

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

**1. Criteria for Beneficiaries to Access Specialty Mental Health Services**

Effective January 1, 2022, the Contractor shall implement the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) established below, update the Contractor's policies and procedures as needed to ensure compliance with this policy effective January 1, 2022, and communicate these updates to providers as necessary.

In addition, the Contractor shall update beneficiary handbooks, manuals, and related materials to ensure the criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected in all materials, including materials reflecting the responsibility of Medi-Cal managed care plans and the Fee for Service delivery system for covering non-specialty mental health services.(BHIN 21-073).

- A. Pursuant to Welf. & Inst. Code section 14184.402(a) the following definitions of "medical necessity" or "medically necessary" apply:
- 1) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5
  - 2) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services needed to correct and ameliorate mental illness and conditions. Federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a mental health condition. All mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services as established in W&I Code section 14184.402(b) that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services and the Contractor shall cover them for beneficiaries who meet the criteria for access to the specialty mental health delivery system.

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Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

**B. Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System**

For beneficiaries 21 years of age or older, the Contractor shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
  - a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
  - b. A reasonable probability of significant deterioration in an important area of life functioning

AND

2. The beneficiary's condition as described in paragraph (1) is due to either of the following:
  - a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
  - b. A suspected mental disorder that has not yet been diagnosed

**C. Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System**

For enrolled beneficiaries under 21 years of age, Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria:

- 1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool

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approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

- 2) The beneficiary meets both of the following requirements in a and b below:
- a. The beneficiary 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 specialty mental health services, 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 beneficiary's condition as described in subparagraph (A) is due to one of the following:
  - i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
  - ii. A suspected mental health disorder that has not yet been diagnosed
  - iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

**2. Provision of Services**

- A. The Contractor shall provide or arrange, and pay for, the following medically necessary covered specialty mental health services to beneficiaries who meet access criteria for receiving specialty mental health services. See Exhibit E, Attachment 2, Service Definitions, for detailed descriptions of the specialty mental health services listed below:
- 1) Mental health Services;

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- 2) Medication Support Services;
- 3) Day Treatment Intensive;
- 4) Day Rehabilitation;
- 5) Crisis Intervention;
- 6) Crisis Stabilization;
- 7) Adult Residential Treatment Services;
- 8) Crisis Residential Treatment Services;
- 9) Psychiatric Health Facility Services;
- 10) Intensive Care Coordination (for beneficiaries under the age of 21);
- 11) Intensive Home Based Services (for beneficiaries under the age of 21);
- 12) Therapeutic Behavioral Services (for beneficiaries under the age of 21);
- 13) Therapeutic Foster Care (for beneficiaries under the age of 21);
- 14) Psychiatric Inpatient Hospital Services;
- 15) Targeted Case Management;
- 16) Peer Support Services (If the Contractor has opted to provide Peer Support Services and has been approved by DHCS, the Contractor shall comply with the peer support services provisions in Attachment 15); and
- 17) For beneficiaries under the age of 21, the Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welf. & Inst. Code 14184.402 (d)).

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- B. Medi-Cal Managed Care Plan beneficiaries receive mental health disorder benefits in every classification - inpatient, outpatient, prescription drug and emergency - that the beneficiaries receive medical/surgical benefits, in compliance with 42 C.F.R. 438.910(b)(2). The Contractor is only required to provide inpatient and outpatient specialty mental health services, as provided for in this Contract and as required pursuant to section 1396d(r) of Title 42 of the United States Code, as prescription drug and emergency benefits are provided through other delivery systems.
- C. Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet criteria to access SMHS, documented in accordance with state and federal requirements.
- D. The Contractor shall provide or arrange and pay for all medically necessary covered specialty mental health services in a sufficient amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered specialty mental health service solely because of diagnosis, type of illness, or condition of the beneficiary. The Contractor may deny services based on Welfare and Institutions Code sections 14184.402, subdivisions (a), (c), and (d), 14059.5; and departmental guidance and regulation. (42 C.F.R. § 438.210(a)(2) and (3).)
- E. The Contractor shall make all medically necessary covered specialty mental health services available in accordance with Cal. Code-Regs., tit. 9, sections 1810.345, 1810.350 and 1810.405, and 42 Code of Federal Regulations part 438.210.
- F. The Contractor shall provide second opinions from a network provider, or arrange for the beneficiary to obtain a second opinion outside the network, at no cost to the beneficiary. (42 C.F.R § 438.206(b).) At the request of a beneficiary when the Contractor or its network provider has determined that the beneficiary is not entitled to specialty mental health services due to not meeting the criteria for access to SMHS, the contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (Cal. Code Regs., tit. 9, § 1810.405(e).)

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- G. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with Cal. Code-Regs., tit. 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(I).

**3. Requirements for Day Treatment Intensive and Day Rehabilitation**

- A. The Contractor shall require providers to request prior authorization for day treatment intensive and day rehabilitation services, in accordance with Information Notice 22-016 and any subsequent departmental notices.
- B. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of Cal. Code Regs., tit. 9, §§ 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.
- C. The Contractor shall require that providers include, at a minimum, the following day treatment intensive and day rehabilitation service components:
- 1) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children and adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.
  - 2) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation

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may include psychotherapy instead of process groups, or in addition to process groups.

- 3) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.
- 4) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

D. Day treatment intensive shall additionally include:

- 1) Psychotherapy. Psychotherapy means the use of psychological methods within a professional relationship to assist the beneficiary or beneficiaries to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

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- 2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.
  - 3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.
- E. Staffing Requirements. Staffing ratios shall be consistent with the requirements in Cal. Code Regs., tit. 9, section 1840.350, for day treatment intensive, and Cal. Code Regs., tit. 9 section 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.
- a. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).
  - b. The Contractor shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.
  - c. The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables the Contractor and the Department to audit the program if it uses day treatment intensive or day



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rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

- F. The Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.
- G. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation requirements in BHIN 22-019.
- H. The Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult beneficiaries may decline this service component. The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.
- I. Written Program Description. The Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review the written program description for compliance with this section with prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

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- J. Continuous Hours of Operation. The Contractor shall ensure that the provider applies the following when claiming for day treatment intensive and day rehabilitation services:
- a. A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.
  - b. A full-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.
  - c. Although the beneficiary must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.
  - d. The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

**4. Therapeutic Behavioral Services**

Therapeutic Behavioral Services (TBS) are specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). (Cal. Code Regs., tit. 9, § 1810.215.) TBS are intensive, one-to-one services designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. TBS is described in the Department of Mental Health Information Notice 08-38.