KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Mental Health Services				POLICY #: 3.14-P	
DEPARTMENT: Utilization Management					
Effective Date: 10/2000	Review/Revised Date: 7/3/2023	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY[1]:

All specialty mental health services or Serious Emotional Disorders (inpatient and outpatient) are carved out of the Medi-Cal Product contract and are therefore excluded from Kern Health Systems (KHS) coverage.[2] KHS shall cover outpatient mental health services that are within the scope of practice of Primary Care Providers[3] or when performed for mild to moderate mental health conditions on an outpatient basis by a licensed mental health provider. Members who need specialty mental health services are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or to the local mental health plan for specialty mental health services.[4] Treatment for Serious Emotional Disturbances is provided by the Kern County Behavioral and Recovery Services (KBRS) Specialty Mental Health Plan (SMHS).

KHS required to provide and cover all medically necessary services for members, with the exception of those services that are carved out of KHS's contract. However, even for carved-out services, KHS remain contractually responsible for providing Comprehensive Case Management, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of KHS's provider network. Comprehensive case management for medically necessary services, including both basic and complex case management, is described in KHS's contracts.[20]

KHS' responsibility to provide services related to mental health conditions is described in this policy and procedure. The KHS Utilization Management Department (UM) collaborates with KBRS in the delivery of mental and physical health services to KHS Plan members.

KHS must enter into a Memorandum of Understanding (MOU) with KBRS in the county where KHS operates, which for KHS is Kern County. KHS is responsible for updating, amending, or replacing existing Memorandum of Understandings (MOUs) with KBRS to delineate KHS and KBRS responsibilities when covering mental health services. The existing MOUs between KHS and KBRS are required based on Specialty Mental Health Services (SMHS) regulations and existing KHS contracts.

The MOU will include the following elements:

- Basic Requirements;
- Covered Services and Populations;
- Oversight Responsibilities of the KHS and KBRS;
- Screening, Assessment, and Referral;
- Care Coordination;
- Information Exchange;
- Reporting and Quality Improvement Requirements;
- Dispute Resolution;
- After-Hours Policies and Procedures; and,
- Member and Provider Education.

The MOU is the primary vehicle for ensuring member access to necessary and appropriate mental health services. The MOU addresses policies and procedures for management of the member's care for both KHS and KBRSs, including but not limited to:

- Screening, assessment, and referral,
- Medical necessity determination, care coordination, and exchange of medical information.

The MOU must include a process for resolving disputes between KBRS and KHS that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services (SMHS) and prescription drugs, while the dispute is being resolved. If KHS and KBRS have a dispute that they are unable to resolve regarding the obligations of KHS or KBRS under their respective contracts with DHCS, state laws and/or the KHS - KBRS MOU, the parties are required to

submit the dispute to the state for resolution. DHCS encourages both KHS and KBRS to attempt to resolve all disputes collegially, effectively, and at the local level before submitting the dispute to the state for resolution. The local resolution policy should be exhausted within the below prescribed timeframes before filing the dispute with the state.

MOU elements will promote local flexibility and acknowledge the unique relationships and resources that exist at the county level.

KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.
.
KHS will coordinate and/or provide mental health services as appropriate in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- APL 22-025 Cognitive Health Assessment for Eligible Members 65 Years Of Age Or Older
- 2024 DHCS contract. Exhibit A, Attachment III, Section 5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services
- Safety Code §1374.72; §1367.01
- 42 CFR 438.910(d)
- DHCS Contract Exhibit A – Attachment 10 (8) (E); Attachment 11 (6); and Attachment 12 (3) (Medi-Cal Product only)
- 2024 DHCS Contract Exhibit A- Attachment III (5.3) (5.5); 4.3.13; 5.6.1; 5.5; 5.5.2 ; 5.5.5
- APL 22-005 - No Wrong Door for Mental Health Services Policy
- APL 22-006 - Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
- W&I Code section 14184.402(b)(2)
- W&I Code section 14184.402(h)- No Wrong door

PURPOSE:

To provide guidelines for the provision and/or coordination of mental health services.

DEFINITIONS

Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is

	Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain, or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Serious Emotional Disturbance (SED)[5]	One or more of the mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to the expected developmental norms. Members of this target population shall meet one or more of the following criteria: A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: 1. The child is at risk of removal from home or has already been removed from the home 2. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
Severe Mental Illness (SMI)[6]:	Includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
Specialty Mental Health Services (SMHS) [7]	Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary specialty mental health services.

Mild to Moderate Mental Health Services	Includes Mental Retardation, Learning Disorders, Motor Skills Disorders, Communication Disorders, Autistic or Pervasive Disorders, Developmental Disorders, Tic Disorders, Delirium, Dementia, and Amnestic and other Cognitive Disorders, Mental Disorders due to General Medical Condition, Substance Related Disorders, Sexual Dysfunctions, Sleep Disorders, Antisocial Personality Disorder, or Other Conditions that may be a Focus of Clinical Attention, except Medication-Induces Movement Disorders which are included.
Non-Specialty Mental Health Service (NSMHS)	All of the following services that must be provided when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice: A. Mental health evaluation and treatment, including individual, group, and family psychotherapy. B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. C. Outpatient services for the purposes of monitoring drug therapy. D. Psychiatric consultation E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.
Specialty Mental Health Provider	A person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.
Substance Use Disorder (SUD)	Disorders set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.
Primary Care Provider Mental Health Scope of Services	Primary Care Providers (PCPs) are required to provide outpatient mental health services within their scope of practice.[8] These include services for members diagnosed with minor depression, minor anxiety, uncomplicated grief

	reaction, screening for elderly cognitive impairment.

PROCEDURE:

1.0 ACCESS [9]

KHS and KBRS work collaboratively to coordinate referrals for mental health services that are excluded from coverage by KHS.[10] Services that are the responsibility of KHS are subject to utilization management protocols as described in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* and other KHS policies specific to the type of service/supplies provided. KHS will continue to be responsible for the arrangement and payment of all medically necessary Medi-Cal physical health care services, not otherwise excluded by contract, to beneficiaries who require specialty mental health services.

Primary Care Providers (PCPs) are required to provide outpatient mental health services within their scope of practice.[11] These include services for members diagnosed with minor depression, minor anxiety, or uncomplicated grief reaction.

At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within KHS's provider network. KHS is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the beneficiary to a mental health provider within the KHS network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with KBRS to assess the beneficiary's disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools are identified in the MOU between KHS and KBRS.

Primary care providers will identify the need for a mental health screening and refer to a specialist within the contracted network. KHS providers must use a DHCS approved standardized screening tool (tool specific for adults and tool specific to children and youth). Upon assessment, the mental health specialist can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to KBRS for a Specialty Mental Health Services (SMHS) assessment. When a member's condition improves under SMHS and the mental health providers in the plan and the County System of care coordinate care, the member may return to the mental health provider in KHS network.

If a KHS beneficiary with a mental health diagnosis is not eligible for KBRS services because they do not meet the medical necessity criteria for SMHS, then KHS is required to ensure the provision of outpatient mental health services as listed in the DHCS contract.

KHS will ensure its network providers refer adult beneficiaries with significant impairment resulting

from a covered mental health diagnosis to the county KBRS. Also, when the adult KHS beneficiary has a significant impairment, but the diagnosis is uncertain, the KHS must ensure that the beneficiary is referred to KBRS for further assessment. Services beyond the PCP's scope of practice should be referred as described below.

KHS will also cover outpatient laboratory tests, medications (excluding carved-out medications that are listed in the KHS's relevant Medi-Cal Provider Manual), supplies, and supplements prescribed by the mental health providers in the KHS network, as well as by PCPs, to assess and treat mental health conditions. KHS may require that mild to moderate mental health services to adults are provided through KHS's provider network, subject to a medical necessity determination. KHS may contract with KBRS to provide these mental health services when the KHS covers payment for these services.

KHS will continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for KHS beneficiary receiving SMHS. KHS will coordinate care with KBRS. KHS is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the KHS provider network.

Referrals for mental health services may be generated by the provider of care, KHS UM Case Managers, school systems, employers, or self-referrals. To ensure confidentiality, KHS has a designated Case Manager RN or Social Worker (MSW/LCSW) with Behavioral Health experience that is responsible for all aspects of the member's mental health care and the coordination of physical health care when indicated. Referrals for Medi-Cal members may be sent either directly to KCMHD or to KHS for forwarding to KCBRS.

Kern County Behavioral and Recovery Services
2151 College Ave.
Bakersfield, CA 93305
Fax: (661) 868-8087

OR

Kern Health Systems
Mental Health Case Manager
2900 Buck Owens Boulevard
Bakersfield, CA 93308
Fax: (661) 664-5190

Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit due to the availability of an on-site Mental Health staff 24 hours a day. The Memorandum of Understanding (MOU) with the county mental health plan allows Members in need of urgent and emergency care, including person-to-person telephone transfers, to be referred to the county crisis program during their call center hours.

2.0 Trauma Screening – Adverse Childhood Experiences (ACEs)

PCPs may screen children annually up to age 19 for traumatic life events using the Pediatric ACEs and Related Life-events Screener (PEARLS), which includes screening for several social determinants of health.

Coding results of screening will depend on the result of the screening.
1) G9919: Screening performed and positive and provisions of recommendations (4 and greater)
2) G9920: Screening performed and negative (0 to 3)

The California Department of Health Care Services (DHCS) develops recommendations for stratifying the risk, based on the screening, and tailoring interventions to this risk stratification. These recommendations are based on consensus of experts and have not yet been studied systematically. DHCS maintains provider resources for administering trauma screenings and provision of trauma informed care. More information is available on the DHCS website. See also ACESaware.org.

At this time, trauma screening for children is recommended but not required to be performed by primary care providers caring for children.

Provider attestation of completion of DHCS-approved training (accessible through the ACESaware.org website) by individual clinicians performing the screening is required for payment for billing of trauma screening services.

3.0 Mental Health Parity

KHS will adhere to updated Mental Health Parity practices set forth by the Department of Health Care Services. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) provides that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. 20 This precludes any restrictions to a member's access to an initial mental health assessment. Therefore, Kern Health Systems must not require prior authorization for an initial mental health assessment.

DHCS recognizes that while many PCPs provide initial behavioral health assessments but not all do. If a member's PCP cannot perform the mental health assessment, they must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in the KHS provider network or the county mental health plan's network, is made in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and APL 22-005.

KHS must ensure direct access to an initial mental health assessment by a licensed mental health provider within the KHS provider network. .KHS must not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a mental health network provider. KHS must notify members of this policy, and the KHS member informing materials must clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment from a network mental health provider. KHS is required to cover the cost of an

initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 19-002 or subsequent guidance.

If further services are needed that require authorization, Kern Health Systems is required to follow guidance developed for mental health parity, as set out below. KHS must disclose the utilization management or utilization review policies and procedures that they utilize to DHCS, their Network Providers, and any Subcontractors they use to authorize, modify, or deny health care services via prior authorization, concurrent authorization, or retrospective authorization, under the benefits included in the KHS contract.

KHS policies and procedures (P&P) must ensure that authorization determinations are based on the requested medically necessary health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management P&Ps may also take into consideration the following:

- Service type.
- Appropriate service usage.
- Cost and effectiveness of service and service alternatives.
- Contraindications to service and service alternatives.
- Potential fraud, waste, and abuse.
- Patient and medical safety.
- Providers' adherence to quality and access standards.
- Other clinically relevant factors.

KHS will comply with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, §438.930. KHS will also ensure direct access to an initial mental health assessment by a licensed mental health provider within KHS's provider network. KHS will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. KHS will notify beneficiaries of this policy, and KHS's informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider. KHS is required to cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

If further services are needed that require authorization, KHS is required to follow guidance developed for mental health parity, as follows:
KHS will disclose the utilization management or utilization review policies and procedures that KHS utilizes to DHCS, its contracting provider groups, or any delegated entity, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits included in the KHS contract.

KHS policies and procedures must ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-

based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- Service type
- Appropriate service usage
- Cost and effectiveness of service and service alternatives
- Contraindications to service and service alternatives
- Potential fraud, waste, and abuse
- Patient and medical safety
- Other clinically relevant factors

The policies and procedures must be consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS will notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for KHS include making utilization management criteria for medical necessity determinations for mental health and substance use disorder benefits available to beneficiaries, potential beneficiaries, and providers upon request in accordance with Title 42, CFR §438.915(a). KHS will also provide to beneficiaries, the reason for any denial for reimbursement or payment of services for mental health or substance use disorder benefits in accordance with Title 42, CFR, §438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.

4.0 Accessing Specialty Mental Health Care from KBRS Practitioners

KBRS reviews referrals and refers the member to the appropriate KBRS mental health provider. KBRS coordinates the care between the member and the designated mental health provider. Arrangements for appointments are per KBRS established protocols.

KHS or the mental health provider may submit the request directly to KBRS for review and approval/denial for outpatient treatment of Serious Emotional Disorders or Inpatient Mental Health Services. If the follow-up visits are denied, KBRS will discuss alternatives with the mental health provider and follow established KBRS protocol.

Services Provided by KBRS for Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services include:

Mental Health Services (assessments plan development, therapy, rehabilitation, and collateral)
- Medication Support
- Day Treatment Services and Day Rehabilitation
- Crises Intervention and Crises Stabilization
- Targeted Case Management
- Therapeutic Behavior Services

Residential Services Provided by KBRS

- Adult Residential Treatment Services
- Crises Residential Treatment Services

Inpatient Services

- Acute Psychiatric Inpatient Hospital Services
- Psychiatric Inpatient Hospital Professional Services
- Psychiatric Health Facility services, including an institution for mental diseases (IMD) defined by 9 CCR section 1810.222.1, regardless of the age of the member.

Services Provided by County Alcohol or Other Drug Programs for Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services

- Outpatient Drug Free
- Intensive Outpatient (newly expanded to additional populations)
- Residential Services (newly expanded to additional populations)
- Narcotic Treatment Program
- Naltrexone
- Voluntary Inpatient Detoxification Services

If a beneficiary with a mental health diagnosis is not eligible for KBRS services because the adult beneficiary's level of impairment is mild to moderate, or, for adults and children, the recommended treatment does not meet criteria for Medi-Cal specialty mental health services, then KHS will ensure the provision of the outpatient mental health services listed or other appropriate services within the scope of the KHS's covered services.

KHS will ensure its network providers refer beneficiaries with significant impairment resulting from a covered mental health diagnosis to KBRS. Also, when the beneficiary has a significant impairment, but the diagnosis is uncertain, KHS will ensure that the beneficiary is referred to KBRS for further assessment.

4.1 Non-Specialty Mental Health Services Providers

KHS will increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will be evaluated on an annual basis through the annual network certification. KHS may contract with any mental health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per H&S Code section 1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (Network Composition).

- If a NSMHS Provider is accredited by the NCQA, KHS may deem the Provider credentialed or re-credentialed. KHS develops and maintains policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 19-004.

KHS will authorize and arrange for Out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of Out-of-Network Providers in the KHS Service Area(s) must be prioritized over authorization of Out-of-Network Providers in adjoining Service Area(s), unless an Out-of-Network Provider in an adjoining Service Area(s) is more conveniently located for a member or meets time or distance standards.

- Any time that a Member requires a Medically Necessary NSMHS that is not available within the Provider Network, Contractor must ensure timely access to Out-of-Network Providers and Telehealth Providers, in accordance with H&S Code section 1367.03, and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

KHS provides KBRS the appropriate member information to facilitate referrals and care coordination as needed, to ensure access to NSMHS. This may include the authorization to release information to allow treatment history, active treatment, and health information to be exchanged.

- KHS will ensure data sharing agreements between KBRS to ensure appropriate sharing of information related to mental health services and substance use disorder services. Data may also consist of collecting and reporting of member data receiving NSMHS.

For members under 21 years of age, KHS cover medically necessary covered Non-specialty Mental Health Services

5.0 Mental Health Provider Responsibilities

The mental health provider is required to directly refer members needing medical care to the KHS Mental Health Care Management or delegated contractor. Referrals are processed in accordance with KHS Policy and Procedure #3.22-P: Referral and Authorization Process.

If a member requires medical treatment while admitted to a mental health treatment facility, the admitting mental health provider contacts the PCP for consultation and development of the treatment plan. Members who require transfer to a medical bed for treatment of a medical condition will be transferred by the PCP to the appropriate level of acute care. The KBRS provider continues to consult with the PCP regarding treatment of the member. When the member is medically stable, the member will either be discharged by the PCP with appropriate follow-up by KBRS and the PCP or will be transferred back to the inpatient treatment facility by the KBRS provider. Upon discharge, the member is instructed to follow-up with the KBRS and the PCP, as appropriate.

KHS shall make appropriate referrals for Members needing Specialty Mental Health Services as

follows:

- For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the County Mental Health Plan (KBRS), as defined in MMCD Mental Health Policy Letter 00-01 Revised, the Member shall be referred to KBRS in accordance with the Memorandum of Understanding (MOU) between Contractor and KBRS as stipulated in Exhibit A, Attachment 12, Provision 3, Local Health Department KBRS Coordination for the coordination of Specialty Mental Health Services to Members.

- For those Members whose psychiatric diagnosis is not covered by KBRS, but is a covered diagnosis, the Member shall be referred to an appropriate Medi-Cal mental health provider within KHS's provider network. KHS shall consult with KBRS as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services available through the Medi-Cal FFS program. Any time a member requires medically necessary Outpatient Mental Health Service that is not available within the provider network, KHS shall ensure access to out-of-network and Telehealth mental health providers as necessary to meet access requirements.

- KHS may negotiate with KBRS to provide the outpatient mental health services when KHS covers payment for these services. Disputes between KHS and KBRS regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If KHS and KBRS cannot agree, disputes shall be resolved pursuant to Title 9, CCR, and Section 1850.505.

6.0 PROVISION OF SERVICES DURING DISPUTE PROCESS

As outlined in APL-21-013, guidance is defined for KHS on how to submit a service delivery dispute to the Department of Health Care Services (DHCS) when the dispute cannot be resolved at the local level with a Mental Health Plan (KBRS). Guidance to KBRSs is provided in Behavioral Health Information Notice (BHIN) No: 21-034.19

Any decision rendered by DHCS regarding a dispute between KHS and KBRS concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

State law requires that the provision of medically necessary services must not be delayed during the pendency of a dispute between KBRS and KHS and sets forth rules for determining financial responsibility for services provided to a member during that period. In addition, KHS is contractually responsible for the provision of case management and care coordination for all medically necessary services a member needs, including those services that are the subject of a dispute between KHS and KBRS. KHS is responsible for working with KBRS in order to ensure that there is no duplication of SMHS, for which KHS also provides case management.

6.1 ROUTINE DISPUTE RESOLUTION PROCESS

Regardless of MOU status, KHS and KBRS must complete the plan level dispute resolution process within 15 business days of identifying the dispute. Within three business days after a failure to resolve the dispute during that timeframe, either KBRS or KHS must submit a written "Request for Resolution" (see content requirements below) to DHCS. If KHS submits the Request for Resolution, it must be signed by the KHS's Chief Executive Officer (CEO) or his/her designee. The information submitted must contain the following:

1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party member by either KHS or KBRS and the expected rate of payment for each type of service;
2. A history of the attempts to resolve the issue(s) with KBRS;
3. Justification for KHS's desired remedy; and
4. Any additional documentation that KHS deems relevant to resolve the disputed issue(s), if applicable.

The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov. Within three business days of receipt of a Request for Resolution from KHS, DHCS will forward a copy of the Request for Resolution to the Director of the affiliated KBRS via secure email ("Notification"). KBRS will have three business days from the receipt of Notification to submit a response to KHS's Request for Resolution and to provide any relevant documents to support KBRS's position. If KBRS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS. Conversely, if KBRS submits a Request for Resolution to DHCS, DHCS will forward a copy of the Request for Resolution to KHS, within three business days of receipt. KHS will have three business days to respond and provide relevant documents.

If KBRS requests a rate of payment in its Request for Resolution, and KBRS prevails, the requested rate shall be deemed correct, unless the KHS disputes the rate of payment in its response. If KHS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KBRS. Conversely, if KHS requests a rate of payment in its Request for Resolution, and KHS prevails, the requested rate shall be deemed correct, unless KBRS disputes the rate of payment in its response. If KBRS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS.

At its discretion, DHCS may allow both KHS and KBRS representatives of KHS and KBRS the opportunity to present oral arguments.

The Managed Care Quality and Monitoring Division and the Medi-Cal Behavioral Health Division will make a joint recommendation to the DHCS' Director, or the Director's designee, based on their review of the submitted documentation; the applicable statutory, regulatory, and contractual obligations of KHS and KBRS; and any oral arguments presented.

Within 20 business days from the third business day after the Notification date, DHCS will

communicate the final decision will be communicated via secure email to KHS's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and KBRS's Director. (or the Director's designee, if the designee submitted the Request for Resolution). DHCS' decision will state the reasons for the decision, the determination of rates of payment (if the rates of payment were disputed), and any actions KHS and KBRS are required to take to implement the decision. Any such action required from either KHS or KBRS must be taken no later than the next business day following the date of the decision.

6.2 EXPEDITED DISPUTE PROCESS

KHS and KBRS may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and KHS and/or KBRS determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.

Under this expedited process, KHS and KBRS will have one business day after identification of a dispute to attempt to resolve the dispute at the plan level. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.

If KBRS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS. Conversely, if KHS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KBRS.

DHCS will provide a decision no later than one business day following DHCS' receipt of Request for Resolution from both parties and affirmation of the stated jeopardy to the member.

7.0 FINANCIAL RESPONSIBILITY

If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services rendered by the successful party, KHS or KBRS is required to comply with the requirements in Title 9, California Code of Regulations (CCR, §), section 1850.530, If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

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

KHS is responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance,

including APLs and Policy Letters. These requirements must be communicated by KHS to all subcontractors and network providers.

8.0 COVERED SERVICES

Per DHCS guidance and as set forth in the W&I Code section 14189 covered services in accordance with W&I Code section 14184.402, Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services, and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, KHS is required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS) and Substance Use Disorder services (SUD):

- Mental health evaluation and treatment, including individual, group and family psychotherapy, and dyadic services.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- All Medically Necessary Medi-Cal covered psychotherapeutic drugs when administered Outpatient (this includes drugs administered by Out-of-Network providers).
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies and supplements.
- Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications.
- Supplies may include laboratory supplies.
- Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).
- Hypnotherapy
- Health behavior assessments and interventions
- Psychiatric collaborative care
- Mental health screening services described in the Medi-Cal Provider Manual as NSMHS, applicable DHCS All-Plan Letters
  including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, Cognitive health assessment for eligible members 65 years of age or older and other screening services.
- Substance Use Disorder (SUD) services that may include alcohol and drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and medically necessary behavioral health SUD services.
- Covered NSMHS and SUD Services can be delivered in person and via telehealth/telephone.

DHCS has contracted with Magellan Medicaid Administration, Inc. (Magellan) to provide administrative services and supports relative to the Medi-Cal pharmacy benefit as of January 1, 2022, which is collectively known as "Medi-Cal Rx". Magellan will provide administrative services, as directed by DHCS, which include claims management, prior authorization (PA) and utilization management, pharmacy drug rebate administration, provider and member support services, program integrity (PI) activities, and other ancillary and reporting services to support the administration of Medi-Cal Rx.

PCPs are required to provide outpatient mental health services within their scope of practice.[12] KHS is responsible to provide emergency mental health services to all members.[13] 24-hour Mental Health Crisis services are available via the crisis hotline at (800) 991-5272. Member's will continue to have access to an existing relationship with a mental health provider in an emergency or urgent care situation and care will be coordinated through communications with KBRS and emergency room personnel. KHS Case Management Registered Nurses are available 24/7/365 at 661/331-7656 to provide support and coordination of services to providers involved in member's mental health evaluation and care. All specialty mental health services (inpatient and outpatient) are carved out of the KHS Medi-Cal LOB.

KHS will cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual (DSM). The clinical tool will define the provisional diagnosis, functional impairment resulting from the mental disorder, probability of deterioration or other risk factors linked to the mental disorder, or if a alcohol drug dependence or abuse disorder is present.

KHS is responsible for the delivery of non-Specialty Mental Health Services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current DSM.

The clinical assessment tools used will be specific for 2 age groups:

- Child 0-17 years of age (see Attachment B) and,
- Adult 18 years of age or older (see Attachment C).

The referral algorithm will determine which system of care is appropriate to deliver the necessary mental health services for maximum patient outcomes.

Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by KHS nor by KCBRS. All services must be provided in a culturally and linguistically appropriate manner.

Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

- Diagnose a mental health condition and determine a treatment plan.
- Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
- Refer adults to KCBRS for specialty mental health services when a mental health diagnosis covered by KCBRS results in significant impairment; or refer children under age 21 to KCBRS for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the beneficiary meets medical necessity criteria.

9.0 EPSDT BENEFIT

Pursuant to the EPSDT benefit, KHS is required to provide and cover all medically necessary services.

For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

And "[such other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)).

In accordance with California Welfare and Institutions Code (W&I Code) sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.).

The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan. For children under the age 21, KHS will provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01

Consistent with federal guidance from the Centers for Medicare & Medicaid Services, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services.

In accordance with W&I Code sections 14059.5 and 14184.402, 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.

KHSs must provide or arrange for the provision of the following NSMHS:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy. 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation.
5. Outpatient laboratory, drugs, supplies, and supplements prescribed by mental health providers in KHS’s network and PCPs, including physician administered drugs administered by a health care professional in a clinic, physician’s office, or outpatient setting through the medical benefit, to assess and treat mental health conditions. KHS may require that NSMHS for adults are provided through KHS's provider network, subject to a medical necessity determination.

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

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

KHS must ensure that its network is adequate to provide the full range of covered NSMHS to its pediatric and adult members.

However, for children under the age 21, KHS is required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by KBRS.

10.0 ENHANCED CARE MANAGEMENT PROGRAM (ECM)

KHS will be participating in the Enhanced Care Management Program (previously identified as Health Homes Program (HHP) as required by the DHCS and will coordinate care for members enrolled in the ECM who also receive care through KBRS. The MOU is the vehicle for ensuring this coordination, as detailed in the MOU Template (Attachment 2).

11.0 MATERNAL MENTAL HEALTH

KHS will ensure that the maternal mental health program is designed to promote quality and cost-effective outcomes and is consistent with sound clinical principles and processes.

Kern Health Systems (KHS) cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

Maternal mental health disorders include depression, the range of anxiety disorders (including general anxiety disorder, obsessive compulsive disorder (OCD) with reoccurring unwanted thoughts and birth related Post Traumatic Stress Disorder (PTSD).

Maternal depression screenings are conducted by the Provider (OB/GYN, Nurse Midwives, and PCP) who is providing care to the mother during pregnancy and the early postpartum period. Screening tools, such as the PHQ-9 or Edinburgh Postnatal Depression Scale, are recognized by the American College of Obstetrics and Gynecology and the US Preventative Task Force as clinically sound assessment tools. Those members identified as positive on the screening will be referred to KHS for Case Management services and Mental Health evaluation and treatment.

12.0 CARE MANAGEMENT AND CARE COORDINATION

KHS will continue to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for a member receiving SMHS. KHS will coordinate care with the KBRS. KHS will take responsibility for the appropriate management of a member's mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the KHS provider network.

Consistent with W&I Code section 14184.402(b) KHS will cover clinically appropriate and covered NSMHS even when:

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

KHS will assist members in locating available treatment service sites. At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the KHS provider network. KHS will ensure that a mental health screening of members is conducted by network Primary Care Providers (PCP). Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The member may then

be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the KHS network.

KHS will ensure direct access to an initial mental health assessment by a licensed mental health provider within the KHS provider network. KHS will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. KHS will notify beneficiary members of this policy, and member informing materials must clearly state that referral and prior authorization are not required for a beneficiary member to seek an initial mental health assessment from a network mental health provider. KHS will notify the members of such applicable policies.

KHS will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 19-002 or subsequent guidance.

If further services are needed that require authorization, KHS will follow guidance developed for mental health parity.

KHS will disclose the utilization management or utilization review policies and procedures that they utilize to DHCS, and any Subcontractors they use to authorize, modify, or deny health care services via prior authorization, concurrent authorization, or retrospective authorization, under the benefits included in the KHS contract.

Authorization determinations will be based on the medical necessity of the requested medically necessary health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- Service type.
- Appropriate service usage.
- Cost and effectiveness of service and service alternatives.
- Contraindications to service and service alternatives.
- Potential fraud, waste, and abuse.
- Patient and medical safety.
- Providers' adherence to quality and access standards.
- Other clinically relevant factors.

The P&P's will be consistently applied to medical/surgical, mental health and SUD benefits. KHS will notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all network providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Utilization management criteria for medical necessity determinations for mental health and SUD benefits will be available to members, eligible beneficiaries, and network providers upon request. KHS will also provide members the reason for any denial or partial denial for reimbursement of payment of services or any other adverse benefit determination for mental health or SUD. All services will be provided in a culturally and linguistically appropriate manner

Clinically appropriate and covered NSMHS delivered by KHS providers are covered by KHS during the assessment process prior to the determination of a diagnosis or a determination that the member meets criteria for NSMHS. KHS must not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does **not** meet the criteria for NSMHS or meets the criteria for SMHS. Likewise, MHPs will not deny or disallow reimbursement for SMHS services provided during the assessment process if the assessment determines that the member does **not** meet criteria for SMHS or meets the criteria for NSMHS.

NSMHS Not Included in an Individual Treatment Plan Clinically appropriate and covered NSMHS delivered by KHS providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan. It includes voluntary inpatient detoxification, outpatient heroin and other opioid detoxification providers are available as a benefit available to KHS members through the Medi-Cal fee-for-service program. 2nd paragraph

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

If a member receiving NSMHS is determined to meet the criteria for SMHS, as defined by W&I code section 14184.402, due to a change i22-2n d2ndn the member's condition, KHS providers must use DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for children and youth) and continue to provide NSMHS to the member concurrently receiving SMHS, when those services are not duplicative and coordinated between KHS and KBRS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I Code section 14184.402, the MHP must use DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for children and youth), as required when members who have established relationships with SMHS providers experience a change in condition requiring NSMHS.

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

KHS has an MOU with the MHP in accordance with to ensure services for its members are properly coordinated and provided in a timely and non-duplicative manner. Concurrent NSMHS and SMHS Members may concurrently receive NSMHS from a KHS provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. KHS will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Likewise, MHPs will not deny or disallow reimbursement for SMHS provided to a member on the basis of the member also meeting NSMHS criteria and/or receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

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

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

Members with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if the member simultaneously receives NSMHS from a KHS provider (billed to the KHS), as long as the services are coordinated between these delivery systems and are non-duplicative.

KHS members may simultaneously receive SMHS from a MHP provider (billed to the MHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).

Treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. This precludes any restrictions to a beneficiary's member's access to an initial mental health assessment. Therefore, KHS shall not require prior authorization for an initial mental health

13.0 SUBSTANCE USE DISORDER (SUD)

KHS must provide covered substance use disorder (SUD) services, including but not limited to

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

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

Please refer to Policy #3.10 Alcohol and Substance Abuse Treatment Services

For members under 21 years of age, KHS must cover medically necessary covered SUD services. Medical necessity determinations for NSMHS are SUD services must be made pursuant to W&I Code section 14059.5, and as required pursuant to Section 1396d(r) of Title 42 of the United States Code. For Members under 21 years of age, NSMHS and covered SUD services are medically necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an EPSDT screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition. KSH coverage of NSMHS and SUD services complies with W&I Code section 14184.4-2(f).

14.0 CO-OCCURRING SUBSTANCE USE DISORDER

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

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

15.0 NON-SPECIALTY MENTAL HEALTH COVERED SERVICES

The following medically necessary services remain the responsibility of KHS[14]:

- Emergency room professional services to include services provided by psychiatrists,

psychologists, licensed clinical social workers, marriage family and child counselors, or other specialty mental health provider for mild to moderated mental health diagnoses. See *KHS Policy and Procedure #3.31-P: Emergency Services* for additional information on emergency services.

- Facility charges for emergency room visits which do not result in a psychiatric admission
- All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a mental health condition. Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.
- Emergency medical transportation services necessary to provide access to emergency mental health services within KHS's mental health provider network.
- All non-emergency medical transportation (NEMT) as described in *KHS Policy and Procedure #5.15 – Non-Medical Transportation* required to access Medi-Cal covered mental health and SUD services, in compliance with APL 17-010, subject to a written prescription by a KHS Mental Health Network Provider, Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.
- Non-Medical Transport (NMT) services and, for Members less than 21 years of age, NEMT services, to and from Drug Medi-Cal (DMC) services, Drug Medi-Cal Organized Delivery System (DMC-ODS) services, and SMHS, in compliance with APL 17-010.
- All Medi-Cal covered psychotherapeutic drugs not otherwise excluded that are prescribed by the member's PCP or a psychiatrist.[15] (See Attachment A for a list of excluded drugs.)
- Medically necessary covered services after KHS has been notified by a DMC, DMC-ODS, MHP, or mental health Provider that a member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:
    a) The initial health history and physical examination required upon admission,
    b) Consultations
    c) Skilled Nursing Facility (SNF) room and board when IMD services are provided to Members less than 21 years of age or age 65 and over.

16.0 EATING DISORDERS

KHS and MHPs share a joint responsibility to provide medically necessary services to Medi-Cal beneficiaries with eating disorders. Some treatment for eating disorders (both inpatient and outpatient SMHS) is covered by MHPs. Some treatment for eating disorders is also covered by KHS. Since eating disorders are complex conditions involving both physical and psychological symptoms and complications, the treatment typically involves blended physical health and mental health interventions, which KHS and MHPs are jointly responsible to provide.

KHS is responsible for the physical health components of eating disorder treatment and NSMHS, and MHPs are responsible for the SMHS components of eating disorder treatment, specifically:

- MHPs must provide, or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
- KHS must provide inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization. KHS must also provide or arrange for NSMHS for members requiring these services.
- KHS must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services that are medically necessary to stabilize the member. Emergency services include professional services and facility charges claimed by emergency departments.
- For partial hospitalization and residential eating disorder programs, MHPs are responsible for the medically necessary SMHS components, and KHS is responsible for the medically necessary physical health components.

KHS is contractually responsible for providing Comprehensive Medical Case Management Services, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of the KHS provider network. These services are provided through either basic case, complex case or Enhanced Care Management activities based on the medical needs of the member. As a result, KHS must coordinate all medically necessary care for members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a member.

DHCS does not require a specific funding split for MHPs and KHS to share the cost of services provided in partial hospitalization and residential eating disorder programs. Instead, both parties will mutually agree upon an arrangement to cover the cost of these medically necessary services. MHPs and KHS will proactively come to an agreement on the bundle of services, unit costs, and total costs associated with an episode or case of eating disorder treatment. Additionally, KHS and MHPs must agree on the division of the financial responsibility.

KHS and MHPs must have a memorandum of understanding (MOU) in place. The division of financial responsibility agreement must be documented in the MOU between KHS and MHP, inclusive of details about which plan will be responsible for establishing contracts detailing payment mechanisms with providers. If KHS and the MHP cannot agree on how to divide financial responsibility for those services, the KHS and the MHP should split the costs equally.

The MOU must include a requirement that any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both KHS and the MHP. In addition, the MOU must specify procedures to ensure timely and complete exchange of information by both the MHP and KHS for the purposes of medical and behavioral health care coordination to ensure the

member's medical record is complete and the KHS can meet its care coordination obligations.

Should disputes arise between parties that cannot be resolved between KHS and the MHP, KHS must follow the dispute resolution process contained in APL 21-013 ("Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans"), including subsequent revisions to APL 21-013. MHPs are required to follow a parallel dispute resolution process contained in BHIN 21-034.Nonetheless, KHS must not delay the case management and care coordination, as well as the coverage of, medically necessary services pending the resolution of a dispute.

17.0 DOCUMENTATION

Hard copies of referrals received by KHS are filed in the member's KHS mental health chart for any follow-up and tracking purposes. This includes any referrals from mental health providers for medical services, which may include but not limited to mental and behavioral health screenings, assessments, and treatment provided by a licensed mental health care provider.

18.0 COORDINATION OF CARE, MONITORING, AND REPORTING[16]

KHS has established and maintains mechanisms to identify members who require non-covered psychiatric services and make appropriate referrals.[17] KHS continues to cover and facilitate the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Practitioner and the psychiatric service provider(s).[18] KHS coordinates care with KCBRS in accordance with a Memorandum of Understanding that meets the requirements of DHCS Contract Exhibit A – Attachment 12 (3).[19]

Referrals for mental health services received by KHS or delegated contractor are reviewed for appropriateness then entered into the referral system and mailed to either the Contracted Behavioral Health provider or KBRS access supervisor. If for any reason the referral is not appropriate for mental health, the Case Manager RN, or Social Worker (MSW/LCSW) with Behavioral Health Experience notifies the submitter to discuss the case for alternatives of care.

KHS ensure) members seeking mental health services who are not currently receiving non-specialty mental health services (NSMHS), or Specialty Mental Health Services (SMHS) receive Closed Loop Referrals to the appropriate delivery system for mental health services, either in KHS provider network or the MHP network.

19.0 PCP RESPONSIBILITIES

PCPs are responsible to monitor that the member is following up with mental health appointments. The KHS Case Manager RN or Social Worker (MSW/LCSW) with Behavioral Health experience or delegated contractor assists the PCP in the coordination of the member's care when requested and upon verification of the release of mental health information from the member.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with KHS, and shall include:

- Initial Health Assessment (IHA) performed within 120 calendar days of enrollment
- California Child Health and Disability Prevention (CHDP) assessment and ensure immunization compliance
- Individual Health Education Behavioral Assessment (IHEBA) performed within 60 calendar days of enrollment for members under the age of 18 and within 120 calendar days for members over the age of 18; and that all existing Members who have not completed an IHEBA, must complete it during the next preventative care office visit according to the Staying Healthy Assessment (SHA) periodicity with annual reviews of the member's answers.
- KHS will allow each member at least one expanded screening, using a validated screening tool, every year. Additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. KHS will ensure that PCPs maintain documentation of the IHEBA and the expanded screening. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the new PCP must provide and document this service.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

KHS will ensure that:

a) Primary Care Providers shall use the DHCS updated SHA questionnaires and forms, DHCS 7098 A through I, the AAP Bright Futures assessment tools, or a DHCS-approved alternative approved IHEBA, per MMCD Policy Letter PL 13-001. Utilizing applicable mental health and substance use screenings, including but not limited to provision of alcohol and drug screening, assessment, brief intervention and referral to treatment (SABIRT) Services, and referrals for additional assessments and treatments as indicated by the discovery of a condition or potential conditions from screening services.

b) The IHEBA is:

- Administered and reviewed by the Primary Care Provider during a scheduled office visit, according to the SHA periodicity schedule: 0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, and every 3-5 year for adults and seniors.
- Reviewed at least annually by the Primary Care Provider with Members during a scheduled office visit.
- Re-administered by the Primary Care Provider at the appropriate SHA periodicity age-intervals.
- Based on the Member's identified behavioral risks and willingness to make lifestyle changes, the Primary Care Provider shall provide tailored heath education counseling, intervention, referral, and follow-up during the initial IHEBA administration, re-administration, and annual review of the assessment;

- The Primary Care Provider must sign, print their name, and date the "Clinic Use Only" section of the SHA for newly administered, re-administered, or annually reviewed SHAs. The Primary Care Provider must check the appropriate boxes to indicate the specific behavioral topics and counseling, anticipatory guidance, referral, and follow-up provided to the Member; and
- Documentation equivalent to the SHA must be kept by Primary Care Providers who use AAP's Bright Futures or a DHCS-approved alternative IHEBA.
- In addition to the SHA, the Primary Care Provider (PCP) must administer a Alcohol Misuse Screening and Counseling (AMSC) questionnaire to adults ages 18 years or older to determine if alcohol misuse or have engaged in risky or hazardous drinking behavior that requires additional treatment beyond the scope of the Primary Care Provider. Each member is granted at least one expanded screening, using a validated screening tool, per year. If a member answers "yes" to the alcohol prescreen question in the SHA, a second screening test such as the AUDIT-C will be performed and can be billed separately as a screening tool. If the results of the expanded screening indicate a potential alcohol misuse problem, the PCP must offer (or refer) the member for brief intervention, one to three sessions (which may be combined). If the expanded screening indicates that a member might have an alcohol use disorder (whether or not the member definitely meets DSM criteria for alcohol use disorder), then the member must be referred to local alcohol and drug programs for further evaluation and treatment to receive expanded services covered under Medi-Cal Fee-For-Service. Expanded treatment modalities beyond the brief interventions of three 15-minute sessions maybe conducted in person, by telehealth, by phone, or by the PCP. Providers may provide brief intervention services on the same date of service as the expanded screen or on subsequent days. These sessions may also be combined in one or two visits or administered as three separate visits.
- KHS shall cover and pay for behavioral counseling intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder or responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment. Treatment for alcohol use disorders is not a service covered under this health coverage.
- Primary care providers (PCPs) may offer AMSC (Alcohol Misuse Screening and Counseling) in the primary care setting as long as they meet the following requirements:
- AMSC services may be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider, including but not limited to, the following:

    - Licensed Physician
    - Physician Assistant
    - Nurse Practitioner
    - Psychologist

- At least one supervising licensed provider per clinic or practice may take four hours of AMSC training after initiating AMSC services. The training is not required; however, it is recommended.
- Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. Providers may refer offsite for behavioral counseling interventions; however, KHS will encourage PCPs and their teams to offer the service within the primary care clinic, to increase the likelihood of members following through on the interventions.
- KHS will allow each member at least three behavioral counseling intervention sessions per year. Providers may combine these sessions in one or two visits or administer the sessions as three separate visits. Additional behavioral counseling interventions can be provided if medical necessity has been determined by the member's provider.

c) KHS shall provide Members with the following:

- Information on the purpose of the IHEBA/SHA or AMSC and assurances that the IHEBA will be kept confidential in the Member's Medical Record, prior to the administration of the IHEBA/SHA or AMSC;
- Assistance in completing the SHA, IHEBA/SHA or AMSC translations, interpretation services, accommodation for any disability as needed; and
- Information on the Member's right to omit or not answer any assessment question, or to decline to complete the entire assessment.
- KHS will ensure that members who, upon screening and evaluation, meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the County Department for alcohol and substance use disorder treatment services or DHCS-certified treatment program.
- KHS will include AMSC services in their member-informing materials and their procedures that address grievances and appeals regarding AMSC services.

20.0 COGNITIVE HEALTH ASSESSMENT FOR ELIGIBLE MEMBERS 65 YEARS OF AGE OR OLDER BENEFIT

California Senate Bill (SB) 48 (Chapter 484, Statutes of 2021) expands the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal Members who are 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare Program.

The Cognitive Assessment Tools shall be conducted by a qualified / certified provider in accordance with DHCS policy utilizing one of the cognitive assessment tools listed below.

Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- 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

Providers are required the do the following in order to appropriately bill and receive reimbursement for conducting an annual cognitive health assessment:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the brief cognitive health assessment;
    - DHCS will maintain a list of Providers who have completed the training;
        - KHS will have access to the list.
        - KHS will verify a billing provider is on the list prior to reimbursing for the service.
- Administer the annual cognitive health assessment as a component of an E&M` visit including, but not limited to an office visit, consultation, or preventive medicine service (elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider);
- Document all of the following in the Member's medical records and have such records available upon request:
    - The screening tool or tools that were used (at least one cognitive assessment tool listed
    - Verification that screening results were reviewed by the Provider;
    - The results of the screening;
    - The interpretation of results; and
    - Details discussed with the Member and/or authorized representative and any appropriate actions taken in regards to screening results.
        - Appropriate actions include providing appropriate follow-up care based on assessment scores, including but not limited to additional assessments or specialist referrals.
        - KHS will conduct medical record audits for the screenings to ensure compliance with the provisions above. This will be done as part of KHS medical record auditing for primary care providers
- Providers are to use allowable CPT codes as outlined in the Medi-Cal Provider Manual.
    - CPT 1494F is only applicable for Members 65 years of age and older with or without signs or symptoms of cognitive decline who do not have Medicare coverage.

For Members under 65 years of age who are reporting symptoms or showing signs of cognitive decline, KHS will provide medically necessary and appropriate coverage of assessments, which may include but is not limited to cognitive health assessments, appropriate treatment services, and necessary referrals, billed through established practices.

21.0 DELEGTION AND MONITORING

KHS is responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by KHS to all subcontractors and network providers.

Service delivery disputes between KHS and MHPs must be addressed consistent with DHCS guidance regarding the dispute resolution process between KHS and MHPs.

The KHS Case Manager RN or Social Worker (MSW/LCSW) with Behavioral Health experience or delegated contractor actively coordinates all services between the member and providers. KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors. Any problems identified in coordination of care are reported to the Chief Medical Officer and Chief Health Services Officer for intervention/resolution. The Chief Medical Officer and/or Chief Health Services Officer may submit the problem to the KHS QI/UM Committee for review and action, as appropriate.

22.0 REIMBURSEMENT

Reimbursement for mental health services is made per contract agreement. Claims must be submitted in accordance with *KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement* and other KHS policies specific to the type of service/supplies provided. **KCBRS** sub-contractors should not submit claims directly to KHS. **KCBRS** must submit all DHCS required encounter data to KHS with transmitted claims. **Providers** under contract with KHS must meet the requirements outlined in *KHS Policy and Procedure #4.01 –* P, *Credentialing*. **KHS** provides mental health services through health care providers who are acting within the scope of their licensure and acting within their scope of competence, established by education, training and experience.[20] **KHS** providers are educated regarding mental health carve-outs, PCP responsibilities, licensed mental health professionals' responsibilities, and referral procedures through orientations and through this policy and procedure which is included in the *KHS Provider Manual*. Reimbursement to pharmacies for psychotherapeutic drugs shall be provided through the Medi-Cal FFS program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

ATTACHMENTS

- Attachment A - Excluded Psychotherapeutic Drugs

- Attachment B - Child 0-17 Behavioral Health Screening form
- Attachment C - Adult Behavioral Health Screening form
- Attachment D - PHQ-9 Mental Health Questionnaire
- Attachment E - Edinburgh Postnatal Depression Scale (EPDS)

REFERENCE:

Revision 2023-02: Updated per DHCS APL 22-025, approval received on 3/21/2023. **Revision 2022-12:** Updated per 2024 DHCS contract. Exhibit A, Attachment III, Section 5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services. **Revision 2022-01:** Updated per 2024 DHCS contract. Exhibit A, Attachment III, Section 4.3.13 Mental Health Services, Section 5.5 Mental Health, and Substance Use Disorder Benefits; Section 5.6.1 MOUs with third Party Entities and County Programs; Section 5.5.2 Non-specialty Mental eHealth Scare Services and Substance use Disorder Services. **Revision 2022-08:** Updated per 2024 DHCS contract. Exhibit A, Attachment III, Section 5.5.3 Non-specialty Mental Health Services Providers. Exhibit A Attachment III Section 5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services. APL 22-005 - No Wrong Door for Mental Health Services Policy. APL 22-006 - Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services. **Revision: 2022-05** DHCS APL Updates APL22-003; APL 22-005; APL22-006; APL 21-018 updated by Director of Utilization Management. **Revision 2021-11:** Updated per APL 21-013. Updates also made per APL 19-002 DMHC Maternal Depression Screening requested by Chief Health Services Officer . Policy received DHCS approval on 4/14/2022**. Revision 2019-10:** Policy updated during retrospective review of APL 18-015. Minor revisions to correct references and address updated. **Revision 2018-1:** Policy revised to comply with APL 18-015. New section for updating, amending, or replacing existing Memorandum of Understandings (MOUs). **Revision 2017-12:** Major revision to P&P to comply with APL 17-018. **Revision 2017-04: S**ection 5.0 Tobacco Cessation Services removed from policy. To be incorporated into policy 3.10-P. Titles updated. **Revision 2015-11:** Minor addition to reference on page 13 Section (i). No material change, revision date revised. **Revision 2015-03:** Tobacco Cessation Services added to comply with all plan Letter (APL) **14-006. Revision 2015-01: Minor** revisions incorporated due to internal audit of APL 13-021 Outpatient Mental Health Services. Attachments updated. **Revision 2014-03:** Revised to comply with SBIRT Deliverable AIR #1, training requirements added. **Revision 2014-02:** Major revision to policy for Mental Health and SBIRT. References to Healthy Families removed. Revisions provided by Director of Health Services. **Revision 2009-03:** Routine review. **Revision 2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2004-02:** Routine revision. Revised per DHS Comment 04/30/01. Reformatted according to scope of services template (sections simply moved from one part of the policy to another or to the associated internal policy are not marked as redline). Reviewed policy against AB88, DHS Contract, and MRMIB Contract and regulations to ensure compliance. **Revision 2001-02:** Changes requested by UM. **Revision 2000-10:** Routine revision.

[2] DHS Contract A-11 (6)(A)(1)
[3] DHS Contract A-10 (8)(E)(1)
[4] DHS Contract A-10 (8)(E)(3)
[5] Health and Safety Code §1374.72 (e)
[6] Health and Safety Code §1374.72 (d)
[7] DHS Contract A-10 (8)(E)(3)
[8] DHS Contract §6.7.3.3 (A)
[9] DHS Contract A-11 (6)(A)(2)
[10] DHS Contract §6.7.3.3(A)
[11] DHS Contract §6.7.3.3 (A)
[12] DHS Contract §6.7.3.3 (A)
[13] Health and Safety Code §1374.72. These services are not exempted per the DMHC Healthy Families exemption filing (024A).

[14] DHS Contract A-10 (8)(E)(2)
[15] DHS Contract A-10 (8)(E)(1)
[16] *Medical case management required as well as coordination of services with the Specialty Mental Health Provider 6.7.3.3B.*
[17] DHS Contract A-10 (8)(E)(4)
[18] DHS Contract A-10 (8)(E)(4)

[19] DHS Contract A-10 (8)(E)(4) and A-11 (6)(B) and MRMIB Contract §V(D)
[19] 18 2021 BHIN's are searchable at https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx
[20]Exhibit A, Attachment 11, Case Management and Coordination of Care. KHS boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[21]Exhibit A, Attachment 12, Local Health Department Coordination.
[22]Title 9, CCR, section 1810.370.

Psychiatric Drugs

The following psychiatric drugs are carved out under Kern Health Systems benefit coverage:

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

Child 0-17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ____/____/____ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type: ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain resulting from mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** SUD
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse Control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Pervasive Development Disorder (except Autism) ☐ Disruptive Behavior/Attention Deficit D/O ☐ Feeding and eating, Elimination D/O ☐ Other disorders of infancy, childhood, adolescence ☐ Somatoform disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulties dressing, grooming, cleaning, following parental instructions) ☐ Social relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Educational/Vocational/Employment / Meaningful Activity (disruptive behavioral problems with school or other age appropriate activities)	☐ Psychiatric hospitalizations – 2 or more in last 6 months ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Alcohol Abuse ☐ Alcohol Dependence ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Management Department** Fax (661)664-5190	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric/substance abuse history, trauma history):

_____

_____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain below resulting from the mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** Substance Use Disorder
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Disruptive Behavior/Attention Deficit D/O ☐ Somatoform Disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulty cooking, cleaning, self-management, Activities of Daily Living, using transportation, residential instability/homelessness in last 30 days) ☐ Social Relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Vocational/Employment/Meaningful Activities (disruptive behavior problems with work/education/volunteer performance)	☐ Persistent symptoms & impairments after 2 medication trials ☐ 2 or more psychiatric hospitalizations in the past 12 months ☐ Present LPS (Mental Health) Conservatorship ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Failed SBI (screening & brief intervention at primary care ☐ Alcohol Abuse (with failed SBI) ☐ Alcohol Dependence (with failed SBI) ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Department** Fax (661) 664-5190)	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric history, substance abuse or trauma history): _____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have copied quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199