Behavioral Health Workgroup
Stakeholder Feedback: Medical Necessity

Policy category	Comments and recommendations	DHCS policy response
Screening	Develop universal screening tool. The tool should be delivered over the phone in 10 minutes or less. MCP providers should not be required to use the screening tool. Assume eligibility for specialty services based on a referral from the mild/moderate network. DHCS should develop a universal transitions tool to facilitate transfers between MCP and MHP delivery systems. Clarify key terms such as "significant impairment, probability of deterioration, important areas of life functioning" as they relate to defining behavioral health needs and whether they can be met in the MCP delivery system. Incorporate ACES into screening tool for beneficiaries under 21. Require creation and use of a HIPAA-compliant web-based referral tracking mechanism between the plans, counties and regional centers.	DHCS proposes to develop a universal screening tool to identify beneficiary BH needs and determine which delivery system is best suited to meet those needs (MCP or MHP) if the beneficiary has an SUD, SUD screening questions will be asked to determine the correct place of services. The standardized tool will be used for beneficiaries who have not yet accessed care. Beneficiaries already receiving care (whether MCP or MHP network) will be assessed by the clinician and provided behavioral health services. If the beneficiaries' needs are better met in the other delivery system, the clinician or plan will use a standardized care transitions tool and ensure the beneficiary is able to access care. ACES screening would be included in the screening tool for beneficiaries under 21 and will be part of determining behavioral health needs and needed treatment. DHCS does not plan to mandate the use of a particular tracking tool.
Assessment	Develop standardized lean assessment tool to be used in the SMHS network. MCP network providers should not be required to use a standardized tool.	DHCS is considering a lean assessment tool with core domains to assess clients for mental health and SUD needs. This tool would be required for SMH providers, and optional for providers in MCP networks.
Electronic health record	Develop statewide behavioral health electronic health record (EHR)	Thank you for your comment.
Early and	Establish clear expectations for MCPs and MHPs	Removing the requirement for a diagnosis and changing

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Periodic Screening, Diagnostic and Treatment Services.	regarding requirements for covering services protected by EPSDT	medical necessity to be based on need will help remove barriers to the full range of EPSDT services. All beneficiaries (regardless of age) may receive treatment prior to diagnosis.
Medication Assisted Treatment	Mental health providers should be able to provide MAT	Integrating SUD into MH treatment is the long-term goal of BH integration. DHCS will provide guidance about how MAT can be offered in MH clinics in the current administrative structure.
Physician Consultation Services	DHCS should cover collaborative care codes in MHPs to allow consultation between primary care, MCP MH, and MHP psychiatrists.	IN 17-040 clarifies that some collaborative care services within SMH are currently reimbursable by MHPs, such as case conferences (e.g., multi-disciplinary team meeting)
Autism, eating disorders, traumatic brain injury, dementia	Frequently raised as a concern: currently no good system of care; lack of clarity about MHP and MCP coverage of services. Allowing care to be billed without a diagnosis may be problematic here.	DHCS is finalizing edits on an information notice regarding division of responsibility. ECM and In Lieu of Services are available for high-needs patients with co-occurring brain disorders.
No wrong door	Allow beneficiaries to continue services in MCP and MHP delivery systems, with established continuity providers. Explicitly state that an individual may receive services simultaneously in the MCP and MHP delivery systems. CBHDA: if a patient is stable and could step down to MCP network, and continues care in MHP, DHCS should develop financial offset. DHCS should develop method to monitor whether MCPs are appropriately managing care that could be provided in MCP network before referring to MHP. DHCS needs to re-visit same-day billing restrictions, and ensure benefits in both delivery systems are distinct and nonduplicative. Clarify that crisis services, including arranging	DHCS is proposing no wrong door for children, and still considering no wrong door for adults. Services may be reimbursed for the same beneficiary in both the MCP and MHP networks. Same day billing to allow transitions between delivery system would be allowed if provided at different addresses (e.g. a therapy visit at an MCP contracted provider and an MHP contracted provider, during an urgent transition of care). Individuals may receive services simultaneously in the MCP and MHP delivery systems, if needed for continuity of care. DHCS would not do a financial off-set. In cases where specialty mental health services are no longer needed in the foreseeable future, the patient should transition to the MCP network. Since several MH benefits already are duplicative (both

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	inpatient or other stabilization levels, remain the responsibility of the MPH. Expand MCP benefits to allow reimbursement of care management, collateral and family partner/peer services	MCPs and MHPs cover therapy and medication management); DHCS will not be changing the scope of benefits in MCPs. Whether a beneficiary's needs can be met in the MCP is based on scope and intensity of service, not on type of service. The transitions of care tool should help with these distinctions. DHCS does not plan to expand MCP MH benefits at this time, other than what is outlined in the ECM proposal. Crisis services remain an MHP responsibility.
ASAM criteria: MAT, incarceration or homelessness	Adjust ASAM criteria to account for incarceration and/or homelessness, and to direct people appropriately to MAT when indicated.	National ASAM criteria are under revision to address these problems.
Diagnosis requirement	Allow treatment prior to diagnosis. Claim forms require diagnosis; clinical monitoring should be in place to prevent inappropriate ongoing care without a diagnosis. Counties shall have the discretion to require beneficiaries to complete the ASAM assessment with county staff, only for residential level of care, as part of the prior authorization process. MH progress notes should not require co-signature from a LPHA.	Revise medical necessity requirements in waiver: 1. If a beneficiary calls the triage line or walks into a clinic, counties should use a brief standardized screening tool to determine needs and initial place of care (MCP or MHP delivery system). 2. If a beneficiary accesses lower levels of care directly, the provider is responsible to complete an assessment (standardized domains in the MHP networks) and start treatment. Medical necessity is determined by the presence of MH symptoms, conditions, or diagnoses. The county may NOT require a call to the triage line, or prior authorization, or an assessment done by county staff prior to starting treatment. Higher levels of care (e.g. intensive outpatient, residential, and inpatient) are an exception, and the county should apply medical necessity criteria through a prior authorization process. 3. Care may be provided prior to a diagnosis. Codes can include provisional, unspecified, or adjustment disorder and could include relevant ICD-10 codes. A diagnosis

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		must be in place (at least provisional) prior to discharge from higher levels of care (residential and inpatient). 4. SUD and MH providers may treat patients with MH and SUD diagnoses. DHCS will remove the requirement for one diagnosis to be primary. 5. DHCS needs to better understand pros/cons of LHPA oversight of MH progress notes. (See DMC ODS feedback for other SUD-specific examples)
Peer-Based Services	Define a scope of practice for peer-based services and allow reimbursement for peer-based services across the continuum of care.	DHCS will consider options for further defining scope for peers within SMH system building on IN 17-040. In the DMC ODS: added peers in the case management benefit, and added placeholder language around peers scope of practice in the event this becomes state law during the waiver period.
Same-Day Billing	Adjust same-day billing restrictions to facilitate and incentivize transitions between levels of care by allowing claims to be processed in two different levels of care during a 48 hour period.	Same-day billing for same service will be allowed if at different addresses (to allow transitions of care).
Medical clearance	Standardize medical clearance criteria	DHCS will not be recommending changes to medical clearance for 5150 holds.
Inpatient medical necessity	Physician certification (and physician oversight over re-certification) is sufficient to document medical necessity for the purposes of DHCS retrospective review. Counties will still need sufficient clinical documentation and communication with clinicians to ensure medical necessity criteria are met for concurrent review. DHCS should develop evidence-based medical necessity criteria for all higher levels of care (partial hospitalization, intensive outpatient, residential,	DHCS proposes to modify documentation requirements to align with federal guidance regarding physician certification and recertification. Concurrent review will still require more clinical information than a physician's certification; medical necessity can be determined through the concurrent review process. DHCS will consider an inpatient stay medically necessary if the following two components are in place: 1. Physician certification, and recertification by a licensed clinician supervised by a physician, that a patient

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	STRTPs, CTFs, should have specific criteria for pre-certification, continued stay and discharge). DHCS should direct counties to move away from collecting paper facility records to justify medical necessity post-discharge and should allow medical necessity to be determined by clinical review over the phone or through review of documents through an on-line portal, as permitted by NCQA and DMHC. Ensure level of care tools are only used for higher levels of care.	meets criteria for an inpatient stay. 2. The county has determined the stay to be medically necessary during concurrent review. Prior authorization should only be used for higher levels of care.
Duplicative oversight leading to barriers to care or decrease in workforce capacity	For counties contracting with out-of-county providers: a. Counties should deem a provider compliant if the provider has passed a facility audit by the in-county MHP. b. Counties should deem credentialing done by the in-county MHP or through a national credentialing body. c. Counties should continue to do chart reviews as needed for their own beneficiaries (remotely is sufficient) d. Counties may not require staff to repeat training if the training on the same topic (e.g., evidence-based practice) has been completed on-line, through the provider, or through another county.	DHCS anticipates that changes in medical necessity and documentation requirements, with accompanying guidance, will enable counties to streamline oversight requirements. DHCS will explore providing guidance in the interim.
Documentation	Consider following Washington's documentation guidelines: 1. Assessment of behavioral health needs 2. Needs lead to specific goals 3. Treatment goals have measurable objectives 4. The provider orders specific interventions	DHCS will be implementing the BH QIP to help counties improve their data infrastructure, including the potential to ingest electronic data files from providers containing client demographics and claiming information, which could eliminate the need for providers to do duplicate data entry.

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	connected to assessed needs and treatment plan 5. Record progress and outcomes Counties should not impose documentation requirements that add administrative burden without clinical value: a. Require providers to do duplicate entry into county EHRs. b. Require providers to complete standardized treatment plan templates, treatment narratives, etc. Providers should use problem lists and progress notes to document assessments and individualized treatment plans. c. Require providers to send treatment plans and progress notes for county review. d. Utilization review or prior authorization review should not be done on lower levels of care (other than outlier analysis) DHCS should create a single set of simplified and uniform formed and require counties to use them.	DHCS proposes to refine many of the current documentation requirements, instead providing guidance to providers to use a lean standardized assessment, problem lists, and progress notes. Other than in cases of fraud, waste and abuse, DHCS would move away from financial disallowances, and instead use quality improvement efforts to incentivize good documentation. DHCS will no longer monitor that a treatment plan has been completed, signed by the beneficiary, and that interventions directly tie to the treatment plan. DHCS does not plan to develop standardized forms.
Disallowances	Excessive disallowances due to MH diagnosis or clinical chart documentation not following requirements.	DHCS would move away from disallowances based on clinical chart documentation alone, in the absence of fraud, waste or abuse.
Resolve COS/COR Issue	Providers and counties would like the county of service to be financially responsible from the time a beneficiary makes a change with the county staff to a new county of residence.	DHCS appreciates the feedback.
Out-of-state providers	Consider a reciprocity agreement that would allow California to grant streamlined DMC certification or otherwise bill Medi-Cal for Medicaid providers in neighboring states	DHCS requires all providers to complete the Medi-Cal application and cannot make exceptions for out-of-state providers.
Lack of infrastructure	Infrastructure and resource constraints are the key challenges now for early implementer counties and	DHCS acknowledges these resource constraints.

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and resources for counties	smaller counties considering opting in (i.e. workforce, building new facilities, etc.). New tools should include funding for nonprofit providers.	
Workforce training	DHCS should ensure MH professionals have sufficient training in SUD, and SUD professionals receive training in MH.	Thank you for your comment.
Foster youth	Children in child welfare should be presumptively eligible for SMHS services.	Proposal to be discussed in workgroup.
Justice-involved youth	Justice-involved youth should be presumptively eligible for the full range of EPSDT services.	Justice-involved youth should receive the universal screening tool to identify BH needs and connect them to the appropriate delivery system.
ACES screening	DHCS should create a clear pathway to follow-up assessments for youth with high ACE scores and risk for developing a mental health condition.	DHCS is working with the Surgeon General to implement universal ACES screening and to link children to needed follow up.
Children's workgroup	DHCS should develop an expert workgroup to focus on the needs of children. The workgroup should develop guidelines on what "conditions" could qualify children for MH services without a diagnosis. Explore Regional Children and Youth Administrative Organizations.	Thank you for this comment.