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Mental Health Services in Medi-Cal

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Background: The scope of mental health benefits in Medi-Cal after 2014

In 2014, as part of the Affordable Care Act implementation, California expanded the availability of mental health benefits in Medi-Cal and bring the Medi-Cal scope of benefits in line with the benefits offered in private health plans in the state.[2] While this change expanded the scope of mental health benefits available to Medi-Cal beneficiaries, it made delivery and access to these services more complicated. Some mental health services are now available through Medi-Cal health plans (MCPs), while other services are only available through County Mental Health Plans (MHPs), and other services are only available on a fee-for-service basis. If the various entities responsible for delivering mental health services to Medi-Cal beneficiaries are not well coordinated, there is ample opportunity for beneficiaries to go without needed services or to get a lower level of care than their condition requires. This paper examines the legal framework that governs the scope of mental health services available in Medi-Cal and the delivery system that is responsible for ensuring beneficiaries receive those services. It will make recommendations about how California can better coordinate between delivery systems to ensure that all beneficiaries receive the full scope of mental health services to which they are entitled.

Legal Framework

Under federal Medicaid law, mental health services are an optional benefit for most populations.[3] In addition, all state Medicaid programs must provide a broad array of services,

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[2] Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013) (encoded at Cal. Welf. & Inst. Code § 14132.03).

[3] Most mental health services are provided pursuant to the rehabilitative services option (42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130) or other licensed practitioner option (42 U.S.C. § 1396d(a)(6); 42 C.F.R. 440.60). Some services

including mental health services, to beneficiaries under age 21 pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate of the Medicaid Act.[4] Since 1995, California has implemented these provisions in part through a 1915b Medicaid Waiver that provided for California's counties to provide specialty mental health services through a prepaid inpatient health plan (PIHP) administered by each county.[5] These PIHPs are known as Mental Health Plans (MHPs) in California.

California's 1915(b) Waiver and Specialty Mental Health

California most recently renewed its 1915b waiver for a five-year period starting on July 1, 2015.[6] The waiver continues to allow California to provide specialty mental health services to Medi-Cal beneficiaries through the MHPs. Specialty mental health services covered through the waiver include: rehabilitative mental health services (which includes mental health, medication support, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment, crisis residential treatment, and psychiatric health facility services); psychiatric inpatient hospital services; targeted case management; psychiatrist services; psychologist services; and psychiatric nursing facility services.[7] The waiver also sets forth medical necessity criteria for outpatient specialty mental health services, consistent with California regulations; the criteria dictate that in order to receive specialty mental health services, a person must have a listed diagnosis, and meet specified impairment and intervention criteria.[8] See Appendix A for detailed medical necessity criteria.

Consistent with the EPSDT mandate, California requires MHPs both to use less stringent medical necessity criteria, and to provide a broader array of services to beneficiaries under age 21. Specifically, MHPs must comply with federal law that requires state Medicaid programs to provide services when they are necessary to correct or ameliorate a child's illness or condition.[9]

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may also be delivered as part of broader optional benefits, such as pharmacy benefits (42 U.S.C. §§ 1396d(a)(12), 1396r-8; 42 C.F.R. § 440.120), or targeted case management (42 U.S.C. § 1396n(g)).

[4] 42 U.S.C. 1396d(r); Cal. Welf. & Inst. Code § 14132(v); *see also* APL 14-017.

[5] The PIHP model was phased in between 1995 and 1998. *See* SARAH ARNQUIST & PETER HARBAGE, A COMPLEX CASE: PUBLIC MENTAL HEALTH DELIVERY AND FINANCING IN CALIFORNIA 15-18 (2013) (describing this history), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComplexCaseMentalHealth.pdf

[6] Letter from Hye Sun Lee, Ctrs. Medicare & Medicaid Servs., to Mari Cantwell, Cal. Dep't Health Care Servs. (June 24, 2015), http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf.

[7] Cal. Code Regs., tit. 9, § 1810.247.

[8] CAL. DEP'T HEALTH CARE SERVS., SECTION 1915(B) WAIVER PROPOSAL FOR MCO, PIHP, PAHP, PCCM PROGRAMS AND FFS SELECTIVE CONTRACTING PROGRAMS 21-24 (2015) [hereinafter CALIFORNIA 1915(B) PROPOSAL], http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf.

[9] *See* Cal. Code Regs. tit. 9, § 1810.215 (requiring MHPs to comply with 22 CCR §§ 51340(e)(3) & (f)) and 42 U.S.C. § 1396d(r)); *see also* CAL. DEP'T HEALTH CARE SERVS., MHSUDS INFORMATION NOTICE NO. 16-061 at 2-3 (2016) [hereinafter MHSUDS NOTICE 16-061], http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf.

Compared to the adult medical necessity standard, which requires a more narrow showing that a person's mental health condition is causing substantial impairment, and that the requested intervention is likely to significantly diminish the level of impairment, or prevent further deterioration, the child standard requires that services be delivered whenever they can address or improve a child's mental health condition, and cannot be addressed by a physical health intervention. See Appendix A for a more detailed comparison of the medical necessity criteria for adults and children. In addition, MHPs must provide mental health diagnostic services and treatment to beneficiaries under 21 when they meet those medical necessity criteria, even when requested services are "not otherwise covered . . . specialty mental health services."[10] Some additional mental health services for children have been established through litigation, including therapeutic behavioral services, and therapeutic foster care.

Non-Specialty Mental Health Services in Medi-Cal

For many years, individuals with a mental health condition who were not eligible to receive specialty mental health services through the waiver had few options to receive non-specialty mental health services. Beneficiaries could access limited services through the fee-for-service delivery system: mental health services provided by an FQHCs, and up to two psychotherapy sessions per month for adults when prior authorized.[11] Services that could be treated through physical health interventions or provided by a PCP were theoretically covered, either in fee-for-service Medi-Cal or in Medi-Cal managed care. In general, before 2014, MCPs had a very limited role in delivering mental health care to Medi-Cal enrollees.

Starting in 2014, MCPs took an expanded role in delivering mental health services to their enrollees. As part of the Affordable Care Act, starting on January 1, 2014, California was required to provide behavioral health services, including mental health services, to the Medicaid Expansion population.[12] California has chosen to align its benefits for both populations, and thus provides the same scope of behavioral health services to all Medi-Cal

[10] Cal. Code Regs. tit. 9, § 1810.215.

[11] *See* Letter from Margaret Tatar, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans (Dec. 13, 2013) [hereinafter APL 13-021], http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf; *see also* DON KINGDON *ET AL.*, CAL. HEALTH CARE FOUND., THE CIRCLE EXPANDS: UNDERSTANDING MEDI-CAL COVERAGE OF MILD-TO-MODERATE MENTAL HEALTH CONDITIONS 3 (2016), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CircleMediCalMentalHealth.pdf .

[12] 42 U.S.C. §§ 1396a(k)(1),1396u-7(b)(5) (benefits for expansion population must include essential health benefits (behavioral health services are an essential health benefit per 42 U.S.C. § 18022(b)(1)(E)); *see also* MICHELLE LILIENFELD, ALTERNATIVE BENEFIT PLANS FOR THE MEDICAID EXPANSION POPULATION (2014), http://www.healthlaw.org/about/staff/michelle-lilienfeld/all-publications/alternative-benefit-plans-for-the-medicaid-expansion-population.

beneficiaries.[13] To implement the alignment, California required MCPs to cover the following mental health services: individual and group mental health evaluation and treatment (psychotherapy); psychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; outpatient laboratory, drugs, supplies, and supplements; and, psychiatric consultation.[14] While DHCS has been clear that "eligibility and medical necessity criteria for Medi-Cal specialty mental health services provided by MHPs have not changed pursuant to this policy. . . . MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning."[15] For this reason, the scope of services provided by the Medi-Cal plans is sometimes referred to as "mild to moderate."

Relationship between plans providing specialty and non-specialty mental health services

As MCPs implemented this new mental health benefit, DHCS renewed its 1915(b) waiver for specialty mental health services. This waiver clarifies the relationship between the services provided by MHPs, and those provided by the MCPs. It specifies that treatment for Medi-Cal beneficiaries who do not meet the "criteria for specialty mental health services (for example, excluded diagnoses, mental health conditions resulting in mild to moderate impairment of mental, emotional or behavioral functioning as well as all non-mental health medical conditions and services) . . . . may be provided through other California Medi-Cal programs – primarily the Medi-Cal Managed Care Plans (MCPs) or the Fee-for-Service Medi-Cal (FFS/MC) program."[16] The "mild to moderate" language has not appeared in prior versions of the waiver.[17] As described in more detail below, the use of this phrase has generated significant confusion among plans, providers, and beneficiaries.

DHCS recently issued new guidance clarifying the medical necessity criteria for specialty mental health: "Medi-Cal beneficiaries that meet medical necessity criteria for SMHS [specialty mental health services] are entitled to receive medically necessary SMHS from their MHP . . . . MHPs may not use alternate criteria as a basis for determining SMHS medical necessity or making

[13] CALIFORNIA STATE PLAN AMENDMENT # 13-035, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf; *see also* LILIENFELD, *supra* note 12, at 2-3 (discussing benefit alignment).
[14] APL 13-021 at 4. These services are also covered in fee-for-service for beneficiaries who are not enrolled in a Medi-Cal plan. *See* Cal. Welf. & Inst. Code § 14132.03.
[15] APL 13-021 at 3-4.
[16] CALIFORNIA 1915(B) PROPOSAL, *supra* note 8, at 24.
[17] *See id*.

referrals to the MCP or a FFS Medi-Cal provider."[18] The guidance does not use the words "mild to moderate."

Memorandums of Understanding (MOUs) between the MCPs and MHPs are the primary vehicle for ensuring beneficiary access to necessary and appropriate mental health services. MHPs are required by regulation to maintain MOUs with each MCP that contain a variety of elements concerning the coordination of beneficiaries' care, including referral protocols, clinical consultation, care management, information sharing, provision of prescription drugs and laboratory services, emergency care and transportation.[19] Additionally, the MOUs with MCPs must address: the coordination of physical and mental health care;[20] a dispute resolution process;[21] and the provision of medically necessary services pending resolution of disputes.[22] Similarly, DHCS is required to ensure MCP contracts include a process for screening, referral, and coordination with MHPs and MCPs must develop and maintain MOUs with the MHPs.[23] In 2014, MCPs were responsible for updating, amending, or replacing existing MOUs with MHPs to account for the expansion of mental health services that were provided by the MCPs.[24] Each MCP must now conduct a mental health assessment for beneficiaries with a potential mental health condition using a tool mutually agreed upon with the MHP to determine the appropriate care needed.[25] The MOU should include a process for resolving clinical and administrative differences of opinion between the MCP and MHP (including dispute resolution).[26] Finally, the MOU must include identifie points of contact for each party responsible for managing the MOU, overseeing quality improvement, and resolving disputes.[27]

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[18] MHSUDS NOTICE 16-061, *supra* note 9, at 2-*3.*

[19] Cal. Code Regs., tit. 9, § 1810.370.
[20] *Id*. § 1810.415
[21] *Id.* § 1850.505
[22] *Id.* § 1850.525
[23] Cal. Welf. & Inst. Code § 14681; Letter from Margaret Tatar, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans (Nov. 27, 2013) (APL 13-018), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY MENTAL HEALTH PLANS, Ex. A, Attach. 11 (discussing responsibilities with respect to case management and care coordination), http://www.dhcs.ca.gov/services/MH/Documents/Attachment%202%20MHP%20Contract%20Boilerplate.pdf; *id.* at Ex. A, Attach. 12 (discussing MHPs responsibility to coordinate with local health departments).
[24] MHSUDS NOTICE 16-061, *supra* note 9, at 2.
[25] *Id.* at 3.
[26] *Id.* at 4.
[27] *Id*.

Findings

To understand where consumers experience problems accessing needed mental health services in California's complex system, we reviewed several sources. We surveyed providers and spoke to key informants. We also reviewed the MOUs between the MHPs and MCPs. Our findings were consistent across all sources. We found that there are often serious disconnects between the MCP and MHP systems. These disconnects sometimes result in Medi-Cal beneficiaries who are seeking services being referred back and forth between the MCP and MHP. Beneficiaries who are receiving services in one system or the other often experience gaps in services or are forced to change providers when the severity of their condition changes. The differences in the appeal and grievance systems between the MCPs and MHPs also make navigating these service gaps particularly challenging for consumers and advocates. Moreover, there is no external clinical review process for denials of care by MHPs, which sometimes leaves consumers without adequate recourse to address serious issues. Our methods and findings are described in more detail below.

Surveys and Interviews

We surveyed 39 mental health providers serving Medi-Cal beneficiaries in 48 of California's 58 counties. We also spoke to approximately thirteen key informants -- a combination of consumer advocates and providers--from around the state. Only 38% of survey respondents reported that they were aware of a written policy in the counties they serve that delineated when adults should receive care in the MHP versus the MCP. By contrast, nearly all (92%) of respondents were aware of such a policy for children. Thirty-two percent of respondents reported that the MHP in their counties permitted children to receive specialty mental health services regardless of the severity of their mental health condition, while 46% reported that children with mild-to-moderate conditions were referred to the MCP even if they met medical necessity for specialty mental health services. The remaining 21% of respondents reported that the policy or practice in their county was not consistent -- sometimes children were able to receive specialty mental health services from the MHP regardless of the severity of their condition, but sometimes they were not. (For example, a respondent noted that in one county, foster children received specialty mental health services from MHP regardless of severity, but other children did not.)

Along the same lines, 55% of respondents reported that their county's MHP required children to be transitioned to the MCP for care if their mental health condition improved to mild-to-moderate. Indeed, 21% of respondents reported that they had personally been asked to "stop," "wind down," or "transition" a patient whose condition had become less severe. These surveys revealed that counties and plans are not consistent in their division of responsibilities for mental health services. Moreover, there has been a significant degree of sending beneficiaries

back and forth between delivery systems to receive care, sometimes with little coordination. These issues are particularly concerning for children under 21, for whom the law is very clear that a broad range of mental health services must be provided without delay.

MOU Review

We also reviewed 101 MOUs between MCPs and county MHPs. Our review confirmed the findings of our survey. It revealed that many of the MOUs fail to meet the minimum requirements of the law. At least one third of the MOUs (33) failed to even discuss one or more required topics. More than 20% failed to cover two or more topics, and nearly 10% failed to cover three or more topics.

In addition, the content, detail, and structure of the MOUs varies widely.[28] While coordination between the MCP and MHP is crucial, few county MOUs cover that topic in great detail. Rather, most of the MOUs simply require each plan to identify a person responsible for care coordination, and regular meetings.[29] While many MOUs refer to an assessment or screening tool that MCPs and MHPs must use to determine whether a particular individual requires specialty mental health services, few MOUS actually include those tools, limiting our ability to evaluate their thoroughness and consistency. Some MOUs simply parrot the regulatory criteria for covered services and medical necessity criteria, while others provide a significant level of granularity in terms of what is covered and when.[30]

Our review of the MOUs suggests that, to this point, DHCS has provided minimal oversight of the coordination between MHPs and MCPs. Instead, it appears that DHCS has chosen to intervene only when an MCP or MHP requests resolution of a dispute. But without closer scrutiny of the MOUs, DHCS may be missing areas where coordination is seriously lacking, or where MCPs and MHPs are incorrectly applying rules to deny care. Moreover, MCPs and MHPs lack clarity and guidance on the scope of their responsibilities, and how best to coordinate care.

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[28] For example, the MOU between Anthem Blue Cross and the Madera County Department of Behavioral Health runs a mere five pages, whereas the MOU between California Health and Wellness Plan and the County of Tuolumne spans 62 pages. All MOUs are on file with NHeLP's Los Angeles office.

[29] *See, e.g.,* Sacramento-Health Net MOU at 4 (requiring "[a]n identified point of contract from each party who will initiate, provide, and maintain ongoing care coordination as mutually agreed. . . [and r]egular meetings to review referral, care coordination, and information exchange protocols and processes"); Kern-Kern Family Health Care AT 6 (requiring quarterly meetings between MHP Authorization Team Supervisor and the Health Plan Liaison); Riverside-IEHP MOU AT 11, 24 (requiring the MHP to host a co-located IEHP care management liaison and a multidisciplinary team of both MCP and MHP staff, to meet quarterly and ongoing); *see also* Allison Hamblin *et al.,* Ctr. Health Care Strategies, Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members 10-11 (2016), http://www.chcs.org/media/BSCF-Brief_060716.pdf.

[30] Compare, e.g., Solano-Partnership MOU (referencing the regulatory requirements without additional detail) with Sacramento-Molina MOU (providing det

Case examples

To illustrate some of the serious problems our research uncovered, we are sharing the following case examples (some details have been changed to protect confidentiality).

A 16 year-old has a history of depression and an eating disorder. She was placed on a psychiatric hold by her county MHP and subsequently hospitalized at a private hospital. Although the county MHP began to deliver services, the youth was hospitalized again and upon discharge, her mother voluntarily placed her into a residential treatment program for eating disorders. However, coverage for the services was identified as the responsibility of her Medi-Cal MCP rather than the MHP. As a result, there was a delay of 3-4 weeks in providing appropriate mental health services due to billing questions. In the meantime, the youth had problems in the facility due to lack of appropriate services and eventually ran away from the facility.

A 52 year-old man was referred for mental health services after he experienced intimate partner violence. A county MHP therapist met with the man for 4 sessions and determined that he no longer met medical necessity for mental health services. He was not referred for any follow-up from his Medi-Cal MCP, nor was he told that he might be able to continue treatment through his MCP. After the man began isolating himself and reporting that he continued to be frightened of his ex, the therapist agreed to put him back on a waiting list for additional services. He waited for more than six weeks before receiving additional therapy services from the County MHP.

A 26 year-old woman was diagnosed with anxiety and depression. After several months of working with her Medi-Cal MCP to identify an appropriate therapist to help her treat her mental health conditions, the woman found a therapist she trusted and a treatment regimen that addressed the symptoms of her illnesses. Then, in 2015, her father and best friend passed away suddenly within weeks of each other. The woman's anxiety and depression increased in severity, and she requested more treatment from her MCP. Her plan referred her to the county MHP, which approved her treatment, but told her that she would not be able to continue seeing her existing mental health provider, because that provider did not contract with the county MHP. The woman was forced to disrupt her treatment and care, and start the process of identifying a provider she could trust all over again. As a result, she experienced a two-month gap in care at a time when she really needed more treatment.

Recommendations

Based on our review of the legal requirements and state policies, and the findings made above, we have identified a number of steps California should take in order to (1) establish more consistent standards and practices across the state between MHPs and MCPs, and (2) better

ensure beneficiaries are able to timely access medically necessary care, Our recommendations are described in detail below.

1. Require MCPs and MHPs to provide continuity of care with the beneficiary's existing provider for specific services covered by both plans.

Currently, enrollees in MCPs have a right to continue care with their existing out-of-network providers in certain circumstances.[31] Thus, in most cases where Medi-Cal beneficiaries have been receiving care from an MHP contracted provider, and the severity of their condition decreases, they will be eligible to continue seeing that provider from the MHP, even if the MCP is now responsible for their care and does not contract with that provider. This right is not clearly specified in regulation or policy, however. Moreover, there is no policy whatsoever regarding continuity of care for beneficiaries whose care (within the same service type) moves from the MCP to the MHP. To ensure that beneficiaries have full continuity of care, and are able to transition seamlessly between systems for the same type of service (e.g. psychotherapy / counseling), DHCS should issue guidance requiring both MCPs and MHPs to ensure continuity of care with a beneficiary's existing mental health providers from the MCP or MHP when responsibility for a beneficiary's care moves from one entity to the other due to a change in the severity of the beneficiary's mental health condition for the same service type. The guidance should ensure that beneficiaries are able to continue treatment for that same service without interruption, even if the payment obligation changes from the MCP to MHP or vice versa.

[31] Cal. Health & Safety Code § 1373.96; *see also see also* CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 9 § 16.B (2014) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96), http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 9 § 16.B (2014) (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96), http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf. Most COHS plans are not Knox-Keene licensed, and unlicensed plans are not subject to Knox-Keene COC requirements by contract. Instead they are simply exhorted to describe their activities "designed to assure the provision of . . . coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management." CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 4 § 7.I (2014), http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf; APL 15-019. For addition discussion of these provisions, see ABBI COURSOLLE, & SHYAAM SUBRAMANIAN, NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN MEDI-CAL MANAGED CARE (2016), http://healthconsumer.org/wp/wp-content/uploads/2016/10/6-012016-ManagedCareinCaliforniaSeries-6-continuityofcareinmedi-cal.pdf.

2. For service types covered by both the MCP and MHP, require MCPs to contract with all providers of services contracted under the county MHPs so that beneficiaries may continue care if the severity of their mental health condition changes.

Aside from the continuity of care requirements described above in existing policy, MCPs and MHPs that cover the same Medi-Cal service type (e.g. psychotherapy / counseling) are not required to have an overlapping or congruent network of providers. Having the same network of providers for such services will ensure beneficiaries do not have to change providers in the middle of a course of treatment when the severity of their condition improves or worsens. DHCS should issue a policy guidance and contract amendment to MCPs to require that MCPs contract with any and all willing contracted MHP providers, within the service types offered by both plans, at a rate no lower than that rate paid to providers by the MHP. Some MCPs have already made voluntary efforts to contract with MHP providers to reduce disruptions in care when people transition between delivery systems.

3. Provide additional guidance to MCPs and MHPs with respect to the plans' responsibilities to provide services for complex conditions, such as eating disorders that require health and mental health services be provided in an integrated or highly coordinated manner.

Complex medical conditions, such as eating disorders experienced by children under age 21, require a highly integrated and well-coordinated plan of care and treatment. Often in these cases, as exemplified by one of the case summaries provided in our findings, highly specialized (residential) treatment services may also be needed which provide both a medical and mental health component. In these cases it is very common for beneficiaries (and their parents/guardians) to be denied services by both plans, each claiming it is the responsibility of the other, causing delays in necessary care and leaving families unsure where to turn for assistance. These types of cases have arisen across the state and have frequently only been resolved through state DHCS' dispute resolution process. DHCS should issue specific written guidance to MCPs and MHPs to clarify which services to treat eating disorders are the reasonability of the MCP and which services are the responsibility of the MHP, including residential or inpatient services that are medically necessary.

4. With respect to children under age, clarify that MHPs are responsible for providing the full range of covered specialty mental health services, regardless of the severity of the condition, when such services are medically necessary.

Before and after 2014, MHPs have been responsible for providing all specialty mental health services to beneficiaries when such services are medically necessary. Nevertheless, confusion arose when MCP covered mental health benefits were expanded in 2014, and DHCS issued guidance indicating MCPs were now responsible for providing mental health services to

beneficiaries with "mild to moderate" mental health conditions. Under the EPSDT mandate that applies to children under age 21, children are entitled to all medically necessary services to correct or ameliorate a mental health condition. Many of those services are only available as specialty mental health services through the MHPs. DHCS should clarify through policy guidance to MCPs and MHPs that specialty mental health services must be provided to children, when medically necessary, without respect to any severity test or screening tool employed by the MCPs and MHPs. After much urging form stakeholder, DHCS just issued such clarifying guidance on December 9, 2016, [32] which should help to alleviate further confusion.

5. Require all plans that offer mental health services to institute a clinical external review process.

In addition to the grievance and paper as process available to beneficiaries in MCPs and MHPs, 438.408(f)(1)(ii) authorizes external medical necessity review for Medicaid managed care plans, including MCOs and PIHPs. Currently, Knox-Keene licensed plans already provide this type of review to beneficiaries when services are denied for reasons of medical necessity. This process is called Independent Medical Review (IMR) for licensed plans. But not all plans that deliver mental health services in Medi-Cal are licensed. None of the MHPs is Knox-Keene licensed, and thus no external clinical review is available when an MHP denies a requested mental health services claiming that it is not medically necessary. While most MCPs are Knox-Keene licensed, the six County Organized Health System (COHS) plans are not required to hold a license, and currently, only one such plan is licensed; thus five MCPs also do not have any process for external clinical review. This creates an inconsistency where some plans provide external clinical review for medical necessity denials of mental health services, and others do not. Without external clinical review, consumers have a difficult time appealing these denials, since the decision-makers in the appeal and fair hearing processes are not clinical experts. California should take up the option to provide external medical necessity review for the COHS plans and the MHPs.

6. Conduct monitoring and oversight of MOUs between MCPs and MHPs.

Given that MOUs between the MCPs and MHPs are the primary vehicle for ensuring beneficiary access to necessary and appropriate mental health services, it is critical that DHCS reviews these documents for compliance with the state regulations and policies, as well as contract requirements. Our review of these MOU documents revealed that many of them did not meet these basic requirements or were otherwise not detailed enough to address the requirements for coordination adequately. DHCS should review all MOUs for adequacy and compliance with the rules, and require plans of correction for areas that are deficient. Furthermore, the state's

[32] MHSUDS NOTICE 16-061, supra note 9, at 2-3.

External Quality Review Organization (EQRO) for MHPs should conduct audit reviews and evaluation related to such coordination policies and practices with MCPs as part of its annual reviews of plans related to quality, timeliness, and access to specialty mental health services.

7. Require all plans to provide consumer information about the specific mental health services covered by each plan and how to address coverage disputes.

There is little to no information provided by MCOs and MHPs about the different mental health services that each plan is responsible to provide. Additionally, the grievance and appeals process available to plan members/beneficiaries does not specifically address the disputes that can arise between the plans over which mental health services must be provided to the member/beneficiary. This lack of consumer information results in significant confusion among beneficiaries and providers alike as to how to resolve such disputes when each plan claims it is the other plan's responsibility. DHCS should require all plans to provide such informing materials to all members/beneficiaries about who is responsible for which mental health services and how to address disputes between plans (including plan specific contact information) when disputes arise.

Appendix A: Medical Necessity Criteria for specialty mental health services in Medi-Cal

	Adults 21+	Children < 21
Has a covered diagnosis	1. Pervasive Developmental Disorders; 2. Disruptive Behavior and Attention Deficit Disorders; 3. Feeding and Eating Disorders of Infancy or Early Childhood; 4. Elimination Disorders; 5. Other Disorders of Infancy, Childhood, or Adolescence; 6. Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; 7. Mood disorders, except mood disorders due to a general medical condition; 8. Anxiety disorders, except mood disorders due to a general medical condition; 9. Somatoform disorders; 10. Factitious disorders; 11. Dissociative disorders; 12. Paraphilias; 13. Gender Identity Disorder; 14. Eating disorders; 15. Impulse control disorders not elsewhere classified; 16. Adjustment disorders; 17. Personality disorders, excluding antisocial personality disorder; 18. Medication-induced movement disorders related to other included diagnoses.	1. Pervasive Developmental Disorders; 2. Disruptive Behavior and Attention Deficit Disorders; 3. Feeding and Eating Disorders of Infancy or Early Childhood; 4. Elimination Disorders; 5. Other Disorders of Infancy, Childhood, or Adolescence; 6. Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; 7. Mood disorders, except mood disorders due to a general medical condition; 8. Anxiety disorders, except mood disorders due to a general medical condition; 9. Somatoform disorders; 10. Factitious disorders; 11. Dissociative disorders; 12. Paraphilias; 13. Gender Identity Disorder; 14. Eating disorders; 15. Impulse control disorders not elsewhere classified; 16. Adjustment disorders; 17. Personality disorders, excluding antisocial personality disorder; 18. Medication-induced movement disorders related to other included diagnoses.
Meets impairment criteria	1. A significant impairment in an important area of life functioning; *OR*	1. A significant impairment in an important area of life functioning; *OR*

	2. A reasonable probability of significant deterioration in an important area of life functioning	2. A reasonable probability of significant deterioration in an important area of life functioning: *OR* 3. A reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness or condition of a child; *OR* 4. The services are necessary to correct or ameliorate a defect, mental illness or condition of a child; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary to correct or ameliorate a defect, mental illness or condition of a child.
Meet intervention criteria	1. The focus of the proposed intervention is to address the impairment/condition identified above; *AND* 2. The expectation is that the proposed intervention will: a. Significantly diminish the impairment, or b. Prevent significant deterioration in an important area of life functioning; *AND* 3. The condition would not be responsive to physical health care based treatment.	1. The focus of the proposed intervention is to address the impairment/condition identified above; *AND* 2. The expectation is that the proposed intervention will a. Significantly diminish the impairment, or b. Prevent significant deterioration in an important area of life functioning, or c. Allow the child to progress developmentally as individually appropriate; *AND* 3. The condition would not be responsive to physical health care

		based treatment; ***OR*** 4. The services are necessary to correct or ameliorate a defect, mental illness or condition of a child; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary to correct or ameliorate a defect, mental illness or condition of a child.

Appendix B: Summary of how Medi-Cal delivers Behavioral Health Services

Covered by County Alcohol & Other Drug Program	Covered by County Mental Health Plan	Covered by Managed Care Plan*	Covered on FFS Basis
		All behavioral health services within PCPs scope of practice	
Outpatient drug free treatment (group therapy and limited individual therapy) & counseling incident to treatment with naltrexone, methadone or buprenorphine	Mental health services including assessments, plan development, therapy, rehabilitation and collateral services & therapeutic behavioral services	Individual and group mental health evaluation and treatment (psychotherapy) & psychiatric consultation	
	Mental health assessment	Psychological testing, when clinically indicated to evaluate a mental health condition & alcohol misuse screening and brief Intervention for adults	
Monitoring of treatment with naltrexone, methadone or buprenorphine	Medication support services	Outpatient services for the purposes of monitoring drug therapy	
Naltrexone, methadone & buprenorphine		Outpatient laboratory, drugs, supplies and supplements (excluding carved out psychotropic medications medications used for the treatment of alcohol and SUDs)	Psychotropic medications** & medications used for the treatment of alcohol and SUDs***

Intensive outpatient treatment	Day treatment intensive & day rehabilitation services		
	Crisis intervention & crisis stabilization		
Perinatal Residential SUD Services	Adult residential treatment services & crisis residential treatment services		
	Psychiatric health facility services	Any physical health components of facility services	
	Acute psychiatric inpatient hospital services & psychiatric inpatient hospital professional services	Any physical health components of hospital services + inpatient services in out-of-network hospitals	Voluntary inpatient detox in a general acute care hospital
	Targeted case management services	Care coordination	

* For beneficiaries enrolled in a Medi-Cal plan. For beneficiaries in Medi-Cal fee-for-service, these services are covered on a fee-for-service basis.

** Carved out psychotropic medications are the following: Amantadine HCl, Aripiprazole, Asenapine (Saphris), Benztropine Mesylate, Biperiden HCl, Biperiden Lactate, Chlorpromazine HCl , Chlorprothixene, Clozapine, Fluphenazine Decanoate, Fluphenazine Enanthate, Fluphenazine HCl, Haloperidol, Haloperidol Decanoate, Haloperidol Lactate, Iloperidone (Fanapt), Isocarboxazid, Lithium Carbonate, Lithium Citrate, Loxapine HCl, Loxapine Succinate, Lurasidone Hydrochloride, Mesoridazine Mesylate, Molindone HCl, Olanzapine, Olanzapine Fluoxetine HCl, Olanzapine Pamoate Monohydrate (Zyprexa Relprevv), Paliperidone (Invega), Paliperidone Palmitate (Invega Sustenna), Perphenazine, Phenelzine Sulfate, Pimozide, Proclyclidine HCl, Promazine HCl, Quetiapine, Risperidone, Risperidone Microspheres, Selegiline (transdermal only), Thioridazine HCl, Thiothixene, Thiothixene HCl, Tranylcypromine Sulfate, Trifluoperazine HCl, Triflupromazine HCl, Trihexyphenidyl, Ziprasidone, Ziprasidone Mesylate

*** Carved out medications for the medications used for the treatment of alcohol and SUD include: Naltrexone/oral form for alcohol dependence (This is pharmacy benefit), Naltrexone/injectable extended release (Vivitrol®) for treatment of alcohol and opioid addiction (This is a medical benefit), Buprenorphine (Subutex® or Suboxone®) for treatment of opioid addiction (This is pharmacy benefit), Disulfiram (Antabuse®) for alcohol dependence (This is pharmacy benefit), Acamprosate Calcium (Campral®) for alcohol dependence (This is pharmacy benefit).

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NHeLP advocates for the rights of low-income and underserved people to access quality health care.