguous. While many primary care providers (PCPs) provide the initial mental health assessments within their scope of practice, not all do. If a beneficiary’s PCP does not perform a mental health assessment, and instead refers the beneficiary to another provider, this creates a barrier to access to an initial mental health assessment.

The Workgroup identified other variances in policies and procedures from plan to plan. For example, some MCP utilized a different panel of experts and committee members to review authorizations for medical/surgical services compared to mental health and substance use disorder services.

To remedy these variances, DHCS will issue guidance and clarify to MCPs that any restrictions to a beneficiary’s access to an initial mental health assessment is prohibited. To add to this, DHCS will affirm the overarching principles of authorizations that provide for a comparable process for both medical/surgical, non-salary mental health, and substance use disorder services as described in the above-mentioned Authorizations section. Taking into account that utilization management may vary between providers, the standards that will be communicated to the MCPs are that the authorization review process and evidentiary standards criteria must be based on clinical standards, applied consistently across medical/surgical and non-specialty mental health services, and communicated to providers. MCPs will be required to submit their utilization management policies and procedures to DHCS for review. The policy must demonstrate that authorizations are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits.

4.3.3 Reimbursement Structures

There are fundamental differences in the financing of the delivery systems in California, which result in distinctive reimbursement arrangements. For parity across MCPs, MHPs, and SUD delivery systems, DHCS does not believe it necessary to examine potential differences in the network reimbursement methodology in the NQTL context, given the fundamental differences in the financing of the delivery systems and how those differences necessarily result in distinctive downstream reimbursement arrangements. MCPs are reimbursed via a full risk-based, capitated rate, whereas MHPs and DMC-ODS entities are reimbursed a non-risk, non-capitated cost basis, and counties in DMC are reimbursed on a fee-for-service basis.

For parity within a MCP’s delivery of medical/surgical and mental health and substance use disorder benefits, DHCS does not have evidence to suggest that plans are applying different factors to network reimbursement rates for covered mental health and substance use disorder services as compared to network rates for covered medical services. For both categories, plans consider multiple factors in determining/negotiating rates, including Medicare or Medi-Cal rates for the service in question, geographic market dynamics, provider supply, and service demand.

MCPs, MHPs, and DMC-ODS counties pay their network providers rates that the plans negotiate with the providers. DHCS does not prescribe the rates plans pay their network providers. The plans and their network providers may consider a variety of factors when negotiating rates. In DMC, the reimbursement rates are set by DHCS on an annual basis in California Code of Regulations, Title 22, Section 51516.1. DHCS does not have any evidence to suggest that plans or DHCS are applying different factors when setting reimbursement rates.

4.3.4 Alcohol Misuse Screening and Counseling Provider Training

The Workgroup identified conflicting statements in State guidance between the Medi-Cal Provider Manual and APL regarding the requirement that providers undergo AMSC training as a condition of reimbursement for
providing AMSC services. The Medi-Cal Provider Manual included a specific requirement of a minimum of four hours of SBIRT training in order to provide and receive reimbursement for AMSC services; conversely, the APL highly encouraged training but did not require it as a condition of reimbursement. Additionally, DHCS does not require training for any other preventative services screenings prior to medical/surgical services being provided. The Workgroup considered this requirement to be a NQTL because the training requirement, and consequently payment condition, could potentially limit the number of providers that can render AMSC services.

The Workgroup determined that the APL and the Medi-Cal Provider Manual language will need to be aligned. Additionally, DHCS will issue guidance to MCPs that clarifies that rendering licensed health care providers are recommended, but not required, to take training in order to provide and receive reimbursement for AMSC services. These clarifications to the training requirement will help to ensure that providers can render the service if it is in their scope of practice and promote comparable access as a medical/surgical service.

4.3.5 Network Adequacy

The Medicaid Managed Care Final Rule established network adequacy requirements but provided flexibility to states to set state-specific standards. In developing California’s network adequacy standards, DHCS was cognizant of utilizing comparable processes, strategies, and evidentiary standards across delivery systems in light of parity. Therefore, DHCS established the same network adequacy standards (time and distance and timely access) for both specialty and non-specialty mental health providers, as well as opioid treatment program providers, thus aligning the standards with specialists providing medical/surgical benefits. California’s network adequacy standards are published at http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf.

4.3.6 Provider Credentialing

The Medicaid Managed Care Final Rule and 21st Century Cures Act set forth new requirements for provider screening and enrollment. Prior to these requirements, there were no statewide credentialing standards in the SMHS delivery system; instead, county MHPs were directed to develop policies and procedures for credentialing and re-credentialing of providers. Specialty mental health and substance use disorder programs will adopt a statewide credentialing policy, consistent with guidance issued to MCPs via APL 16-012. MHPs are already required to comply with the elements in the Managed Care Final Rule and Cures Act specific to provider screening; thus they are in compliance with those specific requirements.

DHCS will require both MCPs and MHPs to follow those policies in accordance with 42 CFR 438.214 and 438.602(b), as well as compliance with Section 1902(kk) of the Social Security Act regarding provider terminations. DHCS will review policies and procedures that reflect these regulation changes to ensure that MCPs and MHPs are in compliance.

Currently, DHCS conducts various aspects of credentialing SUD providers. According to Part II(E)(5)(a) of the DMC-ODS Intergovernmental Agreement, which is based on the Medicaid Final Rule 42 CFR §438.214, counties will align their credentialing policies and procedures with State-established requirements. The State-established

guidance will align with the requirements set forth in the Managed Care Final Rule and 21st Century Cures Act, subject to CMS approval.

4.3.7 Fail First, Step Therapy, and Prescription Drug Network Tiers

Prescription drugs for specialty mental health and substance use disorder services are carved out and paid for by the Medi-Cal FFS delivery system. DHCS compared the MCP pharmacy benefits structure with Medi-Cal FFS to conduct the NQTL analysis on prescription drug protocols. Medi-Cal FFS does not have fail first, step therapy, and/or network tier requirements for drugs, nor does it require labs, drug testing, or patient compliance monitoring before authorizing medications. FFS does not utilize a pre-determined set of benchmarks used in Treatment Authorization Request (TAR) adjudication. All TAR adjudication is performed based on the pharmacist adjudicator’s professional evaluation of documentation provided by the requester validating the medical necessity for the requested drug and clinically ruling out CDL alternatives. If the adjudicator finds that details or data are missing that, if provided, would potentially make the request approvable, the TAR may be deferred asking for additional information. FFS Medi-Cal does not limit medications used to treat conditions based on failure to complete prior treatment or due to patient non-compliance. Out of concern regarding the risk of over-medication, misuse of medication, as well as fraud and abuse potential involved in the dispensing of medications, Medi-Cal FFS has imposed a limit of six (6) prescriptions filled per beneficiary per month without prior authorization.

In compliance with Section 1927(d)(7), FFS covers all seven FDA-approved tobacco cessation medications. Bupropion SR, Varenicline, nicotine gum, nicotine lozenge, and the nicotine patch are available without a TAR, while a nicotine inhaler and nicotine nasal spray do require a TAR.

If a FFS drug requires a TAR, authorization may be granted when:

- The clinical condition of the patient requires the use of an unlisted drug and listed drugs have been adequately considered or tried and do not meet the medical needs of the patient.
- The use of an unlisted drug results in a less expensive treatment than would otherwise occur.

Authorization for prescribed drugs is granted for a specific quantity of medication and number of refills, if any, in accordance with the beneficiary’s medical need and the chronicity of the condition. Similarly, if an MCP has prior authorization requirements on medications, a clinical rationale for such an action and the criteria used to decide medical necessity must be included in the determination. The authorization requests for mental health and substance use disorder medications must be evaluated on a comparable basis, and are applied no more stringently than the clinical rationale and medical necessity criteria used for medical/surgical medications. Since MCPs cover some outpatient mental health medications, DHCS Pharmacy Benefits Division reviews all FFS and MCP drug formularies for compliance with the above requirements.

4.3.8 Continuity of Care

California statutes require MCPs to provide continuity of care to beneficiaries with certain complex conditions (Health and Safety Code Section 1373.96). Per contract requirements and DHCS policy, MCPs are required to allow the services and/or treatment to continue for up to 12 months with the beneficiary’s current provider if certain criteria are met, even if the provider is out-of-network.

Whereas, California’s SMHS system operates under an approved 1915(b) Freedom of Choice Waiver that waives a beneficiary’s freedom of choice in selecting a Medi-Cal provider. Beneficiaries that meet medical necessity
criteria for SMHS are mandatorily enrolled into the MHP in their county of residence. Waiving freedom of choice in this manner does not restrict beneficiaries from choosing among providers within the MHP. MHPs are required to provide, or arrange for the provision of, SMHS to all beneficiaries that meet medical necessity criteria if they are residents of the county in which the MHP is located. This includes beneficiaries who receive physical health care from a MCP or through the FFS system.

As beneficiaries change their residence from one county to another, the beneficiary’s Medi-Cal eligibility is transferred to the new county and the beneficiary can receive services from the MHP in that county. Since all MHPs are required to provide, or arrange for the provision of, all medically necessary SMHS, continuity of care is built in to the structure of the 1915(b) Waiver and the SMHS delivery system. Furthermore, the existing MHP contract required county MHPs to implement procedures to coordinate services furnished by the MHP with services that the beneficiary received from any other Medi-Cal managed care plan or MHP. It also required the MHP to ensure continuity and coordination of care with physical health care providers and other human services agencies used by its beneficiaries. The contract does not specify requirements for operationalizing a continuity of care policy at the local level.

The Workgroup identified the continuity of care policy as a NQTL concern since DHCS’ continuity of care policy for MCPs includes non-participating physician providers. As such, DHCS will adopt a SMHS and SUD continuity of care policy that is consistent with the requirements in place for MCPs.

4.3.9 Home and Community Based (HCBS) Waiver Services

The Workgroup evaluated the HIV/AIDS Waiver, DD Waiver, and MSSP Waiver since these waivers provide some mental health services. However, upon further review, it was determined that these waivers are not primarily intended to treat mental health and substance use disorder conditions. The Parity Toolkit states that when defining LTSS benefits, it is the condition for which the service is provided that determines the benefit type.

The HIV/AIDS Waiver provides services to individuals who are diagnosed with the human immunodeficiency virus (HIV), who are experiencing the symptoms associated with acquired immune deficiency syndrome (AIDS). The DD Waiver provides home and community-based services for developmentally disabled persons who are Regional Center consumers. Local Multipurpose Senior Service Program (MSSP) sites provide therapeutic counseling for the elderly, including treatment for severe anxiety, emotional exhaustion, loss/grief, confusion etc.

Because the primary aims of the HIV/AIDS Waiver or DD Waiver are to treat the HIV/AIDS diagnosis or developmentally disabled conditions and not primarily intended to provide services for a mental health and substance use disorder condition, the Workgroup determined that parity compliance does not apply to either of these Waivers. Likewise, the MSSP Waiver does not provide mental health services for individuals with mental illness or serious emotional disturbance, including services necessary for the diagnosis of a mental illness. Because the MSSP Waiver is not primarily intended to provide mental health services, the Workgroup determined that parity compliance also does not apply to the MSSP Waiver.

Moreover, DHCS did not check the box on the Waiver applications to include services for individuals with chronic mental illness including services necessary for the diagnosis or treatment of the individual’s mental illness in the HIV/AIDS, DD, or original MSSP Waiver. While not explicit in the 2014 renewal, the MSSP Waiver renewal did not list the addition of mental health services as a major change, nor was mental illness listed as one of the target
groups or subgroups of individuals that may receive services under the MSSP Waiver. This is consistent with the July 1, 2004 – June 30, 2009 application excluding mental health services from the MSSP Waiver.

Since these HCBS waivers are not intended to treat mental health and substance use disorder conditions, and are not subject to parity, the Workgroup has determined that are no additional steps necessary for parity compliance.

4.3.10 Transportation

Non-Emergency Medical Transportation (NEMT) is a covered Medi-Cal benefit when a beneficiary needs to obtain medically necessary services and is prescribed by a licensed physician, dentist, podiatrist, mental health provider, or SUD provider. Medi-Cal Managed Care Plans (MCPs) currently provide NEMT to plan-covered benefits for all eligible beneficiaries and non-medical transportation (NMT) for EPSDT services. For non-plan covered benefits, the MCP is required to refer and coordinate NEMT services for the beneficiary.

Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016) requires DHCS to clearly define NMT in the State Plan for all Medi-Cal beneficiaries in both fee-for-service (FFS) and managed care delivery systems. NMT is subject to utilization controls and federally permissible time and distance standards, consistent with a federal requirement that state Medicaid agencies provide assurances of necessary transportation for beneficiaries to and from covered services. In the FFS delivery system, NMT is an indirect benefit that may be covered administratively through programs identified in the State Plan or through local transportation resources reimbursed through Medi-Cal’s County-Based Medi-Cal Administrative Activities (CMAA) program and/or the MCPs.

As a result of AB 2394, DHCS expanded the NMT benefit in the managed care delivery systems, effective July 1, 2017, to include all enrolled beneficiaries, regardless of age, for covered plan services. Additionally, effective October 1, 2017, DHCS will require the MCPs to provide NMT benefits to its enrolled beneficiaries for non-MCP-covered services, including mental health and substance use disorder services, to comply with the Parity Rule.

The changes made by DHCS will result in increasing beneficiary access to transportation for medical/surgical, mental health, and substance use disorder services. DHCS issued guidance on this via the contract, APL, and the MCP’s Member Handbook template.

4.3.11 Federally Qualified Health Centers (FQHC) Same Day Billing

California’s State Plan contains policy that disallows the billing of multiple encounters that take place on the same day in Federally Qualified Health Centers (FQHCs). The FQHC same day billing policy may appear to limit the ability of mental health providers to render and be reimbursed for services, and thus, can be viewed a NQTL. However, the policy does not actually restrict any services as all services are covered under the FQHC rate, regardless of whether medical services or mental health services are provided first. The Workgroup determined that the same day FQHC same day billing policy is applied consistently among medical/surgical, mental health, and substance use disorder benefits. Therefore, the Workgroup concluded that there is not a NQTL concern with FQHC same day billing since the policy is not more restrictive on mental health services.

4.4 Information Requirements

The Parity Rule includes two (2) information requirements related to mental health and substance use disorder benefits. The first requirement is that the criteria for medical necessity determinations for mental health and substance use disorder benefits must be made available upon request to MCO enrollees, potential enrollees, and providers. If an MCO (or other plan governed by the Parity Rule) disseminates practice guidelines (which contain the criteria for medical necessity determinations for mental health and substance use disorder benefits) to its providers and to its beneficiaries upon request it is deemed to be compliance with this requirement. MCPs and MHPs both disseminate practice guidelines and are deemed to be in compliance with this requirement. MCPs are also required to provide beneficiaries the criteria for medical necessity determinations for all benefits, including mental health and substance use disorder services, upon request, free of charge. The Workgroup reviewed policies and procedures related to criteria for medical necessity determinations, as well as the dissemination of practice guidelines. It was determined that DHCS is in compliance with the Parity Rule as it relates to the availability of medical necessity criteria and that no further action is required.

The second information requirement is the requirement to make available to beneficiaries the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits. When an MCP or MHP delays, denies, modifies or terminates a benefit it notifies the impacted beneficiary with a Notice of Action (NOA), otherwise referred to as a Notice of Adverse Benefit Determination.

State and Federal regulations define NOA requirements and timelines. (See CFR 438.228, 42 CFR Part 431, Subpart E and CA Health & Safety Code 1367.01). The Federal requirements apply to MCPs, MHPs, and DMC-ODS opt-in counties. Per 22 CCR 51341.1(p), DMC providers are required to advise beneficiaries in writing prior to the effective date of a denial, involuntary discharge, or reduction in SUD services. Beneficiaries are also notified of their right to a State Fair Hearing at the time they are notified of the change in services.

However, the Workgroup determined the requirements governing the MCPs and outlined in Health and Safety Code Section 1367.01 are more prescriptive than Federal guidelines. Specifically, the H&S Code requires the MCPs to notify the beneficiary, in writing, within two (2) business days of the decision to terminate, modify, or reduce services. Existing State regulations for the MHPs require written notification to the beneficiary within three (3) business days. Further, while the content of the NOA is mandated by Federal regulations, and consistent across all plan types, there were also differences in the layout and formatting of the NOA between the MCPs, MHPs, and DMC-ODS counties.

In May 2017, DHCS updated its Notice of Action (NOA) templates to ensure they contain the required elements and disclosures. The standardized templates are comprised of two components: the NOA and the “Your Rights” templates. DHCS issued the updated templates to MCPs via APL 17-006. The APL also requires MCPs to provide beneficiaries copies of all documents and records relevant to an NOA, including criteria or guidelines used to make medical necessity determinations, free of charge, upon request.

To promote statewide standards and ensure compliance with the Parity rule, DHCS will align the content and timing requirements for NOAs across delivery systems for MCPs, MHPs, and DMC-ODS counties. In addition to the standardized content, the NOA will be sent within two (2) business days after an adverse action.

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22 The Intergovernmental Agreement, Exhibit A, Attachment I (E)(4)(v)(e)(i) governs the requirements for DMC-ODS counties on issuing notices of adverse benefit determination.
5. **Compliance Action Plan**

5.1 Contract Amendment and Deliverables

5.1.1 MCP Contract

In order for the MCPs to come into compliance with the Parity Rule, DHCS will incorporate the required language as instructed by CMS on the Parity Contract Checklist\(^2\) and amend the MCP contract to address the parity findings described in **Section 4, Summary of Parity Analysis Findings**. Additionally, MCPs will be required to adjust their policies and procedures regarding the QTLs and NQTLs that were identified and submit them to DHCS for review to ensure compliance.

To demonstrate compliance, MCPs will be required to amend their applicable policies and procedures and submit them to DHCS for review and approval. DHCS will submit the amended contract in compliance with the Parity Rule along with this Compliance Plan to CMS.

MCPs will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables section of the contract and APL guidance. DHCS will provide guidance that outlines the required deliverables as well as the submission timelines. DHCS subject matter experts will review the submission of deliverables to evaluate Parity Rule compliance and to determine MCP’s contractual compliance.

5.1.2 MHP Contract

DHCS will incorporate the required language for parity, as instructed by CMS on the Parity Contract Checklist, into the MHP contract to ensure parity compliance. The contract amendment and policy changes will address the parity findings described in **Section 4, Summary of Parity Analysis Findings**.

To demonstrate compliance, MHPs will be required to amend their applicable policies and procedures and submit them to DHCS for review and approval.

5.1.3 SUD Contract

CMS provided a draft tool to DHCS SUD for conducting Readiness Reviews of counties that opt into the DMC-ODS waiver after July 1, 2017. CMS will review and approve all Readiness Reviews prior to a county receiving contractual approval to provide services under a DMC-ODS Intergovernmental Agreement.

DHCS identified required changes to the current Intergovernmental Agreement (contract) boilerplate between DMC-ODS counties and the State. The parity contract amendment will include information on meeting parity requirements and the specific processes DHCS will undertake for ensuring ongoing compliance with parity requirements. The amendment will also describe the county monitoring efforts that will focus on identifying changes or restrictions that counties impose on the delivery of SUD benefits that may impact compliance with parity requirements.

5.2 State Guidance

5.2.1 All Plan Letters

5.2.1.1 Revision to APL 13-021: Non-Specialty Mental Health Services

DHCS has revised and issued an APL to supersede APL 13-021, *Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services*, to include the Parity Rule requirements and provide clarification on authorization requirements for non-specialty mental health services with respect to the initial mental health assessment. The APL also included the overarching principles of authorizations as described in the Authorizations section.

5.2.1.2 Revision to APL 14-004: AMSC

DHCS has revised APL 14-004, *Alcohol Misuse Screening and Counseling*, to address the QTL by allowing providers to provide additional brief intervention sessions when medically necessary. Additionally, the APL will clarify that provider training is not required as a condition to providing AMSC in order to address the NQTL.

5.2.1.3 APL 17-010: Transportation

DHCS has revised and issued APL 17-010 to add the expanded transportation benefit as a result of the parity analysis. The APL will require MCPs to provide NEMT and NMT for all Medi-Cal services, regardless whether it is a plan-covered benefit, unless it is provided through another program.

DHCS issued APL 17-010 to the MCPs on May 31, 2017.

5.2.2 County Information Notices

Many of the policy decisions DHCS is making to ensure compliance with the Parity Rule will result in significant changes to the SMHS delivery system and local operations. Since many of these decisions establish new or revise policies, DHCS will work with the county MHPs to operationalize and rollout the implementation of the policies for authorization, credentialing and continuity of care. As DHCS continues to operationalize these policies, guidance will be issued to the MHPs. DHCS will also amend the MHP contract to ensure compliance with the Parity Rule.

5.3 Medi-Cal Provider Manual

The Workgroup identified areas in the Medi-Cal Provider Manual that require modification in order to meet parity compliance. DHCS will update the Preventive Services section for AMSC to incorporate the following changes:

- Add the medical necessity clause to exceed the soft limits of one (1) screen and three (3) brief interventions when medically necessary
- Eliminate the requirement for providers to obtain required training in order to provide, and be reimbursed for, AMSC services

The above changes will align with updates made to the AMSC APL and removes any potential barriers to accessing medically necessary AMSC services.
5.4 Alternative Benefit Plan

Medicaid Alternative Benefit Packages (ABPs) were required to comport with MHPAEA for the Affordable Care Act implementation. DHCS assessed the ABP for comportment with MHPAEA and assured compliance by submission of ABP State Plan Amendment CA 13-035 on December 30, 2013. CMS approved the ABP effective January 1, 2014. Therefore, the State’s ABP is deemed to be compliant with the parity requirements for FRs, QTLs, and NQTLs with respect to beneficiaries entitled to EPSDT benefits. The Workgroup determined that the State Plan is in alignment with the ABP benchmark plan. Therefore, DHCS recommends no revisions to the State Plan ABP.

The State Plan for Children’s Health Insurance Program (CHIP) is deemed in compliance due to the provision that the State covers EPSDT for the full EPSDT population. Please refer to Attachment G in the Appendix for the required EPSDT documentation. Nonetheless, CMS has updated the CHIP State Plan template on September 20, 2017. DHCS may potentially need to submit a CHIP SPA to document consistency with parity regulations. DHCS will post the required public notification of the potential SPA changes and will work towards the amendment until December 29, 2017, if determined to be necessary.

5.5 Statutes

The conclusion of the parity analysis necessitates an amendment to State statute in order to meet parity requirements. DHCS intends to amend Welfare & Institutions Code sections 5709 and 5710 during the next available trailer bill legislative cycle to conform to current practice that MHPs do not charge any resident’s fees for Medi-Cal specialty mental health services.

5.6 Compliance Posting

To demonstrate parity compliance, the State is required to provide documentation of compliance to the general public by posting a summary of the parity findings and compliance recommendation on its website by October 2, 2017. DHCS will post the Compliance Summary at http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx.

6. Monitoring and Reassessment

6.1 State Responsibilities

The Parity Rule requires states to develop and implement monitoring procedures, including a process for ongoing parity reassessment, once the Compliance Summary is posted on October 2, 2017. The Workgroup will continue to meet and discuss operationalizing and refining the ongoing compliance and monitoring activities described below. DHCS is currently making necessary updates, including updating the medical audit tool.

Parity compliance will be monitored through contract renewals with MCPs, MHPs, and DMC, as well as waiver renewals with DMC-ODS, if applicable. Other triggers for parity reassessment include significant changes to the provider networks and added benefits. In instances where new benefits are added to the Medi-Cal program, DHCS will provide guidance on plan readiness, as well as audit the process to ensure that parity requirements are met. DHCS will maintain communication with its plans and interested stakeholders and provide compliance and monitoring updates through State guidance and opportunities for stakeholder feedback.
DHCS intends on leveraging existing MCP oversight and plan assessment tools to monitor parity compliance, specifically new and updated requirements for state monitoring that are a result of the Medicaid Managed Care Final Rule 42 CFR § 438.6624. These monitoring efforts include, but are not limited to:

- **Grievance and Appeal Monitoring** which reviews data to improve overall plan performance on an annual basis. DHCS will utilize the data to ensure that MCPs are complying with parity requirements and disseminating accurate information about parity to providers and beneficiaries.
- **Customer Service Performance Monitoring** utilizes data from call center reports and is reviewed on a quarterly basis. The data will be evaluated to ensure that beneficiaries are not having access issues to MH/SUD and M/S benefits.
- **Utilization Management Process Monitoring** tracks and validates encounter data submission and reported rates on an annual basis. Additionally they are required to submit their policies and procedures regarding their review process. The department will ensure their review criteria is comparable across medical/surgical and mental health and substance use disorder benefits.
- **Financial Monitoring** reviews financial audit reports, financial statements, medical loss ratio summary reports, overpayments and recoveries and are reviewed on an annual basis. These will be reviewed to ensure MCPs performance.

Since these monitoring activities are required by the Medicaid Final Rule it will ensure parity as both MHPs and MCPs will be required to adhere.

DHCS will continue to monitor MHP compliance with State and Federal requirements pursuant to the monitoring plan in its approved 1915(b) Waiver. DHCS conducts various monitoring and oversight activities to ensure compliance, including onsite triennial system reviews of the 56 county MHPs. The system review covers requirements related to network adequacy, access, authorization of services, beneficiary problem resolution, coordination of care, program integrity, provider monitoring, and quality improvement.

### 6.2 MCP Responsibilities

MCPs will be responsible for parity compliance between medical/surgical and non-specialty mental health benefits and ongoing assessment as well. The Department will issue any necessary guidance and updates through APLs and weekly plan operation calls. MCPs will be required to meet contractual requirements and submit deliverables if reassessment is initiated, such as grievance and appeal and call center data. Moreover, MCPs will be required to submit their Evidence of Coverage template that describes covered benefits when applicable. DHCS provides technical assistance when MCP deliverables and submissions do not meet requirements. If identified deficiencies are not corrected within appropriate timeframes, DHCS may administer a corrective action plan or sanctions, respectively, until the issue is resolved.

### 6.3 MHP Responsibilities

MHPs are responsible for demonstrating compliance with all applicable state and Federal requirements. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements during onsite triennial reviews of each MHP. If DHCS determines the MHP to be out of compliance

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with requirements, the MHP is required to submit a Plan of Correction, as well as evidence of correction, to the Department.

6.4 County SUD Services Responsibilities

Counties are responsible for adhering to the state and federal requirements of either the DMC-ODS Intergovernmental Agreement or the DMC state-county contract. Counties must demonstrate compliance during annual DHCS monitoring reviews. Evidence of compliance can be through policies and procedures, support documents, written reports and interviews with county staff. If DHCS determines a county is non-compliant with contract requirements, the county must develop a corrective action plan and submit evidence of correction. DHCS can withhold funds should the county fail to remediate deficiencies.
7. **Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMSC</td>
<td>Alcohol Misuse Screening and Counseling</td>
</tr>
<tr>
<td>APL</td>
<td>All Plan Letter</td>
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<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>COD</td>
<td>Covered Outpatient Drugs</td>
</tr>
<tr>
<td>COHS</td>
<td>County Organized Health Systems</td>
</tr>
<tr>
<td>DMC</td>
<td>Drug Medi-Cal</td>
</tr>
<tr>
<td>DMC-ODS</td>
<td>Drug Medi-Cal Organized Delivery System</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>FFP</td>
<td>Federal Financial Participation</td>
</tr>
<tr>
<td>GMC</td>
<td>Geographic Managed Care</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community-Based</td>
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<tr>
<td>H&amp;S</td>
<td>Health and Safety Code</td>
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<tr>
<td>MCP</td>
<td>Medi-Cal Managed Care Plan</td>
</tr>
<tr>
<td>MHP</td>
<td>Mental Health Plan</td>
</tr>
<tr>
<td>MHPAEAA</td>
<td>Mental Health Parity Addiction and Equity Act</td>
</tr>
<tr>
<td>SABG</td>
<td>Substance Abuse Block Grant</td>
</tr>
<tr>
<td>SMHS</td>
<td>Specialty Mental Health Service</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
</tr>
<tr>
<td>TCM</td>
<td>Targeted Case Management</td>
</tr>
<tr>
<td>USPSTF</td>
<td>United States Preventative Services Taskforce</td>
</tr>
<tr>
<td>WIC</td>
<td>Welfare and Institutions Code</td>
</tr>
</tbody>
</table>
8. APPENDICES

8.1 Medi-Cal Managed Care Models (Attachment A)
8.2 California Counties by Mental Health and DMC-ODS Region (Attachment B)
8.3 Benefits Mapping, Classification, and Definitions (Attachment C)
8.4 Medi-Cal Managed Care Plan Survey (Attachment D)
8.5 County Mental Health Plan Survey (Attachment E)
8.6 Medicaid Alternative Benefit Plan (ABP) State Plan Amendment (Attachment F)
8.7 EPSDT Documentation (Attachment G)
Attachment A
Medi-Cal Managed Care Models

**MEDI-CAL MANAGED CARE MODELS**

- San Benito Model (Expansion)
- Imperial Model (Expansion)
- Regional Model (Expansion)
- COHS Model (Expansion)
- Two Plan Model
- GMC Model
- COHS Model

![Map of Medi-Cal Managed Care Models in California](image-url)
Attachment B
California Counties by Mental Health and DMC-ODS Region

California Counties Map
# Table 1. Medical/Surgical Benefits to the Four Classifications

<table>
<thead>
<tr>
<th>Inpatient¹</th>
<th>Outpatient²</th>
<th>Prescription Drugs³</th>
<th>Emergency Care⁴</th>
</tr>
</thead>
</table>
| - Anesthesiology services  
- Breastfeeding education  
- Diagnostic services  
- Labor and delivery  
- Laboratory  
- Medications administered during admission  
- Physician services  
- Nurse midwife services  
- Radiology  
- Surgery  
- Transplant (organ and tissue) | - Acupuncture  
- Ambulatory surgery  
- Anesthesiology services  
- Audiology  
- Behavioral Health Treatment  
- Blood and blood derivatives  
- CBAS Services  
- Case management services  
- Chiropractic  
- Dental services  
- Diagnostic services  
- Dialysis  
- DME and other medical supplies  
- Eyeglasses and other eye appliances  
- Family planning services  
- Federally Qualified Health Center (FQHC) services  
- Health education services  
- Hearing aids  
- Home health services  
- Hospice services  
- Hospital outpatient and outpatient clinic services  
- Indian health services  
- Laboratory services  
- Local Education Agency (LEA) services  
- Long term care services (unless LTC services are under waivers exclusively)  
- Orthotics and prosthesis | - Medications administered during an outpatient visit  
- Nurse midwife services  
- Occupational therapy  
- Ophthalmology  
- Pediatric subacute services  
- Personal care services  
- Physical therapy  
- Physician services  
- Preventive services  
- Podiatry  
- Primary care services (general medicine, OB/GYN)  
- Psychological testing  
- Radiology  
- Rehabilitative services  
- Respiratory Care  
- Rural Health Clinic (RHC) services  
- Skilled nursing facility  
- Specialty care  
- Speech therapy  
- Treatment therapies (chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/infusion therapy, medication management)  
- Tuberculosis services  
- Transportation  
- Vision services | - Enteral and nutrition formulas  
- Medications (generic and brand name)  
- Pharmacy supplies | - Ambulance  
- Emergency services  
- Laboratory  
- Radiology provided in an emergency department  
- Triage and physician services delivered in the emergency visit  
- Diagnostic services  
- Medications administered during emergency visit  
- Minor surgical procedures |

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¹ **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.

² **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.

³ **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medications-assisted treatment.

⁴ **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.
### Table 2. Mental Health Services to the Four Classifications

<table>
<thead>
<tr>
<th>Inpatient¹</th>
<th>Outpatient²</th>
<th>Prescription Drugs³</th>
<th>Emergency Care⁴</th>
</tr>
</thead>
</table>
| - Administrative day services  
- Psychiatric Health Facility services  
- Acute Psychiatric Hospital services  
- Psychiatric hospital professional services in a FFS hospital | Non- Specialty Mental Health:  
- Psychotherapy (individual and group)  
- Outpatient services for the purposes of monitoring medication therapy  
- Psychiatric consultation  
- Laboratory  
- Mental health services (CBAS) | - Medications (generic and brand name)  
- Supplies and supplements | - Ambulance  
- Emergency services  
- Laboratory  
- Radiology provided in an emergency department  
- Triage and physician services delivered in the emergency visit  
- Diagnostic services  
- Medications administered during emergency visit  
- Minor surgical procedures |

| Specialty Mental Health:  
- Adult Residential Treatment Services  
- Crisis Intervention  
- Crisis Stabilization  
- Crisis Residential/Treatment  
- Day Rehabilitation  
- Day Treatment Intensive  
- Intensive Care Coordination*  
- Intensive Home Based Services*  
- Medication Support Services  
- Mental Health Services  
  - Assessment  
  - Plan development  
  - Therapy  
  - Rehabilitation  
  - Collateral  
- Targeted Case Management  
- Therapeutic Behavioral Services*  
- Therapeutic Foster Care* | | |

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¹ **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.

² **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.

³ **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder mediations-assisted treatment.

⁴ **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.

* EPSDT services.
## Medi-Cal Benefits Mapping to the Four Classifications

**Table 3. Substance Use Disorder (SUD)**\(^*\) Benefits to the Four Classifications

<table>
<thead>
<tr>
<th>Inpatient(^1)</th>
<th>Outpatient(^2)</th>
<th>Prescription Drugs(^3)</th>
<th>Emergency Care(^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DMC-ODS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ ASAM Level 3.7 Medically Monitored Intensive Inpatient Service (Adult) and Medically Monitored High-Intensity Inpatient Services (Adolescents)</td>
<td>▪ Managed Care:</td>
<td>▪ DMC:</td>
<td>▪ Ambulance</td>
</tr>
<tr>
<td></td>
<td>▪ ASAM Level 4.0 Medically Managed Intensive Inpatient Services</td>
<td>▪ SBIRT (Screening, Brief Intervention, and Referral to Treatment)</td>
<td>▪ Naltrexone</td>
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<tr>
<td></td>
<td></td>
<td>▪ Tobacco prevention and cessation services</td>
<td>▪ Methadone</td>
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<td></td>
<td></td>
<td><strong>DMC:</strong></td>
<td>▪ Additional Medication Assisted Treatment (ASAM OTP Level 1)</td>
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<tr>
<td></td>
<td></td>
<td>▪ NTP Group Counseling</td>
<td>▪ Buprenorphine</td>
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<td></td>
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<td>▪ NTP Individual Counseling</td>
<td>▪ Disulfiram</td>
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<tr>
<td></td>
<td></td>
<td>▪ Intensive Outpatient Treatment</td>
<td>▪ Naloxone</td>
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<tr>
<td></td>
<td></td>
<td>▪ Outpatient Drug Free Group Counseling</td>
<td>▪ Acamprosate</td>
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<td>▪ Outpatient Drug Free Individual Counseling</td>
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<td></td>
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<td>▪ Perinatal Residential Treatment</td>
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<tr>
<td><strong>DMC-ODS:</strong></td>
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<tr>
<td>▪ ASAM Level 1 Outpatient Services</td>
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<tr>
<td>▪ ASAM Level 2.1 Intensive Outpatient Services</td>
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<tr>
<td>▪ ASAM level 2.5 Partial Hospitalization</td>
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<tr>
<td>▪ ASAM Level 3.1 Clinically-Managed Low-Intensity Residential Services</td>
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<tr>
<td>▪ ASAM Level 3.3 Clinically-Managed Population-Specific High-Intensity Residential Services</td>
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<tr>
<td>▪ ASAM Level 3.5 Clinically-Managed High-Intensity Residential Services</td>
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<tr>
<td>▪ Withdrawal Management Levels 1, 2 and 3.2</td>
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</table>

1. **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.
2. **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.
3. **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medications-assisted treatment.
4. **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.

\(^*\) Drug Medi-Cal (DMC); Drug Medi-Cal Organized Delivery System (DMC-ODS)
DHCS is conducting an analysis on the mental health parity regulations for managed care health plans (MCHPs) across all statutory systems. Under the final rule, CMS applies certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to all MCHPs that are provided to enrollees of Medicaid managed care plans to ensure the financial limits (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in those programs.

As required by the parity regulations, DHCS is evaluating treatment limitations which limit the scope or duration of the benefits for treatment. Treatment limitations may be non-quantitative treatment limitations (NQTL), which are non-numerical limits on benefits (such as preauthorization requirements) or quantitative treatment limitations (QTL) which are numeric limits (such as visit limits).

### Non-quantitative Treatment Limitations (NQTL) and Quantitative Treatment Limits (QTL) Survey

To address these efforts, DHCS requests MCOs to respond to the survey questions. MCOs must also incorporate responses from each MCO's subcontractors. The information gathered in this survey will help to ensure compliance with Medicaid Mental Health Parity by reviewing limitations and restrictions between medical, mental health and substance abuse disorder benefits and ensuring MCHPs benefits are no more restrictive than the medical/surgical benefits in those programs.

### Non-Quantitative Treatment Limitations (NQTL) and Quantitative Treatment Limits (QTL) Survey

Questions that are Yes or No response require additional information if the response is Yes. Please provide detailed information to support your answers.

### Illustrative List of NQTLs (as listed in 42 CFR 438.900[2][E])

<table>
<thead>
<tr>
<th>NQTL Type</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
<th>Example 5</th>
<th>Example 6</th>
<th>Example 7</th>
<th>Example 8</th>
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<tr>
<td>Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigatory (including standards for concurrent review).</td>
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<td>Reimbursement rates;</td>
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<td>Standards for provider admission to participate in a network, including network tier design;</td>
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<td>Concurrent review;</td>
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<tr>
<td>Exclusions for court-ordered and involuntary holds when the included treatment is experimental or investigative (including standards for concurrent review).</td>
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<td>Concurrent review requirements and policies;</td>
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<td>Retroactive review requirements and policies;</td>
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<td>- Retroactive review requirements and policies;</td>
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<tr>
<td>Standards for providing services by clinical social workers.</td>
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</tbody>
</table>

### Other NQTLs included in mental health parity but not specifically included in the Illustrative List

<table>
<thead>
<tr>
<th>NQTL Type</th>
<th>Example 9</th>
<th>Example 10</th>
<th>Example 11</th>
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<tbody>
<tr>
<td>Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigatory (including standards for concurrent review).</td>
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<tr>
<td>Reimbursement rates;</td>
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<tr>
<td>Standards for provider admission to participate in a network, including network tier design;</td>
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<td>Concurrent review;</td>
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<tr>
<td>Exclusions for court-ordered and involuntary holds when the included treatment is experimental or investigative (including standards for concurrent review).</td>
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<tr>
<td>Concurrent review requirements and policies;</td>
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</tr>
<tr>
<td>Retroactive review requirements and policies;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Concurrent review requirements and policies;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Retroactive review requirements and policies;</td>
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<td></td>
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<tr>
<td>Standards for providing services by clinical social workers.</td>
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<tr>
<td></td>
<td>Prior Authorization and Referral Process</td>
<td>Inpatient</td>
<td>Outpatient</td>
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<tr>
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<td>----------------------------------------------------------------------------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>1</td>
<td>Provide a current copy of your plan’s &quot;No Prior Authorization (NPA) List&quot; or &quot;Prior Authorization List&quot;, whichever guidance is made available to providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please attach your response to question 1. No other response is needed for this question.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Does your plan require prior authorization for any inpatient services? (Yes/No) If yes, what is the review criteria or guidelines used in making a determination?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does your plan have a limit of days a member can receive inpatient care before needing the treatment to be reauthorized?</td>
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<tr>
<td></td>
<td>See Example 1 on guidance tab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does your plan have a process for reviewing retrospective authorization requests? (Yes/No) If yes, what is the review criteria, guidelines and timeframe used in making a determination?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>See Example 1 on guidance tab</td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Does your plan have a process for reviewing concurrent authorization requests? (Yes/No) If yes, what is the review criteria, guidelines and timeframe used in making a determination?</td>
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<td></td>
<td>See Example 2 on guidance tab</td>
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<tr>
<td>6</td>
<td>What is your plan’s process, strategy, evidentiary standard or other factors used to determine prior authorization requirements for services? (e.g. panels of experts, evidentiary standard based on clinically appropriate standards)</td>
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<td></td>
<td>See Example 4 on guidance tab</td>
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</tr>
</tbody>
</table>

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.
### Prior Authorization and Referral Process

<table>
<thead>
<tr>
<th>Question</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>When determining medically appropriate treatment standards, does your plan apply the same evidentiary standard to both medical/surgical and mental health/substance use disorder benefits? (Yes/No) If yes, are the treatment standards based off of recommendations made by panels of experts with appropriate training and expertise? (Yes/No) If yes, please provide policies and procedures related to the process, factors and standards used to make this determination. See Example 4 on guidance tab.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>For services that require authorization after a limit is reached, what is the benefit type and maximum number of visits for needing an authorization? What is your process and underlying factors for the prior authorization policy for these services? See Example 8 on guidance tab.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Can multiple treatments be included under the same prior authorization? (Yes/No) If yes, what treatments can be included together? See Example 9 on guidance tab.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Does your plan require prior authorization in order for a member to obtain substance use disorder services such as SBIRT, tobacco cessation, etc.? (Yes/No) If yes, what is the review criteria or guidelines used in making a determination? See Example 10 on guidance tab.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your plan require approval of referrals made from PCP’s to specialty services? (Yes/No) If yes, what is the review criteria or guidelines used in making a determination and are they more restrictive than the minimum required by DHCS?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

**Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey**

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

<table>
<thead>
<tr>
<th>Prior Authorization and Referral Process</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your plan require prior authorization in order for a member to obtain mild to moderate mental health services? (Yes/No)</td>
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<tr>
<td>If yes, what is the review criteria or guidelines used in making a determination?</td>
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<tr>
<td><em>See Example 12 on guidance tab</em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy and Drug Formulary</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the process, strategy, evidentiary standard or other factors you use for formulary review on prior authorization of pharmacy services (e.g. panels of experts, evidentiary standard based on clinically appropriate standards)</td>
<td></td>
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<tr>
<td><em>See Example 4 on guidance tab</em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Network, Credentialing and Contracting</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you require a member to first try one form of treatment before progressing to other treatments (e.g. fail first, step therapy)? (Yes/No)</td>
<td></td>
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<tr>
<td>If yes, what treatments/services/prescriptions?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Manpower Time Frames</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you require additional credentialing standards beyond DHCS required standards for physicians? (Yes/No)</td>
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</tr>
<tr>
<td>If yes, what additional standards do you require for physicians?</td>
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<tr>
<td><em>See Example 5 on guidance tab</em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Manpower Time Frames</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you require additional credentialing standards beyond DHCS required standards for licensed non-physician providers? (Yes/No)</td>
<td></td>
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</tr>
<tr>
<td>If yes, what additional standards do you require for non-physician providers?</td>
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<tr>
<td><em>See Example 5 on guidance tab</em></td>
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</tbody>
</table>

*All responses must be provided in Excel format. No other formats will be accepted.*
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT
Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey

Summarize the MCP’s applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

<table>
<thead>
<tr>
<th>Provider Network, Credentialing and Contracting</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do you restrict the types of provider specialties that can provide certain mental health and/or substance use disorder benefits? (Yes/No)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what provider types can provide mental health and/or substance use disorder services/treatments?</td>
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<tr>
<td><em>See Example 5 on guidance tab</em></td>
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</tr>
<tr>
<td><strong>What DHCS required services/treatments are covered by your plan for a member who needs treatment while outside of California?</strong></td>
<td></td>
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<tr>
<td><em>See Example 7 on guidance tab</em></td>
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</tr>
<tr>
<td><strong>Do you restrict the geographic location in which services can be received?</strong></td>
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<tr>
<td><em>See Example 11 on guidance tab</em></td>
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</tr>
<tr>
<td><strong>Do you restrict the type(s) of facilities in which enrollees can receive services?</strong></td>
<td></td>
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</tr>
<tr>
<td>This question only pertains to facilities that are considered more restrictive than listed in the DHCS Provider Manual.</td>
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<tr>
<td><strong>Do you have multiple network tiers?</strong></td>
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</tr>
<tr>
<td><strong>Case Management and Care Coordination</strong></td>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Pharmacy</td>
<td>Emergency</td>
</tr>
<tr>
<td><strong>What case management services are available and/or required?</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Are there any limits on case management services? (Yes/No)</strong></td>
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<tr>
<td>If yes, what are they?</td>
<td></td>
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</tr>
<tr>
<td><strong>How do you address court-ordered services that are not covered by Mental Health/Substance Use Disorder?</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>What services require a written treatment plan before a member can receive services and what frequency are they required to be updated?</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Treatment Restrictions and/or Exclusions</strong></td>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Pharmacy</td>
<td>Emergency</td>
</tr>
<tr>
<td><strong>Does your plan limit treatment or service options based on failure to complete prior treatment or due to patient non-compliance? (Yes/No)</strong></td>
<td></td>
<td></td>
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<tr>
<td>If yes, what is the criteria for each benefit?</td>
<td></td>
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<tr>
<td><strong>Does your plan require a member to first try one form of treatment before progressing to other treatments? (Yes/No)</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>If yes, what treatments or services?</td>
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</tr>
</tbody>
</table>

Rev. 1-5-17

All responses must be provided in Excel format. No other formats will be accepted.
Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

<table>
<thead>
<tr>
<th>Financial Requirements</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Pharmacy</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 What is your plan's policy on payment for services that require prior authorization if the prior authorization is not obtained but treatment is provided?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Example 3 on guidance tab</td>
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<td></td>
</tr>
<tr>
<td>32 Are there any group size rules for billing purposes?</td>
<td></td>
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</tr>
<tr>
<td>33 What services can be billed for half day of service?</td>
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</tr>
<tr>
<td>34 What constitutes as a half day of service versus a full day for billing purposes?</td>
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<td></td>
</tr>
<tr>
<td>35 Is your plan required to cover costs for member's first day of admission?</td>
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</tr>
</tbody>
</table>
Mental Health Parity and Addiction Equity Act Overview

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued the Federal Register, which requires state Medicaid agencies to comply with the MHPAEA requirements and included regulations for program compliance with the parity rule.

As a result, the Department of Health Care Services (DHCS) is conducting a mandatory assessment of Medicaid benefits across all managed care delivery systems to ensure the State’s compliance with the Federal Parity rule. In an effort to assess existing practices in key areas, DHCS is surveying the Managed Care Organizations, Mental Health Plans, DMC-ODS County Plans, and counties providing other SUD services.

The rule requires DHCS to examine medical/surgical and mental health and substance use disorder (MHSUD) benefits in four benefit classifications: 1) inpatient; 2) outpatient; 3) emergency; and, 4) pharmacy/formulary. The assessment includes a review of treatment limitations (quantitative and non-quantitative) and financial requirements, which are defined as follows:

- Quantitative treatment limitations (QTLs) include the number of visits/days covered, frequency of treatment, or other limits on duration and scope of treatment.
- Non-quantitative treatment limitations (NQTLs) include utilization management procedures such as prior authorization, concurrent review, medical necessity, and step therapy protocols.
- Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket limits.

The enclosed survey covers NQTLs, QTLs, and financial requirements in the following categories:

- Authorization
- Case Management and Care Coordination
- Client Plans
- Progressive Therapy/Step Therapy
- Provider Network, Credentialing and Contracting
- Medication Prescribing, Authorization, and Monitoring
- Financial Requirements
- Disclosure Requirements

The purpose of the survey is to assess existing practices, not determine compliance.

1 For purposes of this survey, “County” refers to Mental Health Plans, DMC-ODS Plans, and other county SUD services.

2 Step therapy protocols (also called progressive therapies) indicate a progression of services (e.g., group therapy preceding individual therapy and Full Service Partnership levels of care).
Survey Instructions:

1. Please complete the survey below as accurately as possible.
2. For short answer questions, please provide a brief response and include citations for County policies and procedures, or other documentation, that will assist with DHCS' review.
3. Please consider practices for services to both adult and children/youth beneficiaries when responding to the survey questions.
4. The survey questions apply to mental health and substance use disorder services.
5. Please complete and return the survey to DHCS no later than Friday, February 3, 2017.
6. If you have questions or require assistance in completing the survey, please contact Brian Keefer at Brian.Keefer@dhcs.ca.gov
7. Please submit requested documentation to Brian.Keefer@dhcs.ca.gov no later than Friday, February 17, 2017.

Authorization Procedures

Guidance:
- Prior Authorization refers to authorization and approval of services prior to service delivery, which may include review of medical necessity criteria before services begin.
- Concurrent Authorization refers to daily stay review for inpatient and residential services or per treatment (or set of treatments) review for outpatient services.
- Retrospective Authorization refers to post-service delivery review and authorization of services, usually via request for payment/claims processing.
- Pre-Notification refers to notification of services prior to or concurrently with service delivery for a beneficiary.

Please provide the following documentation:
- A list of all services requiring prior authorization
- Policies and Procedures (P&Ps): Authorization of Inpatient Services
- Hospital Utilization Review Committee (URC) Policies and Procedures (P&Ps): Authorization of Inpatient Services
- Policies and Procedures (P&Ps): Authorization of Outpatient Services
- Policies and Procedures (P&Ps): Authorization of Residential Services
- Policies and Procedures (P&Ps): Authorization Criteria and/or Evidentiary Standards
- Authorization Review and Chart Audit Tools
- Provider Manual
- Network Provider Boilerplate Contract (for individual and organizational providers)
<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the COUNTY require prior authorization for any <strong>inpatient services</strong> (including both acute and administrative days)?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>Does the COUNTY limit prior-authorization to a specific number days for <strong>inpatient services</strong> (including both acute and administrative days)?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>Does the COUNTY conduct concurrent authorization review for any <strong>inpatient services</strong> (including both acute and administrative days)?</td>
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<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>Does the COUNTY conduct retrospective authorization review for <strong>inpatient services</strong> (including both acute and administrative days)?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>Are the COUNTY’s P&amp;Ps on authorization of inpatient services more restrictive than the minimum state or federal requirements?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>What is the COUNTY’s process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <strong>inpatient services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the hospital’s Utilization Review Committee (URC) procedures for authorization of <strong>inpatient services</strong> (both admissions and continued stay services)?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the role of psychiatrists and/or physicians in authorization of <strong>inpatient services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require prior authorization for <strong>psychiatric health facility</strong> services?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
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<td>Does the COUNTY limit prior-authorization to a specific number days for <strong>psychiatric health facility</strong> services?</td>
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<td>COUNTY Response:</td>
<td></td>
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<tr>
<td>What is the role of psychiatrists and/or physicians in authorization of <strong>psychiatric health facility</strong> services?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
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<tr>
<td>Does the COUNTY require prior authorization for <strong>residential services</strong>?</td>
<td>MH □</td>
<td>SUD □</td>
<td>SUD □</td>
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<tr>
<td>Question</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
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<tr>
<td>Does the COUNTY limit prior-authorization to a specific number days for <strong>residential services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct concurrent authorization review for any <strong>residential services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct retrospective authorization review for <strong>residential services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Are the COUNTY’s P&amp;P's more restrictive than the minimum state or federal requirements?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>What is the COUNTY’s process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <strong>residential services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the role of psychiatrists and/or physicians in authorization of <strong>residential services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require prior authorization for any <strong>outpatient services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY require approval of referrals for any <strong>outpatient services</strong> (e.g., ICC, IHBS, TBS, Psychiatry, IOT)?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY require a level of care assessment, approved by the COUNTY, for any <strong>outpatient services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY limit prior-authorization to a specific number days/visits (i.e., 10 clinic visits before a new authorization is required) for <strong>outpatient services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct concurrent authorization review for any <strong>outpatient services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct retrospective authorization review (e.g., via claims payment processing, etc.) for any <strong>outpatient services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Are the COUNTY’s P&amp;P's more restrictive than the minimum state or federal requirements?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>What is the COUNTY’s process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <strong>outpatient services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the role of psychiatrists and/or physicians in authorization of <strong>outpatient services</strong>?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require prior authorization for <strong>crisis stabilization services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct concurrent authorization review for any <strong>crisis stabilization services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Does the COUNTY conduct retrospective authorization review (e.g., via claims payment processing, etc.) for any <strong>crisis stabilization services</strong>?</td>
<td>MH</td>
<td>SUD</td>
<td>SUD</td>
</tr>
<tr>
<td>Question</td>
<td>COUNTY Response</td>
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<td>-------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>What is the COUNTY’s process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for crisis stabilization services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the role of psychiatrists and/or physicians in authorization of crisis stabilization services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require providers to pre-notify the COUNTY when providing services to a new beneficiary?</td>
<td>MH ☐ SUD ☐ MH ☐ SUD ☐ MH ☐ SUD ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require providers to pre-notify the COUNTY when providing a new service to an existing beneficiary?</td>
<td>MH ☐ SUD ☐ MH ☐ SUD ☐ MH ☐ SUD ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the COUNTY’s policy on payment for services that require prior authorization if the prior authorization is not obtained by the provider, but treatment is provided?</td>
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</tbody>
</table>

**Case Management and Care Coordination**

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Case Management
- Policies and Procedures (P&Ps): Care Coordination
- Provider Manual
- Practice Guidelines

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any limitations imposed on case management services?</td>
<td>MH ☐ SUD ☐</td>
<td>MH ☐ SUD ☐</td>
<td>MH ☐ SUD ☐</td>
</tr>
<tr>
<td>If yes, please specify:</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any limitations imposed on care coordination services?</td>
<td>MH ☐ SUD ☐</td>
<td>MH ☐ SUD ☐</td>
<td>MH ☐ SUD ☐</td>
</tr>
<tr>
<td>If yes, please specify:</td>
<td>COUNTY Response:</td>
<td></td>
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</tbody>
</table>

**Client Plans**

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Client Plans
- Provider Manual

<table>
<thead>
<tr>
<th>Question</th>
<th>COUNTY Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 What is the COUNTY’s standard timeframe for completion of the client plan?</td>
<td></td>
</tr>
<tr>
<td>11 What is the COUNTY’s standard timeframe for updating the client plan?</td>
<td></td>
</tr>
<tr>
<td>12 What is the COUNTY’s procedure for periodically reviewing the client plan?</td>
<td></td>
</tr>
</tbody>
</table>
## Progressive Therapy/ Step Therapy

**Guidance:**
- Progressive therapies could include, for example, 8 group sessions before individual treatment is authorized.

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Selecting Interventions
- Policies and Procedures (P&Ps): Progressive Therapies
- Practice Guidelines
- Provider Manual

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the COUNTY limit treatment options based on failure to complete prior treatments and/or due to client non-compliance?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
<tr>
<td>If yes, what criteria are used to make such determinations?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require a beneficiary to first try one form of treatment before progressing to other treatments?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
<tr>
<td>If yes, what treatments or services?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the determination at all based on the cost of the treatment?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
</tbody>
</table>

### Provider Network, Credentialing and Contracting

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Credentialing
- Provider Manual

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 What are the COUNTY’s current procedures for credentialing licensed providers (e.g., Psychiatrists, Psychologists, LCSW, LMFT, LPCC, RN)?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 What are the COUNTY’s current procedures for credentialing non-licensed providers?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Does the COUNTY have multiple network tiers (e.g., preferred providers)?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
<tr>
<td>Does the COUNTY restrict the types of provider specialties that can provide certain mental health and/or substance use disorder services?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
<tr>
<td>If yes, what provider types and services are restricted?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the COUNTY require beneficiaries to access services in a specific geographic location/area?</td>
<td>MH ☐</td>
<td>SUD ☐</td>
<td>MH ☐</td>
</tr>
</tbody>
</table>
If yes, under what circumstances are such restrictions imposed? | COUNTY Response:
What are the COUNTY’s limitations regarding access to out-of-network providers? | COUNTY Response:

### Medication Prescribing, Authorization and Monitoring

**Guidance:**
- Pharmacy is not a covered benefit under the 1915(b) Waiver.
- For SMHS, consider prescribing practices rather than authorization procedures.
- For DMC and SUD services, consider prescribing and authorization procedures, if applicable.
- For SUD services, include Medication Assisted Treatment

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Medication Monitoring
- Policies and Procedures (P&Ps): Prescribing Practices
- Policies and Procedures (P&Ps): Medication Assisted Treatment
- Practice Guidelines: Medication

### Parity Review Assessment

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the COUNTY require labs, drug testing, or any other patient compliance monitoring for the purposes of prescribing certain types of medications?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>If yes, list applicable medications.</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
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</tbody>
</table>

21. What criteria are used for prescribing medications? | COUNTY Response: |

22. What are the COUNTY’s procedures for medication monitoring? | COUNTY Response: |

### Regarding Financial Requirements

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Provider Claims Processing
- Policies and Procedures (P&Ps): Group Size Limitations
- Policies and Procedures (P&Ps): Cost Sharing
- Policies and Procedures (P&Ps): Rate Development

### Parity Review Assessment

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>23. What are the COUNTY’s methods for determining usual, customary, and reasonable charges?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. What are the COUNTY’s methods for determining reimbursement rates for providers?</td>
<td>COUNTY Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Does the COUNTY have any group size rules for billing purposes?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
<tr>
<td>Does the COUNTY impose any cost-sharing requirements?</td>
<td>MH □</td>
<td>MH □</td>
<td>MH □</td>
</tr>
</tbody>
</table>
## Disclosure Requirements

**Please provide the following documentation:**
- Policies and Procedures (P&Ps): Medical Necessity Determinations
- Policies and Procedures (P&Ps): Information Dissemination

<table>
<thead>
<tr>
<th>Parity Review Assessment</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
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</thead>
<tbody>
<tr>
<td>Does the COUNTY make the criteria for medical necessity determinations available to any current or potential beneficiaries upon request?</td>
<td>MH □ SUD □</td>
<td>MH □ SUD □</td>
<td>MH □ SUD □</td>
</tr>
<tr>
<td>Does the COUNTY make the criteria for medical necessity determinations available to contracting providers upon request?</td>
<td>MH □ SUD □</td>
<td>MH □ SUD □</td>
<td>MH □ SUD □</td>
</tr>
</tbody>
</table>

## Respondent Information

Please provide the following information. DHCS may contact you with regarding responses.

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Role in County</td>
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</tbody>
</table>
Attachment F
Alternative Benefit Plan

Alternative Benefit Plan
Attachment G EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered Services include all Medically Necessary services, as defined in 42 USC Section 1396d(r), and W & I Code Section 14132(v). Covered Services shall include case management as well as Targeted Case Management services as defined in Attachment 11, Provision 3 of this Contract.

Contractor is required to provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation and Non-Medical Transportation, to and from medical appointments for Medically Necessary Covered Services that Contractor is responsible for providing pursuant to this Contract.

Contractor shall also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Covered Services do not include California Children’s Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to Provision 8 below, regarding Mental Health Services. Contractor shall determine the Medical Necessity of EPSDT services using the criteria established in 42 USC Section 1396d(r), and W & I Code Section 14132(v).