Regulatory Provider Training

Updated February 2025

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Table of Contents

Medi-Cal Program

Medi-Cal Program:
About Medi-Cal Managed Care

- Medi-Cal managed care provides high quality, accessible, and cost-effective health care through managed care delivery systems.
- Medi-Cal managed care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.
- Members select a primary care provider who is responsible for members' primary and preventive care and arranging and coordinating all other aspects of their health care.

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Balance Billing Prohibited

Medi-Cal providers contracted with the Health Plan of San Mateo (HPSM) are prohibited from billing HPSM members according to the terms of their contract and California State Law.

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Medi-Cal State Fair Hearing Process

Medi-Cal members or their authorized representatives have the option of filing a state hearing with the Department of Social Services if they disagree with a Medi-Cal managed care plan's decision regarding denial of a service. A state hearing is an appeal with an administrative law judge from the Department of Social Services.

A Medi-Cal member must first exhaust a Medi-Cal managed care plan's appeals process prior to proceeding with a state hearing. Requests for state hearings must be submitted within **120 calendar days** of an action with which the member is dissatisfied. For standard state hearings, the state will decide within 90 days of the request. For expedited state hearings, a decision will be made within 72 hours.

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Medi-Cal State Fair Hearing Process (continued)

Submit State hearing requests via:	
Online	**https://www.cdss.ca.gov/hearing-requests**
Telephone	800-952-5253
Fax	916-651-5210 or 916-651-2789
Mail	California Department of Social Services State Hearing Division Post Office Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430

Expedited state hearings may also be requested.

Medi-Cal Program: Member Rights

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Members have the following rights per (DHCS):

- To be treated with respect, considering the member's right to privacy and the need to maintain confidentiality of the member's medical information.
- To be provided with information about the plan and its services, including covered services.
- To be able to choose a primary care provider within the plan's network.
- To participate in decision-making regarding their own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.

Medi-Cal Program:
Medi-Cal Member Rights (Continued)

- To receive oral interpretation services for their language. This includes communication access to sensory processing disorder (SPD) beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language methods that ensure communication, including assistive listening systems, sign language interpreters captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English proficient, or non-English speaking.

- To formulate advance directives.

- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside the plan's network pursuant to the federal law.

Medi-Cal Program:
Medi-Cal Member Rights (Continued)

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- To request a state Medi-Cal state hearing, including information on the circumstances under which an expedited state hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend or correct their medical record.
- To access minor consent services.
- To receive written member informing materials in an alternative format (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Medi-Cal Program:
Medi-Cal Member Rights (Continued)

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- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Freedom to exercise these rights without adversely affecting how they are treated by the plan, providers, or the state.
- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

Medi-Cal Program: Clinical Protocol and Evidence-Based Practice Guidelines

Clinical Practice Guidelines are evidence-based recommendations for optimizing patient care. They are intended to assist providers and patients in making decisions about appropriate health care in specific clinical circumstances, including preventive care.

HPSM provides clinical practice guidelines to guide our providers on HPSM's website here: **https://www.hpsm.org/provider/resources/guidelines**

These guidelines are developed by nationally recognized medical organizations, health professional societies, and expert task forces. Some links connect to expert organization websites, and others are direct links to practice guideline documents. HPSM's Quality Improvement Committee reviews the guideline topics and posted guidelines annually, to ensure they remain current and relevant to our member population.

Medi-Cal Program:
Serving Seniors and Persons with Disabilities

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How do we define a disability and/or functional limitation?

Disability may be physical, cognitive, mental, sensory, emotional, developmental or some combination of these. A disability may be present from birth or occur during a person's lifetime.

Functional limitations are difficulties completing a variety of basic or complex activities that are associated with a health problem. For example, vision loss, hearing loss, and inability to move one's legs are functional limitations.

When checking eligibility of your patients, aged/blind/disabled aid codes for SPD are:

10, 13, 14, 16, 17, 20, 23, 24, 26, 27, 36, 53, 60, 63, 64, 65, 66, 67, 1E, 1H, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y.

Medi-Cal Program:
Serving Seniors and Persons with Disabilities

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How seniors and persons with disabilities (SPD) may have barriers to access and care:

Physical Access: The ability to get into a building or the area where healthcare services are offered. Areas to consider: building entrances, restrooms, parking lots, doors, doorways and hallways, waiting areas and reception desk, drinking fountains and water coolers, elevators, posted signs, telephones, forms and documents.

Communication Access: The ability of the provider and member to communicate and understand the information asked and directions given. Methods of communication: Qualified ASL Interpreters, relay service, assistive listening device, text message, email, captioning, qualified readers, audio recordings, braille, large print.

An accommodation checklist was developed to help providers and office staff identify accommodation needs for SPD members. Please place checklist in medical record of patient for easy access and future use.

Medi-Cal Program:
Serving Seniors and Persons with Disabilities

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Here are some ways you may modify your office policies:

- Flexible and/or longer appointment time.
- Support members in filling out forms.
- Providing lifting assistance.
- Providing print materials in alternative, accessible formats.
- Allowing service animals.

How the Health Plan of San Mateo can help you:

- Assistance with arranging for sign language interpreters.
- Methods for providing print materials in alternative formats.
- Sources for equipment such as assistive listening devices, accessible weight scales, conversion of print material to Braille.

Medi-Cal Program:
Serving Seniors and Persons with Disabilities

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Health education materials in alternate formats

Call the Health Plan of San Mateo's Health Education Line at **650-616-2165** or visit **https://www.hpsm.org** for more information and resources, including:

- Accommodation checklist.
- Access to medical care for individuals with mobility disabilities.
- Communication with people who are deaf or hard of hearing.
- Information on the Health Plan of San Mateo's interpreter services.

Medi-Cal Program: Cultural Competency

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What is culture? Culture is comprised of a group's learned patterns of behavior, values, norms, and practices.

What is cultural competency? Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided.

Why is cultural competency important? Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

Medi-Cal Program:
Cultural Competency

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Elements of culture include:

- Collective values, experiences, beliefs- beliefs about health and health care, as well as behavioral styles.
- Non-verbal communication.
- Perspectives, world views, frames of reference.
- Community motivation and social identification.
- Cultural awareness.
- Languages and dialect.

Medi-Cal Program:
Cultural Competency

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Language Assistance Services

Accurate communication between patients and healthcare providers helps reduce health disparities and improves quality of care. HPSM provides 24/7 telephonic video interpreter services at no cost to the member.

- More than 200 languages are available including American Sign Language.
- HPSM can provide an office-based training session to discuss how to identify and address the linguistic needs of patients whose English proficiency is limited.

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Language Assistance Services (continued)

When using interpreter services be sure to:

- Inform assigned members with Limited English Proficiency, on right to qualified interpreter (phone or video) free of charge.
- Document member's language preference in medical record.
- Document member's request or refusal of interpreter service (phone or video) at each visit, and how the language barrier was addressed (i.e. certified bilingual staff person, member brought friend or relative to serve as interpreter)

Medi-Cal Program:
Cultural Competency

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Culturally Competent Care

Visit **https://www.hpsm.org/provider/resources/language-services** for links to cultural competency training and resources, including:

- Tips for working with diverse patients.
- Guidelines for communicating with hard of hearing patients.
- Tips for identifying health literacy issues.

Medi-Cal Program:
Cultural Competency

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Translated Materials

HPSM materials are available translated into HPSM's threshold languages: **English, Spanish, Russian, Chinese and Tagalog.**

You can also request HPSM materials in alternative formats, such as Braille.

For additional resources and questions, call HPSM's Health Education line at **650-616-2165.**

Medi-Cal Program:
Member Complaint Requirements

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Providers must have a process for documenting and submitting to the managed care plan any complaint submitted by members in their offices.

Timeframes for filing & resolving complaints	
Timeframe for filing (from date of denial, service, incident or bill)	
Type of complaint	**Timeframe**
Appeal	60 calendar days
Grievance	No time limit
Timeframe for processing	
Type	**Grievance and appeals processing**
Standard	30 calendar days
Expedited	72 hours

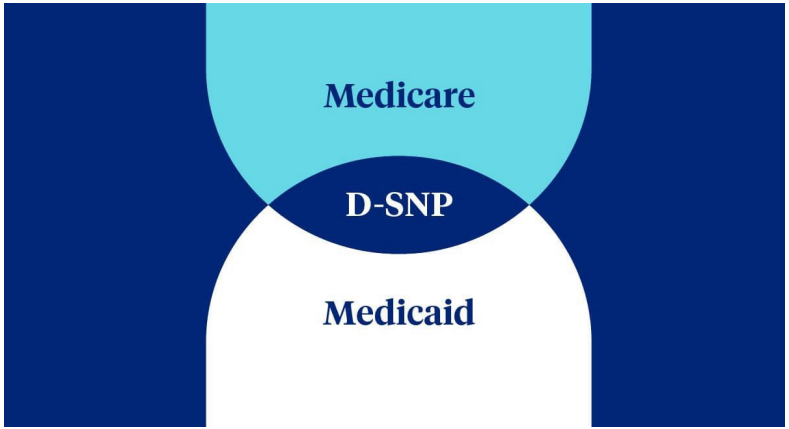
CareAdvantage Dual Special Needs Plan (D-SNP) Program

CareAdvantage D-SNP Program: Eligibility

HPSM offers a Dual-Eligible Special Needs Program (D-SNP) program for members.

Eligible beneficiaries:

- Have Medicare Part A and Part B.
- Have full-scope Medi-Cal through HPSM.
- Reside in San Mateo County.



CareAdvantage D-SNP Program: Description of Population

Dual eligible individuals often experience fragmented care and poor health outcomes due to lack of care coordination.

Social determinants of health such as housing instability, low income, lack of education and transportation, food insecurity, and poor family/social support are some of the barriers this population faces when attempting to access health care.

Dual eligibles have a higher incidence of disability, multiple chronic conditions, and behavioral health disorders.

CareAdvantage D-SNP Program: Description of Population

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Most vulnerable D-SNP enrollees

HPSM identifies the following CICM populations as its most vulnerable D-SNP enrollees:

- Adults experiencing homelessness.
- Adults at risk for avoidable hospital or ED utilization.
- Adults with serious mental health or substance use disorder needs.
- Adults transitioning from incarceration.
- Adults living in the community at risk for LTC institutionalization.
- Adult nursing facility residents transitioning to the community.
- Adults pregnant or postpartum and subject to racial or ethnic disparities.
- Members with serious illness eligible for community-based palliative care.
- Adults with documented dementia needs.
- Members receiving or eligible for palliative care.

CareAdvantage D-SNP Program: Initial Screening and Comprehensive Assessment for Dementia

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The following resources around comprehensive cognitive health assessment and other relevant dementia care topics may be useful to providers:

Patient Assessment Tools:

- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog

Informant tools (family members and close friends):

- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Additional resources include but are not limited to:
Dementia Care Aware Resources California Alzheimer's Disease Centers
Clinical Practice Guidelines - Alzheimer's Association

CareAdvantage D-SNP Program: Model of Care

The Centers for Medicare and Medicaid Services (CMS) requires all D-SNP plans have a model of care (MOC).

The MOC is a document that details how HPSM will provide coordinated care and case management to D-SNP members. The MOC's goals are to:

- Improve access to preventive, medical, mental health, and social services.
- Improve communication and coordination of care.
- Assure appropriate service utilization.
- Assure cost effective service delivery.
- Improve health outcomes.
- Improve quality, reduce costs, and improve the member and provider experience by coordinating service delivery that meets regulatory requirements.

CareAdvantage D-SNP Program: Core Components of Care Coordination

Every D-SNP member receives an initial Health Risk Assessment (HRA) and a reassessment within 365 days of the previous assessment.

The results of the HRA — along with claims, utilization management and pharmacy data — are used to develop an **Individualized Care Plan (ICP)** for every member.

The ICP is reviewed by an Interdisciplinary Care Team (ICT) which includes the member's primary care physician. The team may also include specialists and other community and ancillary providers, as relevant.

Every D-SNP member requires one face-to-face encounter per year with a contracted provider for the delivery of health care. This can be done in-person, or a visual, real-time, interactive telehealth encounter.

CareAdvantage D-SNP Program: Individualized Care Plans

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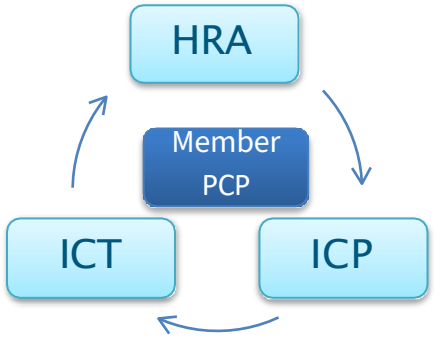
To create an Individualized Care Plan (ICP), HPSM:

- Conducts the Health Risk Assessment (HRA).
- Creates the Individual Care Plan (ICP).
- Coordinates with the Interdisciplinary Care Team (ICT) on the development and implementation of the ICP.
- Applies member risk identification/stratification.



CareAdvantage D-SNP Program: Individualized Care Plans (Continued)

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More on Individualized Care Plans (ICPs):

- ICPs are developed with input from the member and the primary care provider.
- ICPs are at minimum updated annually and upon a significant change of condition.
- A copy of the ICP is mailed to every member.
- An ICP summary is communicated to the member's primary care provider.
- HPSM's Integrated Care Management team and the member's ICT contribute to the development of the ICP, monitoring of effectiveness, and modifying as needed.

CareAdvantage D-SNP Program: Provider Role in Model of Care

Here are tasks assigned to the provider for the D-SNP model of care:

- Actively engage in the development of member's ICP and notify HPSM's Integrated Care Management team of any changes.
- Participate in the member's Interdisciplinary Care Team (ICT) meetings.
- Review the ICP summary with the member during office visits to reinforce goals.
- Coordinate with HPSM's Integrated Care Management team on care coordination services for high risk D-SNP members as needed.

CareAdvantage D-SNP Program: Care Management Referrals and Forms

Any provider can refer HPSM members for Care Coordination support.

Care Coordination Provider Page:
https://www.hpsm.org/provider/care-coordination

Complex Case Management Referral Form:
https://www.hpsm.org/docs/default-source/provider-forms/complex_case_management_referral_form.pdf

Contact:
650-616-2060
carecoordinationrequests@hpsm.org

CareAdvantage D-SNP Program: Clinical Practice Guidelines and Care Transition

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- HPSM inpatient review nurses and care coordination staff assist members with transitions between different settings of care, such as discharge from an acute care facility to a skilled nursing facility.
- The goal of the care transitions program is to ensure continuity of care, reduce hospital readmissions, and improve health outcomes for members.
- Members experiencing a care transition may be followed by the care transitions team for 30 days post-discharge to ensure a smooth transition in levels of care.
- PCPs are notified of member admission and discharges via fax within one business day of notice of event.
- HPSM reviews and approves evidenced-based clinical practice guidelines relevant to the D-SNP population. Guidelines can be accessed on the HPSM Provider Resources page: **https://www.hpsm.org/provider/resources/guidelines**

CareAdvantage D-SNP Program: Model of Care Quality Measurement

In compliance with Centers for Medicare & Medicaid Services (CMS) requirements, HPSM must conduct a Quality Improvement Program to monitor health outcomes and the implementation of the model of care by:

- Identifying measurable goals and collecting data to determine if goals have been met.
- Reporting on identified trends/issues requiring evaluation and/or remediation.
- Developing targeted strategies and opportunities to enhance care delivery.

CareAdvantage D-SNP Program: Model of Care Quality Measurement (Continued)

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Performance measures include clinical and non-clinical indicators:

Clinical examples

- Health outcomes (e.g., HEDIS data).
- Chronic care (e.g., Chronic Care Improvement Program).
- Compliance with clinical practice guidelines (e.g., gaps in care reports).

Non-clinical examples

- Member access to care.
- Plan adherence to care transition protocols.
- Timely completion of Care Coordination activities (e.g., HRA, ICP, ICT).
- Generic dispensing rate for Part D medications.

CareAdvantage D-SNP Program: Performance Assessment

HPSM assesses its quality improvement plan on an annual basis, at minimum. Results are presented to the Quality Committee. If an identified goal has not been achieved the following processes are preformed to identify opportunities for improvement:

- Root cause analysis.
- Discussion with stakeholders.
- Implementation of corrective actions.
- Re-measurement.
- Development of a plan to measure and monitor.

CareAdvantage D-SNP Program: Summary

The model of care requires us to work together to enhance care and services for DSNP members through:

- Effective communication between members, physicians, providers, and HPSM staff.
- An interdisciplinary approach to managing the member's specific care needs.
- Development and implementation of a comprehensive member care plan.
- Improving transitions of care across health settings and providers.
- Identifying benefits that will best serve the D-SNP membership.
- Monitoring model of care performance and health outcomes to continually improve care and services.

Diversity, Equity and Inclusion

Diversity, Equity and Inclusion: About Our Membership

- 173,439 members (in 2024).
- 81% are Medi-Cal members.
- Almost ½ of our members are Hispanic/Latino.
- Largest subgroups in our Asian and Pacific Islander membership are Filipino and Chinese.

Diversity, Equity and Inclusion: Disparities by Race

- Black-identifying members experience disparities in Kidney Exams for Diabetes (KED) and Well Child Visits (W30-2+, WCV).
- Additionally, the Asian or Pacific Islander members experiences disparities in blood pressure control and diabetes (CBP, BPD).
- Finally, Caucasian members experience the highest volume of disparities, including in blood pressure control, diabetes management, cervical cancer screening, well visits, and child and adolescent immunizations.

Diversity, Equity and Inclusion: Federal Regulations

Federal regulations prohibit discrimination based on many factors, including:

- Age
- Race
- Color
- National origin
- Disability
- Religion
- Sex

Diversity, Equity and Inclusion: Institutional Racism

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What is institutional racism?

Institutional racism includes policies or behaviors within an organization discriminating against people of color— either intentionally or unintentionally. Structural racism is a system in which those policies and laws perpetuate racial and ethnic group inequality.

Why should I care about institutional racism?

Because discrimination against people based on their race is so pervasive into our culture, racism is not often explicit or conscious. To best serve our members, we must understand what kinds of daily inequities they experience that impact their health and wellness and our own biases.

Diversity, Equity and Inclusion: Patient-Centered Communication

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Fundamentals of Patient-Centered Communication:

- Eliciting and understanding patient perspectives (e.g., concerns, ideas, expectations, needs, feelings, and functioning).
- Understanding the patient within his or her unique psychosocial and cultural contexts.
- Reaching a shared understanding of patient problems and treatments that are concordant with their values.

Diversity, Equity and Inclusion: Disparities by Language

- 45.1% of members prefer a language other than English.
- Our threshold languages are Spanish, Chinese (Mandarin/Cantonese) and Tagalog.
- Members speaking non-threshold non-English languages experience disparities in Cervical Cancer Screening (CCS), Well Visits (W30-2+, WCV), Perinatal Care (PPC:PN) and childhood immunizations (CIS-10).

Diversity, Equity and Inclusion: Language Assistance Services

- Providing HPSM members with limited English proficiency with language assistance services is a contractual requirement.
- HPSM offers free, on-demand interpreter services via phone, video, and in-person.
- Members should NOT be asked to provide their own interpreter.

Certified Languages International Phone Line (24/7): 1-800-225-5254
Access Code: 64095
https://www.hpsm.org/provider/resources/language-services
Email: interpreters@hpsm.org

Diversity, Equity and Inclusion: Health Literacy

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Health Literacy: the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Make healthcare information more accessible by:

1. Utilizing interpreter services.
2. Using techniques like the teach back method.
3. Ensuring that appointments are accessible for all patients at all points of contact.
4. Providing tools to support patients in getting the care they need.

Diversity, Equity and Inclusion: Disparities by Age

- The 17-21 age group experiences disparities in Diabetes Care (HBD-A1C, EED, KED), well visits (WCV, AAP) and Perinatal Health care (PDS, PND, PPC:PN).
- The 22-50 age group experiences similar disparities in Diabetes Care (HBD-A1C, EED, KED, BPD), Controlling Blood Pressure (CBP), and well visits (AAP).

Diversity, Equity and Inclusion: Disparities by Gender

- Men experience disparities in Diabetes Care (HBD-A1c, EED, BPD) and well visits (WCV, AAP).

Diversity, Equity and Inclusion: Disparities for People with Disabilities

- People with disabilities experience a high volume of disparities, including in Asthma Medication Ratios (AMR), Blood Pressure Control (CBP), Diabetes Care (EED, KED, BPD) and Cervical Cancer Screening (CCS).

Diversity, Equity and Inclusion: LGBTQIA+ Community

HPSM does not currently collect SOGIE (Sexual Orientation, Gender Identity and Expression) data. Review these tips for working with LGBTQIA+ members:

- **ALWAYS ASK:** “What is your preferred name? What are your preferred pronouns?” Once the member answers, do not deviate from their preferred name and pronouns. Be sure to note their preference.

Diversity, Equity and Inclusion: LGBTQIA+ Community

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DEFINITIONS:

- **Gender identity "How I identify":** Gender identity is the personal sense of one's own gender. Gender identity can correlate with a person's assigned sex or can differ from it.
- **Gender expression "How I look and express myself":** Gender expression, or gender presentation, is a person's behavior, mannerisms, interests, and appearance that are socially associated with gender. This can range from masculine, to feminine, to androgenous.
- **Sex assigned at birth:** Sex assigned at birth is the label at birth based on external genital anatomy. This is either Male or Female
- **Sexual attraction:** Sexual attraction is who a person is physically attracted to.

Diversity, Equity and Inclusion: LGBTQIA+ Community

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DEFINITIONS (CONTINUED):

Sexual Orientation: Sexual orientation is a person's identity in relation to the gender or genders to which they are sexually attracted. There are many different types of sexual orientation including but not limited to:

- **Lesbian:** A woman with a significant attraction to members of the same gender, or who identifies as a member of the lesbian community.
- **Gay:** One who has significant sexual attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. Typically associated with men.
- **Bisexual:** The potential to be sexually attracted to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree.

Diversity, Equity and Inclusion: LGBTQIA+ Community

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DEFINITIONS (CONTINUED):

- **Transgender:** Umbrella term for those whose gender expression or identity is not congruent with the sex assigned at birth and/or whose gender is not validated by the dominant culture.
- **Queer:** Reclaimed derogatory slang by many who reject gender and sexual binaries. Also used as a political identity by many who want to dismantle oppressive systems in society.
- **Intersex:** Used for a variety of bodies in which a person is born with reproductive or sexual anatomy that does not fit into the sex binary.
- **Asexual:** Umbrella term for those to tend not to have a sexual desire towards others; asexuals may experience romantic attractions and engage in sexual behavior.

Diversity, Equity and Inclusion: LGBTQIA+ Community

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DEFINITIONS (CONTINUED):

Non-Binary: “Non-binary” is generally used as an umbrella for various gender nonconforming identities and is most often used by those who do not strictly identify as "male" and "female."
Pansexual: One who can feel an attraction to anyone, including individuals who do not identify as a specific gender. Pansexual people may describe their attraction as focusing on personality rather than gender.
Cisgender: Umbrella term for those whose gender expression and gender identity are congruent with the sex assigned to them at birth, and whose gender is validated by the dominant culture.

Diversity, Equity and Inclusion: Gender-Affirming Care

Gender-affirming care is a supportive form of healthcare that includes, medical, surgical, mental health, and non-medical services for transgender and nonbinary people.

Some things you can do:

- Share and list your pronouns.
- Make all-gender restrooms available.
- Use gender inclusive language on forms and during health encounters.
- Ask and use members' preferred names.

https://www.hpsm.org/provider/resources/language-services/tips-for-supporting-lgbtqia-patients

Diversity, Equity and Inclusion: Beliefs Around Illness and Health

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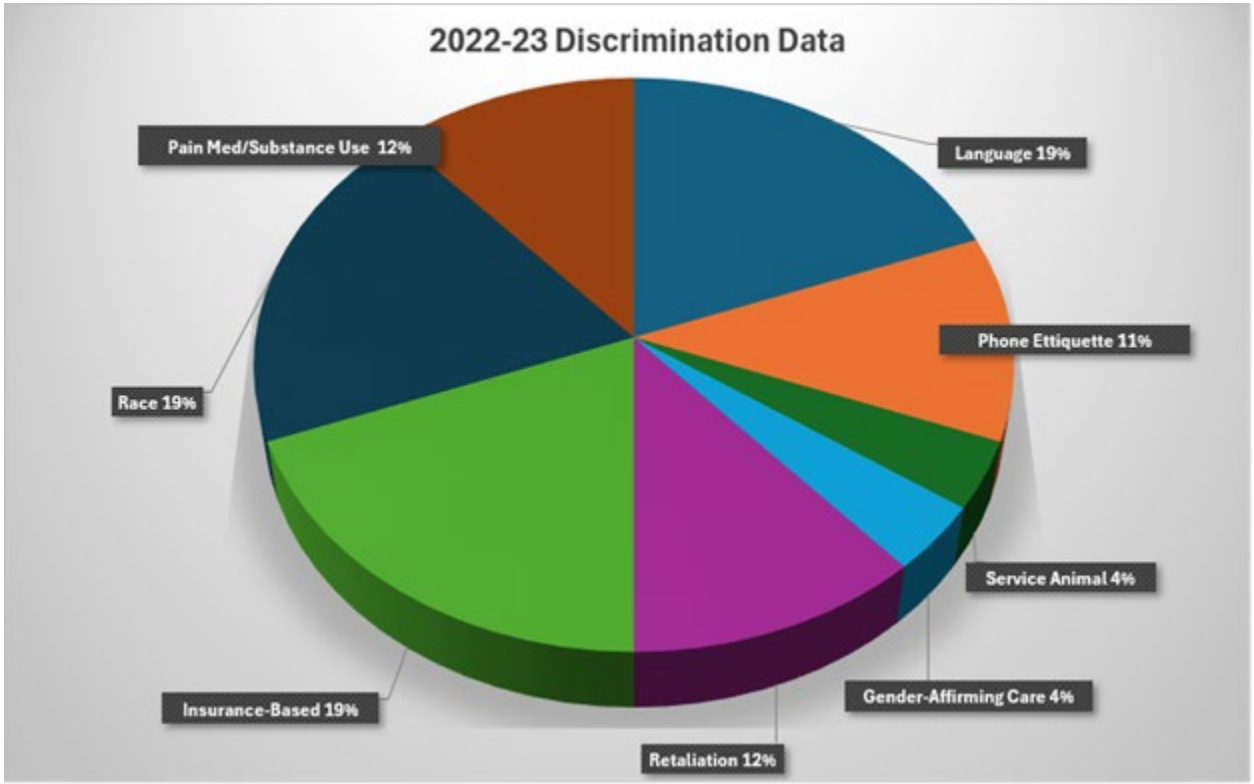
Cultural beliefs can influence:

- Where patients seek help.
- Types of treatments patients prefer.
- Clear communication can help establish trust.
- Home remedies.

About home remedies: Home remedies, may be used more often by communities of color because of cultural, financial, and trust-related factors.

Remember to take a patient-centered approach and work with members to understand what remedies work for them. A treatment plan can be created with these in mind to provide a holistic and more positive health care experience.

Diversity, Equity and Inclusion: Discrimination-Related Grievances



Culturally and Linguistically Appropriate Services (CLAS)

Culturally and Linguistically Appropriate Services (CLAS)

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What is CLAS?

CLAS stands for culturally and linguistically appropriate services which is a phrase created by the Federal Office of Minority Health. The phrase is about respecting and responding to an individual's health needs and preferences.

At HPSM, CLAS refers to activities and services that respect the linguistic and cultural diversity of our membership and are responsive to members' communication needs at points of service. CLAS helps to improve members' experience through customer support, and through health care that responds to our members' unique needs and beliefs.

Culturally and Linguistically Appropriate Services (CLAS)

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What is culture? Culture is comprised of a group's learned patterns of behavior, values, norms, and practices.

What is cultural competency? Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided.

Why is cultural competency important? Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

Culturally and Linguistically Appropriate Services (CLAS)

Elements of culture include:

- Collective values, experiences, beliefs- beliefs about health and health care, as well as behavioral styles.
- Non-verbal communication.
- Perspectives, world views, frames of reference.
- Community motivation and social identification.
- Cultural awareness.
- Languages and dialect.

Culturally and Linguistically Appropriate Services (CLAS)

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Language Assistance Services

Accurate communication between patients and healthcare providers helps reduce health disparities and improves quality of care. HPSM provides 24/7 telephonic video interpreter services at no cost to the member.

- More than 200 languages are available including American Sign Language.
- HPSM can provide an office-based training session to discuss how to identify and address the linguistic needs of patients whose English proficiency is limited.

Culturally and Linguistically Appropriate Services (CLAS)

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Language Assistance Services (continued)

When using interpreter services be sure to:

- Inform assigned members with Limited English Proficiency, on right to qualified interpreter (phone or video) free of charge.
- Document member's language preference in medical record.
- Document member's request or refusal of interpreter service (phone or video) at each visit, and how the language barrier was addressed (i.e. certified bilingual staff person, member brought friend or relative to serve as interpreter)

Culturally and Linguistically Appropriate Services (CLAS)

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Culturally Competent Care

Visit **https://www.hpsm.org/provider/resources/language-services** for links to cultural competency training and resources, including:

- Tips for working with diverse patients.
- Guidelines for communicating with hard of hearing patients.
- Tips for identifying health literacy issues.

Culturally and Linguistically Appropriate Services (CLAS)

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Requirements for Member Materials

Translated Materials and Alternative Formats: HPSM materials are available translated into HPSM's threshold languages, which include English, Spanish, Russian, Chinese and Tagalog, as well as alternative formats, such as Braille. It is the provider's responsibility to provide materials in the member's desired language or in the format of their choosing. It is also the provider's responsibility to offer these materials to the member – it is NOT the member's responsibility to request them.

Reading level: All materials for members should read at a sixth-grade literacy level.

Contact: For additional resources and questions, call HPSM's Health Education line at **650-616-2165.**

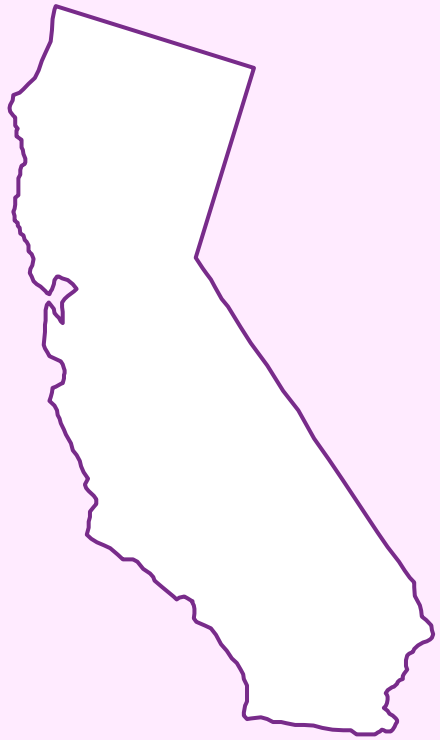
Medi-Cal for Kids & Teens Provider Training (DHCS)

Medi-Cal for Kids & Teens Provider Training

DHCS

Today's Training

- **Goals & Purpose of Today's Training**
- **Training Modules**
  - **Module 1:** What is Medi-Cal for Kids & Teens and How Does it Work?
  - **Module 2:** Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services



Federal law enacted in 1967 established **Early and Periodic Screening, Diagnostic and Treatment (EPSDT),** which guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as

Medi-Cal for Kids & Teens

Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services

In 2019, the California State Auditor released a report highlighting the low rates of children's preventive health services in Medi-Cal. A follow-up audit in 2022 underscored that millions of Medi-Cal-enrolled children are still not receiving preventive services. In response, the Department of Health Care Services (DHCS) committed to developing a standardized provider training on Medi-Cal for Kids & Teens.

The 2019 California State Audit found:

- 2.4 million children enrolled in Medi-Cal did not receive required preventive services – roughly half of all children under age 21 in Medi-Cal
- Pre-pandemic, California ranked 40th nationwide for utilization of children's preventive services, or 10 percentage points below the national average

Since the COVID-19 pandemic, California's preventive services utilization has continued to decline:

1 in 2 children ages 12 – 21 received at least one annual well-care visit

22% of children under the age of 3 received a developmental screening

Less than half of children at age 13 were fully immunized

Goals of Medi-Cal for Kids & Teens Provider Training

The training aims to strengthen understanding and awareness of Medi-Cal for Kids & Teens among Medi-Cal managed care plan-enrolled providers and increase access to children's health services.

- California's managed care plans must ensure that all Medi-Cal licensed providers receive proper education and training regarding Medi-Cal for Kids & Teens at least every two years.
- More information on Medi-Cal for Kids & Teens for providers is available in the Information for Medi-Cal Providers resource document.

Medi-Cal for Kids & Teens Training Modules

Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?

Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

In This Module You Will Learn…

- What is Medi-Cal for Kids & Teens
- What screening, diagnostic services, and treatment services are covered under Medi-Cal for Kids & Teens
- What the definition of “medical necessity” means for children enrolled in Medi-Cal
- What limitations can be placed on Medi-Cal for Kids & Teens services
- How you can help support access to required services for your patients
- Your role in informing children and families about Medi-Cal for Kids & Teens covered services

What is Medi-Cal for Kids & Teens?

- Requires comprehensive age-appropriate health care services be provided to all Medi-Cal enrolled children and youth under age 21
- Requires preventive screening, diagnostic services, and treatment services
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than that for adults' care

Goal of Medi-Cal for Kids & Teens

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Medi-Cal for Kids & Teens Services Are Free for Most Children Under Age 21

- All medically necessary Medi-Cal for Kids & Teens preventive, screening, diagnostic, and treatment services for children and youth are **free** for most children and youth under age 21
- Some youth between ages 18 and 20 enrolled in Medi-Cal may pay a "Share of Cost" for some treatment based on their income and family size. This is determined at the time of Medi-Cal eligibility. These youth are "carved out" of Medi-Cal managed care and receive services through fee-for-service.

Medi-Cal for Kids & Teens Periodicity Schedule

- Medi-Cal for Kids & Teens follows the **Bright Futures/American Academy of Pediatrics (BF/AAP) Periodicity Schedule.**
- The BF/AAP Periodicity Schedule is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.
- The most up to date BF/AAP Periodicity Schedule can be accessed online here.

Medi-Cal for Kids & Teens Periodic Screenings

Medi-Cal for Kids & Teens screening services are designed to identify health and developmental issues as early as possible.

Reimbursable Screening Services

Comprehensive health and developmental history	Comprehensive, unclothed physical exam, including nutritional, height/weight, and Body Mass Index assessment	Behavioral health screening, including depression screening and tobacco, alcohol, or drug use
Developmental screening for physical and mental health using standardized screening tools	Age-appropriate immunizations (based on the Bright Futures / American Academy of Pediatrics (BF/AAP) Periodicity Schedule and Advisory Committee on Immunization Practices (ACIP) Recommendations)	Age-appropriate laboratory tests, including blood lead screening test
Oral health screenings and referrals to a dentist (beginning by age 1 or eruption of first tooth)	Age-appropriate vision and hearing screenings	Health education and anticipatory guidance for child and caregiver

Any qualified Medi-Cal provider (acting within the scope of their practice) may conduct these screenings.

Screenings may be provided at physician offices and clinics, community health centers, local health departments, or schools

Families do not need to request these screenings, and prior authorizations are not permitted

Medi-Cal for Kids & Teens Screenings & Services

The following slides outline requirements for a subset of required screenings and services, including screening tools and billing codes.

Subset of Required Medi-Cal for Kids & Teens Screenings & Services	
Blood Lead Screening Services	Vision Screening Services
Developmental Screening Services	Hearing Screening Services
Autism Spectrum Disorder (ASD) Screening Services	Oral Health Screening Services
Depression Screening Services (for adolescents and postpartum individuals)	Adverse Childhood Experiences (ACEs)/Trauma Screening Services
Dyadic Services	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Blood Lead Screening Services (1 of 2)

Providers must perform blood lead screening tests at specific intervals and deliver anticipatory guidance to parents/caregivers that indicates children can be harmed by exposure to lead and are at risk of lead poisoning.

- **Anticipatory Guidance.** Providers must provide oral or written anticipatory guidance to parents or caregivers at each well-child visit starting at 6 months until 6 years of age; guidance must include information on:
  - The harm of lead exposure to children (especially from lead-based paint and its dust) **and**
  - The risk of lead poisoning from the time a child begins to crawl until 6 years of age
- **Periodicity Schedule.** Providers must order or perform blood lead screening tests for children at the following intervals:
  - At 12 months and 24 months of age;
  - In between 12 to 24 months of age if the child has no documented evidence of a blood lead screening test taken;
  - In between 24 months to 6 years of age if the child has no documented evidence of a blood lead screening test taken;
  - Any time a change in circumstances has put the child at risk; **or**
  - If requested by the parent or caregiver

Blood Lead Screening Services (2 of 2)

- **Refugee Screening.** Providers must follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees, which states that all refugee children ages 0-16 or adolescents over age 16 with suspected lead exposure should be evaluated with a blood lead screening test

- **Billing Codes.** The CPT codes available for blood lead screening include:
  - 36415 (venipuncture)
  - 36416 (finger stick)
  - 83655 (lead test)
  - 99401, 99402, 99403, 99404 (preventive medicine counseling at 15 min intervals)

See California Department of Public Health's (CDPH) Standard of Care Guidelines on Childhood Lead Poisoning for California Health Care Providers for more information

Developmental Screening Services

Providers must deliver developmental screenings at age-appropriate intervals at ages 9 months, 18 months, and 30 months per BF/AAP Periodicity Schedule, and when medically indicated.

- **Overview.** The developmental screening includes a comprehensive health and developmental history, including both physical and mental health development assessments, designed to identify if a child's motor, language, cognitive, social, and emotional development are on track and connect to services, if needed
  - **Billing Codes.** The CPT code for reimbursement is 96110; screenings can be provided twice a year for children ages 0 to 5
  - **Screening Tools.** Providers must use a standardized screening tool, with approved options including:
    - Ages and Stages Questionnaire (ASQ)
    - Ages and Stages Questionnaire (ASQ-3)
    - Battelle Developmental Inventory Screening Tool (BDI-ST)
    - Bayley Infant Neuro-developmental Screen (BINS)
    - Brigance Screens-II
    - Child Development Inventory (CDI)
    - Infant Development
    - Parents' Evaluation of Developmental Status (PEDS)
    - Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- **Referrals to Regional Centers.** Providers should refer children to Regional Centers for services and supports that are needed because of a developmental disability

Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers a supplemental incentive payment of $59.90 for developmental screenings

Autism Spectrum Disorder Screening Services

Providers must perform autism spectrum disorder (ASD) screenings at 18 and 24 months, per the BF/AAP Periodicity Schedule, and when medically indicated.

- **Billing Codes.** Providers should use the developmental screening CPT code 96110 but must include the modifier KX
  - ASD and developmental screenings are reimbursable when performed on the same day at 18 months and when medically indicated
- **Screening Tool.** Providers must use a validated screening tool to screen for ASD, such as: MCHAT-R/F (ages 16 to 30 months old); SCQ (ages 4 years old and up); and STAT (ages 24 to 35 months old)
- **Services & Referrals.** Medi-Cal for Kids & Teens covers all medically necessary behavioral health treatment for eligible enrollees under 21 years of age regardless of ASD diagnosis
  - Behavioral health treatment services include applied behavioral analysis (ABA) and a variety of other evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, and functioning
  - Providers should refer individuals to either their managed care plan or their local Regional Center to receive medically necessary behavioral health treatment services

Examples of behavioral health treatment services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Depression Screening Services

Depression Screening

- **Periodicity Schedule.** Providers must perform depression screenings on children ages 12 and older at every well-child visit
- **Billing Codes.** The HCPCS codes are G8431 (positive screening with follow-up plan) and G8510 (negative screening and no follow-up plan) and may not be submitted more than once a year per child

Postpartum Depression Screening at Infant Visits

- **Periodicity Schedule.** Providers may perform postpartum depression screenings for the birthing parent at up to four times during an infant's first year of life
  - BF/AAP Periodicity Schedule recommends this happens during the well-infant visits at 1, 2, 4, and 6 months
  - **Billing Processes.** These screenings must be billed to the infant's Medi-Cal ID regardless if the birthing parent is enrolled in Medi-Cal; if the infant's Medi-Cal eligibility has not been established during the first two months of life, the screening may be billed to the birthing parent's Medi-Cal ID
- **Billing Codes.** The HCPCS codes, G8431 (positive screening with follow-up plan) and G8510 (negative screening and no follow-up plan), must include a postpartum diagnosis code and may not be submitted more than once a year

Screening Tools. Providers must use a validated depression screening tool for children and youth and pregnant or postpartum individuals, with options including the Patient Health Questionnaire (PHQ-9), Edinburgh Postnatal Depression Scale (EPDS), and Beck Depression Inventory (BDI)

Dyadic Services

As of January 2023, Medi-Cal covers dyadic and family therapy services, which include integrated physical and behavioral health screenings and services for the child and their parent/caregiver or whole family, not just the child who is the identified patient. Dyadic services involve simultaneous treatment for the child and parent/caregiver, with studies showing significant improvements in child behavior issues and increases in positive parent/child attachment.

Dyadic Services for Children ages 0 to 20

Billing Codes. Medi-Cal reimburses a number of dyadic services for recipients ages 0 to 20 years, when billed to the child's Medi-Cal ID with the U1 modifier, including:

- Dyadic Behavioral Health (DBH) Well-Child Visits (H1011)
- Dyadic Comprehensive Community Support Services (H2015)
- Dyadic Psychoeducational Services (H2027)
- Dyadic Family Training and Counseling for Child Development (T1027)

Dyadic Services for Caregivers

Billing Codes. Providers may also deliver dyadic caregiver services during a well child visit in which the caregiver(s) are present, including:

- Brief emotional/behavioral assessment (96127)
- ACE screening (G9919, G9920)
- SABIRT (G0442, H0049, H0050)
- Depression screening (G8431, G8510)
- Health behavior assessments and interventions (96156, 96167, 96168, 96170 and 96171)
- Psychiatric diagnostic evaluation (90791, 90792)
- Tobacco cessation counseling (99406, 9970)

See the Non-Specialty Mental Health Services Manual for more information on dyadic services **billing codes, modifiers, and screenings**

Vision and Hearing Screening Services

Providers must deliver vision and hearing screening for all children and youth under age 21 per BF/AAP Periodicity Schedule to identify need for glasses, contacts, hearing aids, cochlear implants, or other concerns.

Vision Screening

- **Periodicity Schedule.** Providers must conduct vision screenings at years 3, 4, 5, 6, 8, 10, 12, and 15, with risk assessments conducted at other ages
- **Screening Tools.**
  - Providers may use instrument-based screening to assess risk at ages 12 and 24 months and at well child visits at ages 3 through 5 years
  - Providers may deliver a visual acuity screening starting at ages 4 and 5 years, as well as in cooperative 3-year-olds
- **Billing Codes.** Reimbursement codes include CPT 99173*, 99381 thru 99385 and 99391 thru 99395

*For school-based enrolled Medi-Cal providers only

Hearing Screening

- **Periodicity Schedule.**
  - Providers must confirm the initial newborn screening was completed, verify results, and follow up as appropriate
  - After the newborn screening, providers must conduct hearing screenings at years 4, 8, 10, 13, 16, and 20, with risk assessments conducted at other ages
- **Billing Codes.** Reimbursement codes include CPT 92551 (screening test, pure tone, air only) and 92552 (pure tone audiometry [threshold]; air only) with ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11 available for hearing screenings

Oral Health Screening & Assessment Services

Providers must perform oral health screening and assessment services and ensure children ages 6 years and under are referred to a Medi-Cal Dental provider. Primary care providers have an important role in ensuring oral health care, guidance, and education are provided to children and families.

- **Oral Health Screening Schedule.**
  - Primary care providers must conduct an oral health assessment at minimum at the 6, 9, 12, 18, 24, and 30 month well-child visits, as well as annually starting at age 3 and up *or* sooner at eruption of first tooth, should that occur first
  - On this same schedule, primary care providers must assess whether the child has a dental home. If no dental home is identified, then providers must refer the child to a Medi-Cal dental provider
- **Billing Codes.** Reimbursement codes CPT 99381 – 99383 and 99391 – 99393 for oral health risk assessment
- **Fluoride Varnish.** Once teeth are present, fluoride varnish should be applied to all children every 3 – 6 months through age 5 in the primary care or dental office based on caries risk
  - Reimbursement codes HCPCS D1206 and CPT 99188 for fluoride varnish, up to three times in 12-month period
- **Fluoride Supplementation.** If a child's primary water source does not contain fluoride, primary care providers must consider providing fluoride supplementation to children ages 6 months through 16 years of age

Dental providers are responsible for providing dental care that goes beyond oral health assessments (such as dental cleanings and tooth extractions). Medi-Cal managed care providers are responsible for providing referrals to a dental provider in the child's network, which will either be Dental Fee For Services (in most California counties) or Dental Managed Care (in Sacramento and Los Angeles Counties).

ACEs/Trauma Screening Services

Providers may conduct adverse childhood experiences (ACEs) screenings for all children and youth under age 21. ACEs screenings are not currently included in the BF/AAP Periodicity Schedule but are encouraged through the California Surgeon General's ACEs Aware campaign and are reimbursable.

- **Recommended Schedule.** Providers may conduct ACEs screenings once per year, per child
  - ACEs "scores" are designated as high risk for toxic stress if a child's ACEs score is 4 or greater (HCPCS G9919) or low risk for toxic stress if the ACEs score is between 0 and 3 (HCPCS G9920)
- **Screening Tool.** Providers must use the validated PEARLS screening tool for ages 0 – 19 years for ACEs screening
- **Provider Training.** Providers must complete and attest to having completed the ACEs Aware Training in order to be eligible to receive the incentive payment (see box below)
- **Referrals.** Providers who conduct ACEs screenings must provide children with appropriate referrals when necessary for diagnosis and treatment without delay

Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers *who completed and attested to the ACES Aware training* with a supplemental incentive payment of $29.00 for trauma screenings

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Providers must provide SABIRT screening and services to children ages 11 years and older with a potential substance use disorder (SUD).

- **Screening.**
  - Validated screening tools for children/adolescents: Parents, Partner, Past, and Present (4Ps) and Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
  - **Billing Codes.** Reimbursement codes HCPCS G0442 for alcohol use screening and H0049 for drug use screening
    - If using CRAFFT, which is for alcohol and drug use screening, providers can bill both G0442 and H0049
- **Brief Assessment.** If a screening is positive, then providers should assess whether the disorder is present.
  - Validated assessment tools: Drug Abuse Screening Test (DAST-20) and Alcohol Use Disorders Identification Test (AUDIT)
- **Brief Interventions & Referral to Treatment.** If a brief assessment reveals alcohol or drug misuse, providers can conduct brief interventions, which can include alcohol misuse counseling and discussing and agreeing on plans for follow-up, including referral to other treatment if indicated.
  - **Billing Codes.** Reimbursement code HCPCS H0050 for alcohol and/or drug brief intervention services
- **Provider Type.** SABIRT services are reimbursable to physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists
- **Documentation Requirements.** The provider must include in the child's medical records:
  - The service provided (e.g., screen and brief intervention);
  - The name of the screening and/or assessment tool and scores; and
  - If a referral to an alcohol or SUD program was made

Initial Health Appointment

Previously called the "Initial Health Assessment (IHA)," the Initial Health Appointment (IHA) is a Medi-Cal managed care requirement for adults and children to ensure new members receive a comprehensive assessment by a primary care provider.

- The IHA consists of a history of the member's physical and behavioral health, identification of risks, assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases
- Providers must conduct the IHA within **120 days of a child's enrollment** in a managed care plan (or within the BF/AAP Periodicity Schedule timeline for children ages 18 months or younger, **whichever is sooner**)
  - If the first 120 days of a child's enrollment in a managed care plan falls within the timing of a child's scheduled well-child visit according to the BF/AAP Periodicity Schedule, the child's well-child visit will serve as the IHA
  - IHA cannot be delayed beyond the first 120 days of a child's initial enrollment in order to coincide with a scheduled well-child visit according to the BF/AAP Periodicity Schedule that is later than 120 days from enrollment; an earlier, separate IHA will be indicated in this case
- Each managed care plans' processes and policies are different, but managed care plans should support providers in helping to schedule an appointment to conduct the IHA within the required time period

As Needed Screenings (1 of 2)

While regular (periodic) screenings are required, additional screenings must be done any time when medically necessary to assess diagnoses between regularly scheduled screenings. These as needed screenings are called "interperiodic screenings."

- As needed screenings **may not** be limited in number nor require prior authorization
- Medical necessity of as needed screenings may be determined by the child's physician; dentist; or a health, developmental, or educational professional who comes into contact with the child
- A parent or caregiver can request a child receive an as needed screening outside of the BF/AAP Periodicity Schedule
- As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination); the reason for the as needed screening must be documented in the medical record

As Needed Screenings (2 of 2)

Examples of As Needed Screenings (not limited to):

A child receiving **foster care** receives a medical history and physical examination

A child joining a **sports** team or camp receives a pre-participation medical history and physical examination

A child with a history of **perinatal problems** receives additional screenings

A child enrolling in **school** receives a pre-participation medical history and physical examination

A child with a history of **developmental disability** receives additional screenings

A child or their parent/caregiver or guidance receives additional **anticipatory guidance**

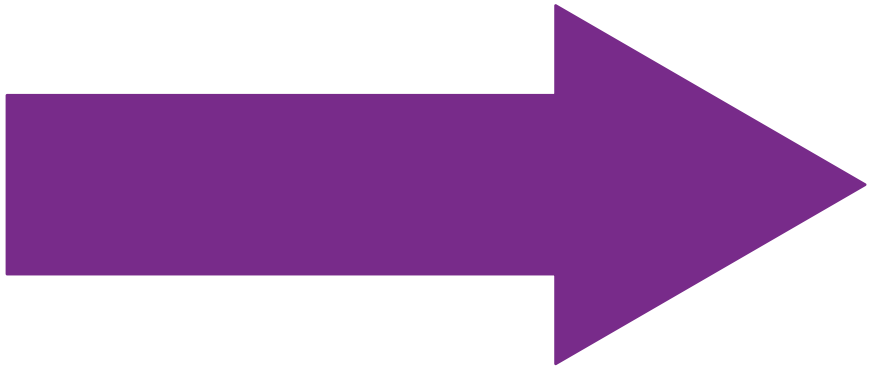
A child entering California as a **refugee** receives a medical history and physical examination

Medi-Cal for Kids & Teens Diagnostic Services

Screening Services

Screenings are designed to identify health and developmental issues as early as possible

When diagnostic and/or treatment services are indicated as a result of a screening, providers must take all reasonable steps, including follow-up, to ensure enrollees receive medically necessary diagnostics and treatment **no later than 60 days after screening**



Diagnostic Services

A child's diagnosis may be provided by a physician or other qualified practitioner

Medical Necessity (1 of 2)

Medi-Cal for Kids & Teens **defines medical necessity as broader for children and youth** enrolled in Medi-Cal compared to adults. If a service is medically necessary and is included within any of the mandatory or optional categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act, then it must be provided to the child, even if the service is not included in the Medi-Cal State Plan.

Under Medi-Cal for Kids & Teens, medical necessity is defined under federal and state requirements as services **correcting or ameliorating conditions, defects, and physical and mental illnesses.**

A service need not cure a condition in order to be covered under Medi-Cal for Kids & Teens. Services that **maintain (by preventing a condition from worsening or preventing additional health problems) or improve a child's condition** are covered because they **"ameliorate"** a condition.

Medical Necessity (2 of 2)

- Medical necessity must be **determined on a case-by-case, individual basis** and **consider all aspects of the child's needs**
- Providers play a significant role in medical necessity determinations, as they are responsible for **justifying why a service is medically necessary for a child** to their contracted managed care plan
- DHCS and its managed care plans **may require prior authorization** in order to safeguard against unnecessary use of services
  - Prior authorization **cannot delay or deny** medically necessary services
  - Limits based on a monetary cap or budgetary constraints **may not be imposed**; for example, if it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week
- California's managed care plans **may not use a definition of medical necessity that is more restrictive** than the federal definition, which is the same definition as in California law

Medical Necessity Review Criteria

What is a medically necessary service per Medi-Cal for Kids & Teens?

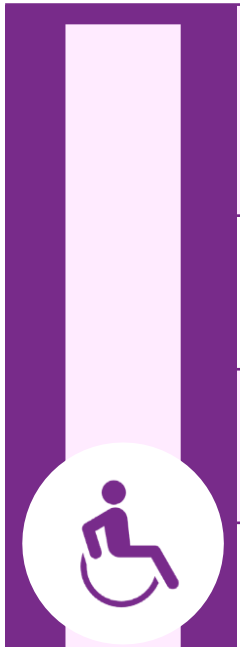
Medically Necessary	Not Medically Necessary
✓ Service is reasonable, appropriate, and effective method to correct, maintain, or ameliorate the child's medical needs ✓ Service is in accordance with current medical standards or practices ✓ Service's scope (e.g., number of hours of skilled nursing care) is sufficient to address the child's needs ✓ Service is necessary to ensure for a safe environment for the child to ameliorate a given condition	✓ Service is experimental or investigational (considered on a case-by-case basis) ✓ Service is primarily for caregiver convenience (e.g., DME duplicated to be provided at divorced parents' homes) ✓ Service is more expensive than an equally effective and less expensive, available service; however, cost is not a basis for determining a service should not be provided

If the service is determined to be medically necessary, the service must be covered if it can be covered under Medicaid, even if it is not in the Medi-Cal State Plan or not provided to adults, or if the child does not have a diagnosis

Second Opinions

- If a provider requests a service for a child that is **denied** by the managed care plan, then the provider can request a **second opinion** from a qualified health professional
- Managed care plans must permit second opinions through their **Utilization Management Program** that ensures appropriate processes are used to review and approve the provision of medically necessary covered services in Medi-Cal Managed Care

Medical Necessity Review Criteria: Occupational Therapy Example

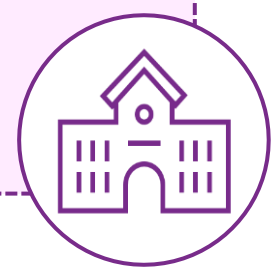


- An 8-year-old enrolled in a Medi-Cal managed care plan receives a periodic developmental screening at their well-child checkup that indicates a developmental delay
- The pediatrician prescribes the child occupational therapy services
- The pediatrician submits a prior authorization request for occupational therapy to the Medi-Cal managed care plan
- The managed care plan conducts medical necessity review and determines the occupational therapy services are **not** medically necessary
- The pediatrician requests a second opinion through the managed care plan's Utilization Management Program with another qualified health professional
- The other qualified health professional agrees with the pediatrician's assessment that the therapy is medically necessary for the child and submits results to the managed care plan
- The managed care plan reviews the second opinion and determines the occupational therapy services are medically necessary
- The pediatrician refers the child to a licensed occupational therapist and provides follow-up care

Settings for Medi-Cal for Kids & Teens Services: School-Based Services

» Medi-Cal-enrolled children and youth under age 21 can receive the following Medi-Cal covered services from schools:

- Nutritional assessments and counseling treatments
- Vision assessments and screenings
- Physical, respiratory, occupational, and speech-language therapy
- Audiology assessment, treatments, and hearing screening tests
- Psychology and counseling services and psychosocial assessments
- Orientation and mobility services
- Developmental assessments
- Specialized medical transportation
- Health education and anticipatory guidance
- School health aide services (administration of specialized physical health care services and assistance with Activities of Daily Living)



Settings for Medi-Cal for Kids & Teens Services: Out-Of-State Services

- DHCS and its managed care plans must cover out-of-state services if the service would be covered in-state, and:
  - Service is required because of an emergency;
  - The child is out of state and the child's health would be endangered if they were required to travel to their home state;
  - Service is more readily available in another state; **or**
  - The child lives in an area that often utilizes services in another state (i.e., if area borders another state)

Settings for Medi-Cal for Kids & Teens Services: Telehealth Modality

- Medi-Cal covered benefits or services may be provided via telehealth if:
  - The treating provider believes the benefits or services are clinically appropriate to deliver via telehealth;
  - Benefits or services meet procedural definition and components of CPT or HCPCS codes and Medi-Cal provider manual guidelines; **and**
  - Benefits or services meet all laws regarding confidentiality and a patient's right to their medical information
- Benefits or services may be delivered via synchronous video, synchronous audio-only, or asynchronous store and forward, so long as those services meet the standard of care and billing code requirements that apply to in-person service. Include the following modifiers when billing for services delivered via telehealth:
  - Synchronous video: 95
  - Synchronous audio-only: 93
  - Asynchronous store and forward: GQ
- Medi-Cal enrolled children or youth may request or decline delivery of services via telehealth modality

Required Services to Support Access (1 of 2)

Necessary Transportation To and From Appointments

- Providers must offer and assist with arranging non-emergency medical transportation (NEMT) and non-medical transportation (NMT) so children/youth under age 21 can receive Medi-Cal for Kids & Teens services
  - **NEMT** is transportation by ambulance, wheelchair van, or litter van for children whose medical and physical condition does not allow them to travel by public or private transportation
    - Providers must submit a Physician Certification Statement (PCS) form to the managed care plan for NEMT prior authorization
  - **NMT** is private or public transportation; families or the child/youth will need to attest to their provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted
    - Providers need to confirm with the managed care plan if prior authorizations are required for NMT services, as it is up to the managed care plan to determine
  - Families or the child/youth may request or refuse transportation assistance at any time

Related Travel Expenses

- California's managed care plans must cover related travel expenses for medically necessary services at the child/youth's request, including the cost of meals and lodging for a child and parent, caretaker, relative, friend, or attendant for the purpose of obtaining needed medical care

Providers can direct families to the **Medi-Cal Member Help Line at 1-800-541-5555 or their Medi-Cal Managed Care Plan** for help accessing transportation and travel supports

Required Services to Support Access (2 of 2)

Language Assistance

- Managed care plans must provide **oral interpretation** for any non-English speaking family or child/youth, free of charge, at all medical encounters (such as an outpatient visit) and certain non-medical encounters (such as scheduling appointments)
- **Sign language interpreter services** must also be provided during all medical and certain non-medical encounters
- Managed care plans must **translate the member handbook and provider directory** into prevalent non-English languages when at least 3,000 or 5% of the managed care plan's members speak a non-English language, whichever is lower
  - The provider directory must include **cultural and linguistic capabilities of each provider**, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, or access to language line interpreters
  - Families, children and youth, and providers can call the **Office of Civil Rights at (916)-440-7370, 711 (California State Relay) or the Medi-Cal Member Help Line at 1-800-541-5555** for assistance accessing language services
- Managed care plans must provide **alternative formats of the member handbook; provider directory; and dental, termination, and appeal notices** such as braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format (e.g., data CD)

Appointment Scheduling Assistance

- Providers must offer and provide, as requested, assistance with scheduling appointments for Medi-Cal for Kids & Teens services

Informing Families of Medi-Cal for Kids & Teens Services

Providers play an important role in communicating about Medi-Cal for Kids & Teens to children and families. A combination of face-to-face, oral, and written communication is recommended. Providers must inform all Medi-Cal eligible families of the services available to them under Medi-Cal for Kids & Teens, including:

- Benefits of preventive health and dental care
- Tips and information for choosing a health or dental care provider
- Nature and scope of Medi-Cal for Kids & Teens medical and dental services
- Appointment scheduling and transportation assistance availability
- Need for prompt diagnosis of suspected defects, illnesses, diseases or other conditions
- Availability of treatment for problems diagnosed during screening
- Referrals to other providers for additional services not offered
- Ability to ask for and receive services, even if the services were initially denied

DHCS and its managed care plans must identify children that are underutilizing Medi-Cal for Kids & Teens screenings and preventive services and ensure outreach to these children

Medi-Cal for Kids & Teens Enrollee Brochures

DHCS has developed brochures for children and families enrolled in Medi-Cal to increase knowledge and awareness of Medi-Cal for Kids & Teens. There are two brochures: (1) children ages 11 and under and (2) children and youth ages 12 through 20).

- Brochures are available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share brochures broadly with families enrolled in Medi-Cal
- Managed care plans will distribute these brochures to families with children on an annual basis

What happens at your child's check-up?

Your child's provider will:

- Do a physical exam
- Ask about your family's health history
- Give recommended shots, when needed
- Talk about dental health and, when needed, give your child fluoride varnish and fluoride supplements, and help in finding a dentist
- Check your child's hearing and vision
- Discuss important health topics such as development, behaviors, your and your child's mental health, nutrition, sleep, safety, and protecting skin from the sun

Your child's provider will check for:

- **Developmental milestones**
- **Lead poisoning**
- **Anemia,** if at risk
- **Autism**
- **Depression screening** in new mothers
- **Anxiety**
- **Tuberculosis (TB),** if at risk
- **Cholesterol,** if at risk
- **Other health issues** or concerns you have

February 2023 for children from birth to age 12

If you have questions or want to learn more

Your Medi-Cal managed care plan
The phone number is on your plan ID card and your plan's website
Or go to www.dhcs.ca.gov/mmchpd

Medi-Cal Member Help Line
Call **1-800-541-5555** (TDD 1-800-430-7077)
Or go to www.dhcs.ca.gov/myMedi-Cal

Medi-Cal Dental
Call Smile, California at **1-800-322-6384** (TTY 1-800-735-2922)
Or go to smilecalifornia.org or www.dhcs.ca.gov/MCP

Specialty Mental Health
Call **1-888-452-8609**
To ask about services for a serious mental health condition, contact your county Mental Health Plan at www.dhcs.ca.gov/CMHP

Alcohol or drug use
Call the Department of Health Care Services (DHCS) Substance Use Resource Center 24/7 at **1-800-879-2772**
Or go to www.dhcs.ca.gov/SUD-NETRL

Crisis support
Call the National Suicide Prevention Line at **988**
Or call **1-833-317-HOPE** (4673)
For live CalHOPE crisis counseling, go to www.calhopeconnect.org

Your rights and responsibilities
Call **1-888-452-8609**

DHCS
www.dhcs.ca.gov/services/pages/EPSDT.aspx

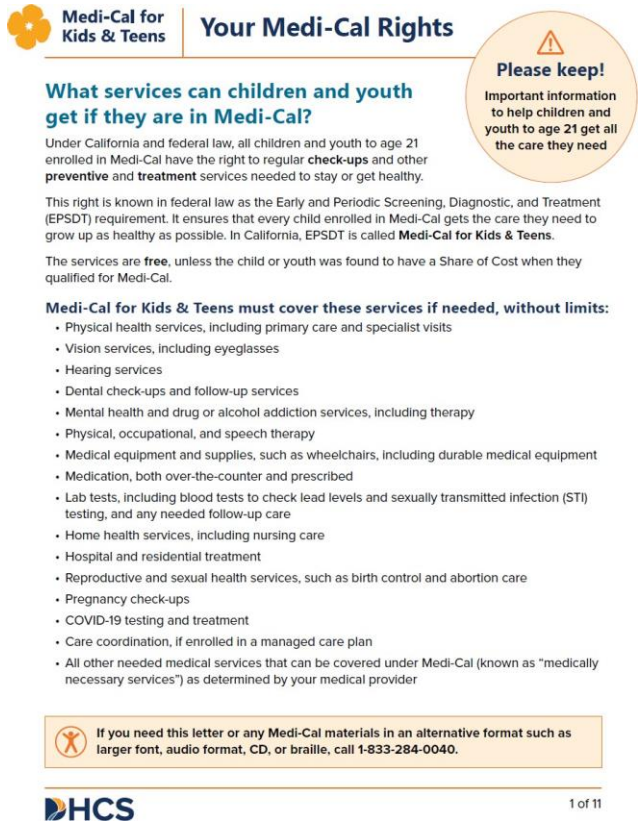
Medi-Cal for Kids & Teens

Preventive and treatment services from birth to age 21

Medi-Cal for Kids & Teens
Your Medi-Cal Rights Letter

DHCS has developed a letter for children and families enrolled in Medi-Cal outlining their rights in accessing Medi-Cal for Kids & Teens, as well as what to do when care is denied, delayed, reduced, or stopped.

- The letter is available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share the letter broadly with families enrolled in Medi-Cal
- Managed care plans will distribute the letter to families with children on an annual basis



Medi-Cal for Kids & Teens | Your Medi-Cal Rights

Please keep!
Important information to help children and youth to age 21 get all the care they need

What services can children and youth get if they are in Medi-Cal?

Under California and federal law, all children and youth to age 21 enrolled in Medi-Cal have the right to regular **check-ups** and other **preventive** and **treatment** services needed to stay or get healthy.

This right is known in federal law as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement. It ensures that every child enrolled in Medi-Cal gets the care they need to grow up as healthy as possible. In California, EPSDT is called **Medi-Cal for Kids & Teens**.

The services are **free**, unless the child or youth was found to have a Share of Cost when they qualified for Medi-Cal.

Medi-Cal for Kids & Teens must cover these services if needed, without limits:

- Physical health services, including primary care and specialist visits
- Vision services, including eyeglasses
- Hearing services
- Dental check-ups and follow-up services
- Mental health and drug or alcohol addiction services, including therapy
- Physical, occupational, and speech therapy
- Medical equipment and supplies, such as wheelchairs, including durable medical equipment
- Medication, both over-the-counter and prescribed
- Lab tests, including blood tests to check lead levels and sexually transmitted infection (STI) testing, and any needed follow-up care
- Home health services, including nursing care
- Hospital and residential treatment
- Reproductive and sexual health services, such as birth control and abortion care
- Pregnancy check-ups
- COVID-19 testing and treatment
- Care coordination, if enrolled in a managed care plan
- All other needed medical services that can be covered under Medi-Cal (known as "medically necessary services") as determined by your medical provider

If you need this letter or any Medi-Cal materials in an alternative format such as larger font, audio format, CD, or braille, call 1-833-284-0040.

DHCS 1 of 11

Test Your Learning

- Can maternal depression screenings be provided during an infant's well-child visit?
- Can providers support children and families in obtaining transportation to a medical appointment?
- A child with a developmental disability needs additional screenings outside of the Medi-Cal for Kids & Teens Periodicity Schedule. Are these additional screenings covered by Medi-Cal?
- If a child breaks their glasses, can they get a new pair?
- If a child needs 10 hours of home health services but their Medi-Cal managed care plan only approved 8 hours, how can the provider get the decision reviewed?
- What age does Medi-Cal for Kids & Teens apply to – up to age 18 or 21?

Medi-Cal for Kids & Teens Training Modules

Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?

Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

In This Module You Will Learn…

- What are Medi-Cal for Kids & Teens covered mental health services and SUD services
- How non-specialty mental health and specialty mental health differ from each other in Medi-Cal
- Which children are eligible for California Children's Services (CCS) or CCS Whole Child Model (WCM) and why
- How children can qualify for Medi-Cal for Kids & Teens covered skilled nursing services

Mental Health Services

Medi-Cal for Kids & Teens covers all medically necessary mental health services for children and youth under age 21 enrolled in Medi-Cal. There are two different systems that the State leverages to deliver mental health services depending on the child and youth's level of need, including:

Non-Specialty Mental Health Services (NSMHS)

- **Managed care plans** are responsible for providing medically necessary NSMHS for children and youth under the age of 21
- NSMHS are **"carved in"** to Medi-Cal Managed Care

Specialty Mental Health Services (SMHS)

- **County mental health plans** are responsible for providing medically necessary SMHS for children and youth under the age of 21
  - If a child/youth meets the criteria for SMHS, then they should be receiving any NSMHS from the mental health plan, except in cases where the No Wrong Door policy applies (see slide 45))
- SMHS are **"carved out"** of Medi-Cal Managed Care

Children and youth under age 21 do **not** require a diagnosis in order to receive mental health services.

Mental Health Services Screening and Transition Tools

- Providers are required to use the **Youth Screening Tool for Medi-Cal Mental Health Services** for children and youth under age 21 who are not currently receiving mental health services and who contact the Medi-Cal managed care plan or county mental health plan seeking mental health services

- Providers are required to use the **Transition of Care Tool for Medi-Cal Mental Health Services** to ensure enrollees who are receiving mental health services from one delivery system receive timely transition of care referrals or services referrals to their managed care plan or county mental health plan

- Both county mental health plan and managed care plan providers will leverage this tool statewide to better identify appropriate behavioral health delivery systems and services that are child and family-centered

No Wrong Door Policy

DHCS implemented a "No Wrong Door" policy in July 2022 to ensure enrollees receive mental health services without delay regardless of where they initially seek care.

Clinically appropriate NSMHS and SMHS are covered and reimbursable even when:

- Services are provided **prior to determination of a diagnosis**, during the assessment period, or **prior to determination of whether NSMHS or SMHS access criteria are met**;
- Services are not included in an **individual treatment plan**; *(currently only applies to NSMHS; guidance forthcoming for SMHS)*
- The child has a **co-occurring mental health condition and SUD**; or
- NSMHS and SMHS services can be **provided concurrently,** if those services are coordinated and not duplicated

Non-Specialty Mental Health Services (NSMHS)

NSMHS (formerly known as Mild to Moderate services) include a variety of behavioral interventions that promote the functioning of children and youth and prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. Managed care plans must provide or arrange all medically necessary NSMHS for children and youth under age 21 regardless of their level of distress or impairment, or the presence of a diagnosis.

- **NSMHS include:**
  - Mental health evaluation and treatment, including individual, group and family psychotherapy
  - Dyadic services for children and their caregiver(s)
  - 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 (not including outpatient pharmacy benefits covered under Medi-Cal Rx), supplies, and dietary supplements (e.g., folic acid, vitamin D, vitamin B12)
- **Provider types include:**
  - Licensed Clinical Social Worker
  - Licensed Professional Clinical Counselor
  - Licensed Marriage and Family Therapist
  - Licensed Psychologist
  - Associate provider types may render services under a supervising clinician
  - Psychiatric Physician Assistant
  - Psychiatric Nurse Practitioner
  - Psychiatrist (as consistent with the practitioner's training and licensing requirements)

For more information, please review the Non-Specialty Mental Health Services: Psychiatric and Psychological Services Provider Manual

County Specialty Mental Health Services

Each county mental health plan must provide or arrange all medically necessary SMHS for children and youth under age 21 enrolled in Medi-Cal who require more intensive mental health services.

County mental health plans must make individualized determinations of each child's need for SMHS. Examples include, but are not limited to:

- Intensive Care Coordination (ICC) (e.g., targeted case management for children in SMHS)
- Intensive Home-Based Services (IHBS) (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community)
- Therapeutic Foster Care (TFC) (e.g., short-term, trauma-informed, intensive SMHS for children with complex emotional and behavioral needs; in TFC, children are placed with trained and intensely supervised TFC parents)
- Therapeutic Behavioral Services (TBS) (e.g., short-term, intensive services for children with a SED)
- Psychiatric Health Facility Services and/or Inpatient Hospital Services (e.g., 24-hour inpatient care)
- Crisis Intervention, Stabilization, and/or Residential Services (e.g., community-based crisis intervention, short-term)
- Day Treatment Intensive and/or Rehabilitation Services (e.g., group therapy, skill building groups, short-term)
- Peer Support Services (optional)
- NSMHS – if a child meets the criteria for SMHS, then they should be receiving any NSMHS from the mental health plan, except in cases where the No Wrong Door policy applies (see slide 45)

SMHS may be provided during an assessment period for the child prior to the determination of a diagnosis or whether SMHS access criteria are met (see next slide for access criteria).

SMHS Access Criteria

Covered SMHS shall be provided to children and youth who **meet either of the following criteria, (1) or (2) below:**

(1) The child is at high risk for a mental health disorder due to experience of trauma (i.e., scores in the high-risk range under a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness) **OR**

(2) The child meets **both of the following** requirements in a) and b), below:

a) The child has at least **one of the following**:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide **AND**

b) The child's condition as described in (2) above is due to **one of the following**:

i. A diagnosed mental health disorder

ii. A suspected mental health disorder that has not yet been diagnosed

iii. Significant trauma placing the child at risk of a future mental health condition, based on the assessment of a licensed mental health professional

For more information, please review BHIN 21-073

Substance Use Disorder Services (1 of 2)

Medi-Cal for Kids & Teens covers all medically necessary substance use disorder (SUD) treatment, such as outpatient care, residential treatment services, and withdrawal management. SUD services are primarily provided through DMC or DMC-ODS programs, depending on the county, and some SUD services are provided by managed care plans.

SUD treatment services are provided to eligible Medi-Cal enrollees, including children and youth under age 21, via county-run **Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)** programs:

- Counties have the option to participate in the DMC-ODS program and provide an expanded array of SUD treatment services to Medi-Cal enrollees
- All counties, regardless of their participation in DMC-ODS, are required to provide all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Medi-Cal for Kids & Teens

Substance Use Disorder Services (2 of 2)

Though most SUD services are provided via DMC or DMC-ODS for children and youth, managed care plan providers must provide:

- SABIRT screening (see slide 22) to children starting at age 11 who are at risk of developing a SUD
- Early intervention SUD services for children and youth determined to be at risk of SUD (e.g., any service component covered under the outpatient level of care)
- Medications for Addiction Treatment (MAT) available in primary care, inpatient hospital, and emergency departments
- Emergency services to stabilize the child (including voluntary inpatient detoxification)

Some children may qualify for both SMHS and SUD services if they have a co-occurring SUD and mental health condition. **Providers are required to coordinate and collaborate across delivery systems** to ensure clinical integration between county mental health plans, DMC or DMC-ODS counties, and managed care plans, and to ensure non-duplicative services

Mobile Crisis Services

Medi-Cal for Kids & Teens covers qualifying mobile crisis services, including an initial face-to-face crisis assessment, crisis response and stabilization, crisis planning, referrals to ongoing services and supports, and follow-up. Mobile crisis services offer community-based interventions to individuals experiencing a mental health or substance use crisis and are available to Medi-Cal enrollees 24 hours a day, 365 days a year.

- Crisis intervention and habilitation services, including when delivered in a mobile modality, are always covered for children and youth under age 21
- Mobile crisis services can provide relief to youth experiencing a behavioral health crisis; reduce the risk or danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement
- In January 2023, counties began implementing the qualifying mobile crisis services benefit in the SMHS and DMC or DMC-ODS delivery systems
  - Counties will develop a standardized screening tool to determine when mobile crisis teams should be dispatched and other policies and procedures to ensure mobile crisis services are delivered effectively to children and youth
  - The qualifying mobile crisis services benefit will be available statewide in SMHS and DMC or DMC-ODS delivery systems by December 31, 2023

Psychiatric Collaborative Care Management Services

- **Overview.** Providers can bill for **psychiatric collaborative care management services** when they reach out to a psychiatric or addiction medicine consultant to help treat a child's mental health and/or SUD
- **Consent.** The child and their parent or caregiver must give permission to consult with relevant specialist; consent can be verbal and must be documented in medical record
  - Starting at age 12 and older, a child may, without parental consent, receive services related to drug and alcohol abuse treatment/counseling and mental health outpatient care
- **Billing Codes & Services.** Reimbursable CPT codes include 99492 (70 minutes in first month), 99493 (60 minutes in subsequent month), and 99494 (additional 30 minutes) for the following services in collaboration with a consulting provider:
  - Outreach and engagement in treatment with another qualified health care professional
  - Initial assessment of the child with a validated rating scale and development of a treatment plan
  - Review and modifications of the plan with the consulting provider
  - Tracking patient follow-up and entering info in a registry
  - Participating in weekly caseload consultation with consulting provider
  - Providing brief interventions

99492 and 99493 can be billed once per month, but not in the same month. 99494 can be billed twice per month

For additional information, see the Evaluation & Management Provider Manual re: Psychiatric Collaborative Care Management Services

For information on how FQHCs can bill for this benefit, see the FQHC Provider Manual

County SMHS: Intensive Home-Based Services (IHBS) Example

- A ten-year-old child enrolled in Medi-Cal managed care has been experiencing issues with self-regulation and behavioral outbursts in school
- The child's pediatrician screens the child using the standardized screening tool and determines the child would benefit from SMHS
- The child's pediatrician refers the child to the county mental health plan

- A pediatric psychologist paneled at the county mental health plan conducts an additional assessment and determines that IHBS supports (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community) would be appropriate to effectively serve the child's intensive behavioral needs and engage the child's caregivers to support building functional skills

- The psychologist submits the IHBS mental health documentation requirements prescribed by the county mental health plan, consistent with the mental health plan's process for authorizing IHBS

- The county mental health plan agrees with the psychologist in determining that the IHBS services are medically necessary based on the child's strengths and needs

- The county mental health plan delivers IHBS to the child in their home and community setting

California Children's Services (CCS) Requirements for Primary Care Providers (1 of 2)

CCS is an important component of the Medi-Cal system of care available to qualifying children and youth under age 21 with certain diseases or health problems.

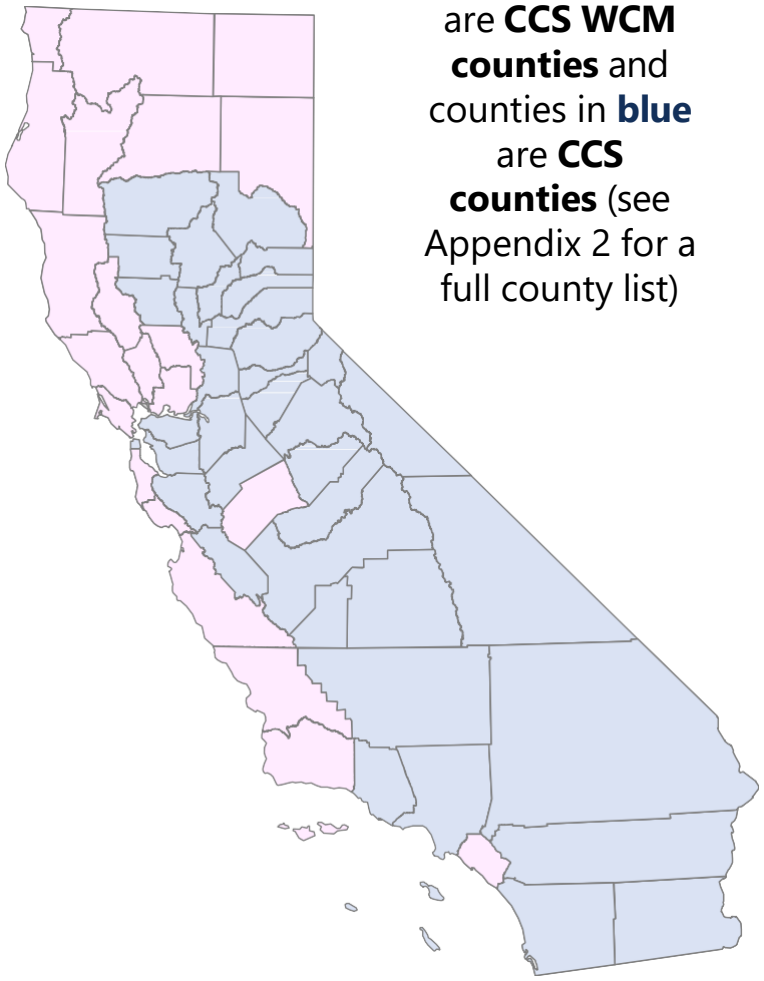
- The CCS Program, which is administered as a partnership between county health departments and DHCS, provides diagnostic and treatment services, medical case management, and physical and occupational therapy services
- Care for children enrolled in CCS is provided by CCS-paneled providers, CCS-approved special care centers (SCCs), and approved pediatric acute care hospitals
- The CCS Medical Therapy Program (MTP) provides direct physical and occupational therapy services for a subset of CCS-eligible children with physical disabilities
- Note: A child can be eligible for CCS services regardless of whether they are eligible for Medi-Cal or enrolled in a Medi-Cal managed care plan

Examples of CCS-eligible conditions include, but are not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, lead poisoning, and traumatic injuries.

California Children's Services (CCS) Requirements for Primary Care Providers (2 of 2)

- Anyone can make a referral to the CCS Program, if they suspect that a child is eligible for CCS. Primary care providers or specialists must provide a baseline health assessment and diagnostic evaluation with sufficient clinical to establish – or raise a reasonable suspicion – that a child has a CCS-eligible medical condition.
  - Children with CCS-eligible conditions must be referred to the local CCS Program on the same day after the condition is identified
  - Referrals can be made via phone, secure email, mail, or fax, and include supporting medical documentation sufficient to allow for a medical eligibility determination
  - Access here for the list of phone and fax numbers for each local CCS Program
- Providers must continue to provide all covered services until the CCS Program eligibility is determined, and the managed care plan must reimburse the provider for those services.

Classic CCS Counties & CCS WCM Counties



- California's 58 counties provide CCS through two different models:
  - In Classic CSS counties, the treatment for the CCS qualifying condition, including medical case management, is provided directly through the CCS county office
  - In CCS Whole Child Model (WCM) counties, the treatment for the CCS qualifying condition, including medical case management, is "carved in" to the managed care plan's responsibility
- The eligibility criteria for CCS are the same in both Classic CCS and CCS WCM counties
- If the local CCS Program or DHCS finds that the child's condition is not medically eligible, then the managed care plan in both Classic CCS and CCS WCM counties remains responsible for providing and reimbursing for the cost of services if determined to be medically necessary
- Local CCS county offices or DHCS determine if a child is eligible for CCS in both Classic CCS and CCS WCM counties
  - Counties with populations greater than 200,000 – known as **independent counties** – have county staff perform medical eligibility determinations
  - Counties with populations less than 200,00 may choose to be independent counties or **dependent counties;** DHCS is responsible for determining medical eligibility for dependent counties

Medi-Cal for Kids & Teens Skilled Nursing Services (1 of 2)

Skilled nursing services are critical for children and youth with serious physical health conditions, many of whom often qualify for CCS.

» Children and youth under age 21 may be eligible for Medi-Cal for Kids & Teens Skilled Nursing Services, including:

- **Private Duty Nursing (PDN)** is skilled nursing services provided by a licensed nurse (RN or LVN) on a shift basis at a child's home for children who require more individualized and continuous care than what would be provided by a visiting nurse; otherwise known as 'shift' nursing
- **Pediatric Day Health Care (PDHC)** is skilled nursing services provided as day programs at PDHC facilities of less than 24 hours, including (but not limited to) comprehensive case management; nutrition and nursing services; developmental and educational services; and physical, occupational, speech therapy

*Limits based on a monetary cap or budgetary constraint may **not** be imposed; for example, if a provider determines it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week*

Medi-Cal for Kids & Teens
Skilled Nursing Services (2 of 2)

Providers must refer a child for skilled nursing services if they determine the services are medically necessary for the child. Service authorization for PDN and PDHC include:

CCS–Eligible Members	CCS WCM–Eligible Members	Non-CCS-Eligible Members
» Providers must fax or secure email a service authorization request (SAR) to the child's local CCS County office or upload the SAR into the Provider Electronic Data Interchange (PEDI) for the local CCS county office or DHCS to adjudicate the PDN or PDHC service request » Providers must submit with the SAR a Plan of Treatment (POT) signed by a CCS paneled physician and supporting clinical documentation such as medical records and discharge summary notes	» Providers must submit a prior authorization request to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization	» Providers must submit prior authorization requests to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization

Medical Necessity Review Criteria: Private Duty Nursing Example

- An infant with chronic lung disease has a tracheostomy and ventilator and requires PDN services
- The infant is enrolled in the CCS Program and enrolled in a managed care plan in a Classic CCS County

- The CCS-paneled provider submits a SAR requesting RN-level PDN services to be performed in the child's home; attachments include the POT signed by the CCS paneled physician and supporting clinical documentation

- The CCS Program adjudicator determines that the services requested relate to the CCS-eligible condition and they conduct a medical-necessity review and determine that the services are within the scope of an LVN

- The CCS Program adjudicator modifies the SAR to reflect the appropriate provider type to render the PDN services and approves the PDN services and units

Test Your Learning

- Do children without diagnosed mental health conditions qualify for mental health services provided by managed care plans and/or mental health plans?
- Can a child receive services from a managed care plan, county mental health plan, and Drug Medi-Cal (DMC)/Drug-Medical Organized Delivery System (DMC-ODS) county at the same time?
- If you believe a child would benefit from family therapy or other supports, are those services available under Medi-Cal for Kids & Teens?
- How does a child enrolled in Medi-Cal managed care and *not* eligible for CCS receive skilled nursing services?

Questions?

Appendix

Billing Codes

Service Category	Billing Codes
Blood lead screening	CPT 36415, 36416, 83655, 99401, 99402, 99403, 99404
Developmental screening	CPT 96110
ASD screening	CPT 96110 and modifier KX
Depression screening	HCPCS G8431 and G8510
Postpartum depression screening	HCPCS G8431 and G8510
Vision screening	CPT 99173*, 99381-99385 and 99391-99395 **For school-based enrolled Medi-Cal providers only*
Hearing screening	CPT 92551 and 92552; ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11
Oral health screening	CPT 99188, 99381 – 99383, 99391 – 99393; HCPCS D1206
ACEs/trauma screening	HCPCS G9919, G9920
Dyadic services	HCPCS H1011, H2015, H2027, T1027
As needed screenings	As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination)

Classic CCS Counties & CCS WCM Counties (2 of 2)

KEY

- CCS WCM counties
- CCS counties

Sources

Module 1 Sources (1 of 3)

- Slide 4: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services
  - CMS Child Core Set Measures FY 2021
  - California State Audit 2019
- Slide 5: Goals of Medi-Cal for Kids & Teens Provider Training
  - Medi-Cal Managed Care Boilerplate Contract
- Slide 8: What is Medi-Cal for Kids & Teens?
  - Social Security Act § 1905(r)
  - 42 CFR § 441.50-441.62
  - EPSDT- A Guide for States
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - State Medicaid Manual - Chapter 5: EPSDT
- Slide 9: Medi-Cal for Kids & Teens Services Are Free for Most Children Under Age 21
  - SB 75: Full Scope Medi-Cal Coverage for All Children FAQs
  - Medi-Cal Preventive Services Provider Manual
- Slide 11: Medi-Cal for Kids & Teens Periodic Screenings
  - Social Security Act § 1905(r)
  - 42 CFR § 441.56
  - CMCS Informational Bulletin: Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children's Health Insurance Program
  - EPSDT- A Guide for States
  - APL 19-010
  - State Medicaid Manual - Chapter 5: EPSDT
- Slide 13: Blood Lead Screening Services (1 of 2)
  - CDC Recommendations for Post-Arrival Lead Screening of Refugees
  - APL 20-016
- Slide 13 (cont.): Blood Lead Screening Services (1 of 2)
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
- Slide 14: Blood Lead Screening Services (2 of 2)
  - CDC Recommendations for Post-Arrival Lead Screening of Refugees
  - APL 20-016
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
- Slide 15: Developmental Screening Services
  - EPSDT- A Guide for States
  - APL 18-009
  - APL 19-010
  - APL 19-014
  - SPA 21-0045 (pending)
  - Public Notice for SPA 21-0045
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
  - Medi-Cal Preventive Services Provider Manual
- Slide 16: Autism Spectrum Disorder Screening Services
  - APL 18-009
  - APL 19-014
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal Preventive Services Provider Manual
  - DHCS BHT Webpage
- Slide 17: Depression Screening Services
  - Medi-Cal Evaluation & Management Provider Manual

Module 1 Sources (2 of 3)

- Slide 17 (cont.): Depression Screening Services
  - Medi-Cal Preventive Services Provider Manual
- Slide 18: Dyadic Services
  - APL 22-029
  - Medi-Cal Non-Specialty Mental Health Services: Psychiatric and Psychological Services Provider Manual
  - Medi-Cal's Strategy to Support Health and Opportunity for Children and Families
- Slide 19: Vision and Hearing Screening Services
  - EPSDT- A Guide for States
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
  - Medi-Cal Preventive Services Provider Manual
  - California EPSDT Periodicity Schedule
- Slide 20: Oral Health Screening & Assessment Services
  - APL 15-012
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
  - Medi-Cal Preventive Services Provider Manual
  - Medi-Cal Dental Benefits Provider Manual
  - Medi-Cal Dental Member Handbook
  - Medi-Cal Dental Program
  - California EPSDT Dental Periodicity Schedule
- Slide 21: ACEs/Trauma Screening Services
  - APL 19-018
  - SPA 21-0045 (pending)
- Slide 21 (cont.): ACEs/Trauma Screening Services
  - Public Notice for SPA 21-0045
  - OSG ACEs Aware Webpage
  - Trauma Screenings and Trauma-Informed Care Provider Trainings
- Slide 22: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
  - APL 21-014
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal Evaluation & Management Provider Manual
- Slide 23: Initial Health Appointment
  - Medi-Cal Managed Care Boilerplate Contract
  - Population Health Management Program Guide
- Slide 24: As Needed Screenings (1 of 2)
  - EPSDT- A Guide for States
  - State Medicaid Manual - Chapter 5: EPSDT
- Slide 25: As Needed Screenings (2 of 2)
  - Medi-Cal Preventive Services Provider Manual
- Slide 26: Medi-Cal for Kids & Teens Diagnostic Services
  - 42 CFR § 441.56
  - EPSDT- A Guide for States
  - APL 19-010
  - Medi-Cal Preventive Services Provider Manual
- Slide 27: Medical Necessity (1 of 2)
  - Social Security Act §1905(a)
  - Social Security Act § 1905(r)
  - EPSDT- A Guide for States
  - APL 19-010

Module 1 Sources (3 of 3)

- Slide 28: Medical Necessity (2 of 2)
  - Social Security Act § 1905(a)
  - Social Security Act § 1905(r)
  - EPSDT- A Guide for States
  - APL 19-010
- Slide 29: Medical Necessity Review Criteria
  - Social Security Act § 1905(r)
  - EPSDT- A Guide for States
- Slide 30: Second Opinions
  - Medi-Cal Managed Care Boilerplate Contract
- Slide 31: Medical Necessity Review Criteria: Occupational Therapy Example
  - Medi-Cal Occupational Therapy Manual
- Slide 32: Settings for Medi-Cal for Kids & Teens Services: School-Based Services
  - EPSDT- A Guide for States
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - LEA BOP Provider Manual
- Slide 33: Setting for Medi-Cal for Kids & Teens Services: Out-Of-State Services
  - EPSDT- A Guide for States
  - APL 19-010
  - SPA 21-0045 (pending)
  - Medi-Cal Managed Care Boilerplate Contract
- Slide 34: Settings for Medi-Cal for Kids & Teens Services: Telehealth Modality
  - EPSDT- A Guide for States
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal Telehealth Provider Manual
- Slide 34 (cont.): Settings for Medi-Cal for Kids & Teens Services: Telehealth Modality
  - DHCS Telehealth Policy
- Slide 35: Required Services to Support Access (1 of 2)
  - 42 CFR § 441.62
  - EPSDT- A Guide for States
  - APL 22-008
  - Medi-Cal Managed Care Boilerplate Contract
  - State Medicaid Manual - Chapter 5: EPSDT
- Slide 36: Required Services to Support Access (2 of 2)
  - EPSDT- A Guide for States
  - APL 21-004
  - APL 22-002
  - Medi-Cal Managed Care Boilerplate Contract
- Slide 37: Informing Families of Medi-Cal for Kids & Teens Services
  - 42 CFR § 441.56(a)(4)
  - APL 19-010
  - Medi-Cal EPSDT Provider Manual

Module 2 Sources (1 of 2)

- Slide 43: Mental Health Services
  - APL 19-014
  - DHCS Mental Health Services Page
- Slide 44: Mental Health Services Screening and Transition Tools
  - APL 19-014
  - APL 22-028
  - DHCS Mental Health Services Page
- Slide 45: No Wrong Door Policy
  - APL 22-005
  - BHIN 22-011
  - No Wrong Door for Mental Health Services Policy DHCS Presentation
- Slide 46: Non-Specialty Mental Health Services (NSMHS)
  - BHIN 22-011
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal Non-Specialty Mental Health Services
  - Psychiatric and Psychological Services Provider Manual
- Slide 47: County Specialty Mental Health Services
  - BHIN: 21-058
  - Medi-Cal Manual for ICC, IHBS, TFC
  - DHCS Mental Health Services Webpage
- Slide 48: SMHS Access Criteria
  - BHIN 21-073
- Slide 49: Substance Use Disorder Services (1 of 2)
  - Social Security Act § 1905(a)
  - Title 22, CCR, Section 51341.1. (d)(1-6)
  - APL 21-014
  - BHIN 22-003
- Slide 49 (cont.): Substance Use Disorder Services (1 of 2)
  - DMC-ODS County Contracts
  - DMC State Plan Contract
- Slide 50: Substance Use Disorder Services (2 of 2)
  - Social Security Act § 1905(a)
  - Title 22, CCR, Section 51341.1. (d)(1-6)
  - APL 21-014
  - BHIN 22-003
  - DMC-ODS County Contracts
  - DMC State Plan Contract
- Slide 51: Mobile Crisis Services
  - BHIN 21-073
  - BHIN 22-064
  - DHCS Mobile Crisis Services Webpage
- Slide 52: Psychiatric Collaborative Care Management Services
  - California Family Code FAM 6929(b)
  - Medi-Cal Eligibility Division Information Letter: 21-09
  - Medi-Cal Evaluation & Management Provider Manual
- Slide 53: County SMHS: Intensive Home-Based Services (IHBS) Example
  - Medi-Cal Evaluation & Management Provider Manual
- Slide 53: County SMHS: Intensive Home-Based Services (IHBS) Example
  - BHIN: 21-058
  - Medi-Cal Evaluation & Management Provider Manual
  - Medi-Cal Manual for ICC, IHBS, TFC
  - DHCS Mental Health Services Webpage

Module 2 Sources (2 of 2)

- Slide 54: CCS Requirements for Primary Care Providers (1 of 2)
  - APL 19-010
  - DHCS CCS Program Overview
- Slide 55: CCS Requirements for Primary Care Providers (2 of 2)
  - APL 19-010
  - DHCS CCS Program Overview
- Slide 56: Classic CCS Counties & CCS WCM Counties
  - APL 19-010
  - APL 21-005
  - DHCS CCS Program Overview
  - DHCS CCS WCM Program Overview
  - DHCS WCM FAQs
- Slide 57: Medi-Cal for Kids & Teens Skilled Nursing Services (1 of 2)
  - APL 19-010
  - APL 20-012
  - Medi-Cal EPDST Provider Manual
  - Medi-Cal EPSDT Skilled Nursing Services
  - Medi-Cal PDHC EPDST Manual
  - EPSDT- Private Duty Nursing Services
  - Changes in the Authorization Process for PDN
- Slide 58: Medi-Cal for Kids & Teens Skilled Nursing Services (2 of 2)
  - APL 19-010
  - Medi-Cal EPDST Provider Manual EPSDT
  - Medi-Cal EPSDT Skilled Nursing Services
  - EPSDT- Private Duty Nursing Services
  - Medi-Cal PDHC EPDST Manual
  - Changes in the Authorization Process for PDN
- Slide 59: Medical Necessity Review Criteria: Private Duty Nursing Example
  - APL 19-010
  - Medi-Cal Managed Care Boilerplate Contract
  - Medi-Cal EPSDT Provider Manual
  - Medi-Cal PDHC EPDST Manual
  - Medi-Cal EPSDT Skilled Nursing Services
  - Medi-Cal EPSDT Private Duty Nursing Services
  - Changes in the Authorization Process for PDN

Contact Information

Here is important contact information for HPSM providers:

- **General email: PSInquiries@hpsm.org**
- **General phone number: 650-616-2106**
- **Contracting: HPSMcontracting@hpsm.org**
- **Credentialing: HPSMcredentialing@hpsm.org**

Ensuring Compliance and Effective Collaboration Among Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Managed Care Plan (HPSM) MOU Training

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Collaboration Statement

This training represents a collaborative effort between our two organizations, BHRS and HPSM, combining expertise and shared commitment to advancing quality in behavioral health care.

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Overview

- Introduction to the MOU
- MOU Requirements
- Accessing Treatment and Services
- Policies and Resources

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Definitions

HPSM: Health Plan of San Mateo
BHRS: Behavioral Health and Recovery Services
MOU: Memorandum of Understanding - An MOU is a binding, contractual agreement between Health Plan of San Mateo (HPSM) and a Third-Party Entity which outlines the responsibilities and obligations of HPSM and the Third-Party Entity to coordinate and facilitate whole-system, person-centered care for members.
MCP: Managed Care Plan
MHP: Mental Health Plan
SMHS: Specialty Mental Health Services - a program that provides mental health services to California residents who are eligible for Medi-Cal
NSMHS: Non- Specialty Mental Health Services - a set of mental health services for people with mild to moderate mental health conditions
DMC-ODS: Drug Medi-Cal Organized Delivery System - a program for the organized delivery of substance use disorder (SUD) treatment services to eligible Medi-Cal members with SUDs by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services.
SUD: Substance Use Disorder

This Presentation does not apply to Kaiser Medi-Cal members, please do not direct Kaiser Medi-Cal Members to HPSM.

Introduction to the MOU

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What is an MOU?

What is an MOU?

- An MOU is a binding, contractual agreement between two parties which outlines the responsibilities and obligations of parties to coordinate and facilitate whole-system, person-centered care for members.

Why is it important?

- Clarifies roles and responsibilities between HPSM and BHRS systems of care
- Facilitates care coordination and the exchange of information necessary to enable care coordination
- Improves referral processes between HPSM and BHRS
- Improves transparency and accountability

Who Needs to Know About This?

All those who carry out activities have responsibilities under this MOU. This includes:

- Health Plan of San Mateo (HPSM) Managed Care Plan (MCP) staff
- San Mateo County Behavioral Health and Recovery Services (BHRS) Specialty Mental Health Services (SMHS) staff
- San Mateo County BHRS Drug Medi-Cal Organized Delivery System (DMC-ODS) staff
- Network Providers, Subcontractors, and Downstream Subcontractors who assist with carrying out responsibilities under the MOUs, as applicable.

MOU's Between HPSM and BHRS

HPSM and BHRS have established **two** Memoranda of Understanding (MOU). These two MOUs are in effect as of **November 1, 2024,** automatically renewing annually thereafter or as amended in accordance with Section 14.f of the MOU.

Mental Health Plan (MHP) – Managed Care Plan (MCP) MOU
Governs coordination between HPSM and BHRS MHP for:

- **Mental Health Services**
  - **Non-Specialty Mental Health Services (NSMHS)** covered by HPSM; may at times be referred to as Mild to Moderate Services
  - **Specialty Mental Health Services (SMHS)** covered by BHRS; for members with serious mental illnesses, include outpatient and inpatient services.

Drug Medi-Cal-Organized Delivery System (DMC-ODS) – Managed Care Plan MOU
Governs coordination between HPSM and BHRS DMC-ODS for:

- Substance Use Disorder (SUD) Services**,** also known as **DMC ODS Services** are covered by BHRS for Medi-Cal members with substance use disorders.

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MOU Requirements

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Training and Education

HPSM and BHRS will provide training and orientation for their staff who carry out activities under the MOU to ensure all staff involved in the MOU have a thorough understanding of their responsibilities.

Training Content:

- MOU Requirements
- What services are provided or arranged for by each Party
- How HPSM covered services, DMC-ODS and MHP covered services, may be accessed, including during non-business hours.
- Policies and Procedures outlined in the MOU

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Obligations and Oversight Responsibility

HPSM is responsible for authorizing medically necessary covered services, including NSMHS, and coordinating member care provided by HPSM's network providers and other providers of carve-out programs, services, and benefits.

BHRS MHP and **BHRS DMC-ODS** are responsible for providing or arranging for the provision of SMHS and covered SUD services.

Liaisons from HPSM and BHRS are responsible to ensure:

- Quarterly Meetings
- Reporting to Compliance Officer no less than quarterly
- That there are sufficient staff to support this MOU
- That the appropriate level of leadership are involved in implementation and oversight of the MOU
- Training and education regarding MOU provisions are conducted annually for employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers
- MOU compliance requirements are met, as determined by policies and procedures established by MHP and DMC-ODS, and reporting to the MHP and DMC-ODS Responsible Person.

Screening, Assessment, and Referrals

HPSM and BHRS are responsible for developing shared policy and process to use the required DHCS screening tools:

Screening and Assessment Tools

- Adult Screening Tool for adults aged 21 and older
- Youth Screening Tool for youth under age 21
- Transition Care tool to facilitate transitions of care for members when their service needs change and for adults aged 21 and older and youth under age 21*
- American Society of Addition Medicine (ASAM) Level 0.5 Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral Treatment (SABIRT)

Referrals

HPSM and BHRS work collaboratively to develop and establish policies and procedures that ensure that members are referred to the appropriate MHP and DMC-ODS services.

- "No Wrong Door" Referral Process
- Patient-centered , shared decision-making process
- Closed Loop Referrals for non-specialty mental health services
- HPSM and BHRS have developed policies and procedures that address how members must be screened and assessed for mental health services.

***Ongoing collaboration is occurring to develop and improve processes and procedures for this item.*

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Care Coordination and Collaboration

HPSM and BHRS are responsible to ensure they have comprehensive policies and procedures that guide care coordination efforts across all aspects of member care.

Care Coordination

- **Transitional Care** – Facilitating smooth transitions between care settings.
- **Clinical Consultation** – Enabling effective communication and information sharing between medical and mental health providers.
- **Enhanced Care Management** – Prioritizing and coordinating care management services for high-need populations.
- **Community Supports** – Coordinating with community-based providers to ensure comprehensive support for members.
- **Eating Disorder Services** – BHRS MHP provides medically necessary psychiatric inpatient hospitalization and outpatient SMHS. HPSM provides or arranges for NSMHS for member requiring eating disorder services.
- **Prescription Drugs** – Coordinating and streamlining prescription drug, laboratory, radiological, and radioisotope service procedures

***Ongoing efforts are focused on further developing and improving processes and procedures.*

Quarterly Meetings

HPSM and BHRS meet quarterly to ensure proper oversight of the MOUs. These meetings are crucial for ongoing communication, collaboration, and effective implementation of the MOUs.

Quarterly Meeting Focus

- Care Coordination
- Quality Improvement (QI) activities
- QI Outcomes
- Systemic and case specific concerns
- Communication within organizations

Quarterly Meeting Participation

- Responsible Persons and appropriate program executives from HPSM and BHRS

Quarterly Meeting Transparency

- Posting meeting dates and times
- Distributing summaries of follow-up actions and process changes

Quarterly Meeting schedule is available here:

HPSM: https://www.hpsm.org/about-us/community-impact/county-agencies

BHRS: Behavioral Health Staff: Forms & Policies - San Mateo County Health

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Quality Improvement and Data Sharing and Confidentiality

Quality Improvement

HPSM and BHRS will develop and implement QI activities to oversee the requirements of the MOU

QI Activities:

- Preventing duplication of services
- Tracking referrals, member engagement, and service utilization
- Monitoring member access to mental health services across different care settings

Data Sharing and Confidentiality

HPSM and BHRS will establish and implement policies and procedures for the secure and timely exchange of the minimum necessary member information.

HPSM and BHRS will share protected Health information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Cal. Code Regs. tit. 9, Section 1810.370(a)(3), and to the fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA") and 42 Code Federal Regulations Part 2, and other State and federal privacy laws.

Dispute Resolution

HPSM and BHRS has a dispute resolution process to address any disagreement regarding service coverage responsibilities arising from or related to the MOU.

- ❑ **Good Faith Efforts**: HPSM and BHRS will attempt to resolve disputes amicably through mutual negotiation and communication.
- ❑ **Documented Procedures**: Agreed-upon dispute resolution procedures is documented in polices and procedures
- ❑ **Continued Service Delivery**: Ensure timely and uninterrupted service delivery to members.
- ❑ **Escalation**: If a resolution cannot be reached within 15 working days, HPSM or BHRS may pursue legal or equitable measures under California law.

Specific Responsibilities During Disputes

SMH –MCP Service Disputes	SUD –MCP Service Disputes
Scenario 1: If HPSM contends that BHRS SMH should provide SMHS services because the member's condition may not respond to physical health care and BHRS SMH disagrees with the diagnosis and coverage. HPSM manages member's care and BHRS SMH provides a qualified mental health professional for consultation to HPSM provider responsible for member's care.	Scenario 1: If HPSM contends BHRS DMC-ODS should provide SUD services and BHRS DMC-ODS incorrect determined the diagnosis is not covered. HPSM manages the member's care and is responsible for providing, arranging, and paying for necessary SUD services.
Scenario 2: If BHRS SMH contends HPSM should provide physical health care, medications, or diagnostic services related to a mental health condition. BHRS SMH is responsible for providing, arranging, and paying for these services.	Scenario 2: If BHRS DMC-ODS contends HPSM should provide physical health care, medications, or diagnostic services related to a mental health condition. BHRS DMC-ODS is responsible for providing, arranging, and paying for these services.

Equal Treatment

No Discrimination

- The MOU does not prioritize members over non-members service by BHRS SMHS, BHRS DMC-ODS, or HPSM MCP.
- HPSM and BHRS may not provide any service, financial aid, or other benefit differently to any individual based on race, color, national origin, religion, sex, disability, or other protected characteristics.

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General MOU Requirements

MOU Posting

- The SMHS and DMC-ODS MOUs are posted on the HPSM and BHRS websites.

  -HPSM website: https://www.hpsm.org/about-us/community-impact/county-agencies

  -BHRS website: https://www.smchealth.org/bhrs

Annual Review

- HPSM and BHRS conduct an annual review of the HPSM - BHRS SMHS and HPSM -DMC-ODS MOUs to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations area required.

Governance

- HPSM MCP MOUs for SMHS and DMC-ODS MOUs are governed by and construed in accordance with the laws of the state of California.

Accessing Treatment and Services

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Accessing Mental Health Services

Members can call their primary care provider (PCP) to check-in

Members can call BHRS ACCESS Call Center at 1-800-686-0101 anytime, 24 hours a day, 7 days a week.

- For mild to moderate mental health issues, Members will be connected with a mental health provider through HPSM. This is known as the ***non-specialty mental health provider network***.
- For more serious mental health issues, Members will be connected with a mental health provider through BHRS. This is also known as the ***specialty mental health provider network***.
- For alcohol and/or substance use treatment needs, Members will be connected through ***BHRS's substance use treatment network***.

If an HPSM Member is having a mental health crisis, and they need support beyond what you can provide, please advise them to call the 988 Lifeline.

To learn more about accessing mental health services, please visit HPSM's website at https://www.hpsm.org/member/health-tips/mental-health/get-mental-health-care

Medi-Cal NSMH Services (HPSM)

Non-Specialty Mental Health Benefit (HPSM Medi-Cal Member Handbook)*

- Individual mental health evaluation
- Individual, Family and group treatment (psychotherapy) Outpatient therapy
- Psychological and Neuro testing when clinically indicated to evaluate a mental health condition (requires provider referral)
- Outpatient services for the purposes of monitoring medication therapy (Network is mostly Psychiatric NP's)

* Providers should look to their NSMH contract with HPSM to see what services they are contracted to provide

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Medi-Cal Specialty Mental Health Services (BHRS SMHS)

For Medi-Cal beneficiaries who meet medical necessity criteria, they may qualify for some of these specialty mental health services. *

- Mental health services (assessment, plan development, therapy, rehabilitation, and collateral)
- Medication support services
- Day treatment intensive services, Day Rehabilitation services
- Crisis intervention services, Crisis stabilization services
- Targeted Case management services
- Therapeutic Behavioral services
- Intensive Care coordination
- Intensive home-based services,
- Therapeutic foster care
- Psychiatric Inpatient hospitalizations

* Providers should look to their SMH contract with BHRS to see what services they are contracted to provide

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Medi-Cal DMC-ODS Covered Services

San Mateo County BHRS provides these specialty DMC-ODS covered services to Medi-Cal members when medically necessary:

- Early Intervention Services (for those under age 21)
- Outpatient Treatment
- Intensive Outpatient Services
- Residential Treatment
- Withdrawal Management
- Narcotic Treatment Program/Opioid Treatment Program Services
- Medications for Addiction Treatment (MAT) – FDA approved medications such as buprenorphine and naltrexone.
- Withdrawal Management
- Peer Support Services
- Contingency Management / Recovery Incentives (pilot through 2026)
- Recovery Services
- Care Coordination
- Clinician Consultation
- Mobile Crisis Services

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Policies and Resources

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Policies and Procedures

These Policies and Procedures guide the collaboration outlined in the MOUs. These resources provide essential information for both HPSM and BHRS, network providers, and ultimately, the individuals served.

HPSM Policies and Procedures and Resources:

- HPSM Provider Manual
- HPSM Member Handbooks
  - Medi-Cal Member Handbook
  - HealthWorx HMO Evidence of Coverage
  - CareAdvantage D-SNP 2025 Member Handbook
- HPSM website: https://www.hpsm.org/

BHRS Policies and Procedures and Resources:

- BHRS DMC-ODS and MHP Member Handbook
- BHRS website

***Ongoing efforts are focused on further developing and improving processes and procedures.*

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HPSM Provider Resources

- https://www.hpsm.org/provider/behavioral-health/
- Primary Care Providers:
  - Behavioral Health Referral Form (MH and SUD services)
  - Developmental Services Referral Guide
    - Behavioral Health Treatment (BHT) Referral Form (under 21 Autism/ABA services)
- HPSM NSMH Providers:
  - Referral for Higher Level of Care Form - Adult
  - Referral for Higher Level of Care Form – Youth
  - Behavioral Health Provider FAQs
  - Medi-Cal Specialty and Non-Specialty Behavioral Health Criteria and Services

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Member Resources

- Take Action for Your Mental Health[English]
  - Tome medidas por su salud mental [Spanish]
  - 為您的心理健康採取行動 [Chinese]
  - Kumilos para sa Iyong Mental Health [Tagalog]
- Key Contacts for HPSM members:
  - To access mental health or substance use services: Access Call Center: 1-800-686-0101

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Provider Questions & Support

- HPSM Contracted Providers: psinquiries@hpsm.org

- BHRS Staff and Contracted Providers, please reach out to HS_BHRS_ASK_QM@smcgov.org

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Thank you!