State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: March 30, 2022

ALL PLAN LETTER 22-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NO WRONG DOOR FOR MENTAL HEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance and clarification regarding the No Wrong Door for Mental Health Services policy. This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption. Corresponding guidance to County Mental Health Plans (MHP) is contained in Behavioral Health Information Notice (BHIN) No: 22-011.[1]

BACKGROUND:
With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes.[2] DHCS' goal is to ensure that beneficiaries have access to the right care, in the right place, at the right time.

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access specialty mental health services (SMHS), implementation of standardized statewide screening and transition tools, payment reform, and other changes summarized in the CalAIM proposal.

Per forthcoming DHCS guidance, Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services, and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are

[1] 2021 BHINs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx.
[2] For more information regarding CalAIM, please visit the CalAIM webpage at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.

required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):[3]

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs,[4] supplies and supplements.

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

- Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;[5]
- Members who are under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;[6] and
- Members of any age with potential mental health disorders not yet diagnosed.

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[3] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. The Medi-Cal provider manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services can be accessed at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual
See W&I Code section 14184.402. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.

[4] This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl.

[5] Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for recipients with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

[6] See Section 1396d(r)(5) of Title 42 of the U.S.C.(requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) and that are necessary to correct or ameliorate a condition, including a behavioral health condition, discovered by a screening service, whether or not such services are covered under the State Plan), U.S.C. is searchable at: https://uscode.house.gov/.

In accordance with California Welfare and Institutions Code (W&I Code) sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.). The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance from the Centers for Medicare & Medicaid Services, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition.[7] Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services.

MCPs must also cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.[8] This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services includes facility and professional services and facility charges claimed by emergency departments.

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

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[7] CMS' federal EPSDT guidance can be found at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.
[8] The CCR is searchable at: https://govt.westlaw.com/calregs/index?__lrTS=20210423013246097&transitionType=Default&contextData=%28sc.Default%29.

- Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and
- Emergency services necessary to stabilize the member.[9]

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

POLICY:
Consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS are covered by MCPs even when:

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
2) Services are not included in an individual treatment plan;
3) The member has a co-occurring mental health condition and SUD; or,
4) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

1. NSMHS Provided During the Assessment Period Prior to a Determination of a Diagnosis or Prior to Determination of Whether NSMHS Criteria Are Met
   Clinically appropriate and covered NSMHS delivered by MCP providers are covered by MCPs during the assessment process prior to the determination of a diagnosis or a determination that the member meets criteria for NSMHS. MCPs must not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does **not** meet the criteria for NSMHS or meets the criteria for SMHS.

   Likewise, MHPs must not deny or disallow reimbursement for SMHS services provided during the assessment process if the assessment determines that the member does **not** meet criteria for SMHS or meets the criteria for NSMHS.

2. NSMHS Not Included in an Individual Treatment Plan
   Clinically appropriate and covered NSMHS delivered by MCP providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan.

[9] Including voluntary inpatient detoxification as a benefit available to MCP members through the Medi-Cal fee-for-service program, as described in APL 18-001.

3. Co-occurring Substance Use Disorder
   Clinically appropriate and covered NSMHS delivered by MCP providers are covered by MCPs whether or not the member has a co-occurring SUD. MCPs must not deny or disallow reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

   Likewise, clinically appropriate and covered SMHS are covered by MHPs whether or not the member has a co-occurring SUD. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the member has a co-occurring mental health condition.

4. Concurrent NSMHS and SMHS
   Members may concurrently receive NSMHS from a MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. MCPs must not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MHPs must not deny or disallow reimbursement for SMHS provided to a member on the basis of the member also meeting NSMHS criteria and/or receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

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

   - Members with established therapeutic relationships with a MCP provider may continue receiving NSMHS from the MCP provider (billed to the MCP), even if the

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

DHCS is developing a set of statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and transitions care for the specialty mental health, Medi-Cal managed care, and fee for service systems.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[10] These requirements must be communicated by each MCP to all subcontractors and network providers.

Service delivery disputes between MCPs and MHPs must be addressed consistent with DHCS guidance regarding the dispute resolution process between MCPs and MHPs.[11]

[10] For more information on subcontractors and network providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.
[11] For more information, see APL 21-013, and any subsequent APLs on this topic.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division