KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Alcohol and Substance Abuse Treatment Services				POLICY #: 3.10-P	
DEPARTMENT: Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 1/25/2023	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Office

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY:

Alcohol and substance abuse treatment services available under the Short-Doyle Medi-Cal (SDMC) program as defined in Title 22, Section 51341.1, outpatient heroin detoxification as defined in Title 22, Section 51328 are excluded from the Kern Health Systems (KHS) Medi-Cal contract,[1] and the implementation of covered tobacco cessation services.

Under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)[2] benefit, KHS is required to provide coverage for screening services for all members under 21 years of age.[3] As part of the EPSDT requirement, KHS is contractually required to provide services as recommended by the American Academy of Pediatrics (AAP) Bright Futures initiative for all

members under 21 years of age. The AAP develops guidance and recommendations for preventive care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies.[4] Per AAP/Bright Futures recommendations, tobacco alcohol, and drug use screening and assessment with appropriate follow-up action as necessary should begin to occur at 11 years of age.

KHS is also contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults, as of November 2018, and for Screening for Unhealthy Drug Use, as of June 2020. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[5]

Additionally, the USPSTF recommends screening by asking questions about unhealthy drug use in adults aged 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.[6]

DEFINITIONS:

The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences, but not meeting criteria for AUD. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "heavy use" as exceeding the recommended limits of 4 drinks per day or 14 drinks per week for adult men or 3 drinks per day or 7 drinks per week for adult women. The term "unhealthy drug use" is defined as the use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.

Unhealthy alcohol and drug use plays a contributing role in a wide range of medical and behavioral health conditions. Counseling interventions in the primary care setting can address risky drinking behaviors in adults by reducing weekly alcohol consumption and increasing long-term adherence to recommended drinking limits. Brief behavioral counseling interventions decrease the proportion of persons who engage in episodes of heavy drinking. Additionally, brief counseling interventions increase the likelihood pregnant women will abstain from alcohol throughout their pregnancy. Effective treatment options for AUDs and/or substance use disorders (SUDs) depend on the severity of the disorder and include some combination of the following: alcohol and/or drug counseling sessions, participation in mutual help groups, structured, evidence-based psychosocial interventions, Federal Drug Administration-approved medications, residential treatment (when medically necessary), or some combination of these services.

PROCEDURE:

1.0 ACCESS

The Kern Health System (KHS) contract requires that for individuals identified as requiring alcohol or SUD treatment services, KHS must arrange for their referral to the Kern County Behavioral and

Recovery Services (KCBRS) for substance use treatment, for appropriate services provided through the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers available through the Medi-Cal fee-for-service program. KHS must assist members in locating available treatment service sites. To the extent that treatment slots are not available in the county alcohol and SUD treatment program within the KHS service area, KHS must pursue placement outside the area. The KHS must continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and SUD treatment and coordinate services between Primary Care Providers (PCP) and treatment programs. KHS must continue to identify individuals requiring alcohol and/or SUD treatment services and refer these individuals to Kern County Behavioral and Recovery Services (KCBRS). Treatment by a Network Provider must not be contingent on the individual complying with a referral to a county treatment program, and the services outlined in this APL must be covered whether an individual has accepted services from the county treatment program or not, as per APL 15-008, Professional Fees for Office Visits Associated with Alcohol and Substance Use Disorder Treatment Services.

KCBRS referrals should be made to the following address and/or phone number:

Kern County Behavioral and Recovery Services
2001, 28th Street
Bakersfield, California 93301
(661) 868-6600
24-hour crisis intervention (661) 868-8000

KHS assists members in locating available treatment service sites.[2] To the extent that treatment slots are not available in the KCBRS Alcohol and other Drugs Program, KHS pursues placement outside of Kern County.[3]

2.0 PROVISION OF SERVICES

2.1 Chemical Dependency

KHS covers psychotherapeutic medications, on the KHS formulary or approved with a TAR, prescribed by PCPs or KCBRS psychiatrists. Psychotherapeutic medications listed in Bulletin #420 are excluded from KHS coverage and should be billed to Fee-For-Service Medi-Cal.

KHS covers the History and Physical examination by a contract PCP if indicated prior to outpatient detoxification services and any associated laboratory studies.

Chemical dependency services are provided by and are the responsibility of KCBRS.

When KHS is aware of a member who is presenting in a general acute care hospital for Voluntary Inpatient Detoxification (VID) services who does not meet the medical necessity criteria above after clinical evaluation by a physician, KHS should refer the member to the county's behavioral health department for referral to other medically necessary substance use disorder (SUD) treatment services. KHS will provide care coordination to ensure members receive appropriate referrals to available county services.

2.2 SABIRT Requirements

Consistent with USPSTF Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, Kern Health Systems (KHS) must provide SABIRT services for members 11 years of age and older, including pregnant women, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations 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. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists. Further, MCPs must provide or arrange for the provision of:

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

For additional details regarding the policy, please refer to the Medi-Cal Provider Manual.7 In providing SABIRT services, Kern Health Systems (KHS) must comply with all applicable laws and regulations relating to the privacy of SUD records, as well as state law concerning the right of minors over 12 years of age to consent to treatment, including, without limitation, Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929

2.3 Screening

Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
- The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C) (see below)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

Individual Health Education Behavioral Assessment (IHEBA) performed within 60 calendar days of enrollment for members under the age of 18 months and within 120 calendar days for members over the age of 18 months; 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.

2.4 Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

2.5 Brief Interventions and Referral to Treatment

For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:

- Providing feedback to the patient regarding screening and assessment results;
- Discussing negative consequences that have occurred and the overall severity of the problem;
- Supporting the patient in making behavioral changes; and
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Kern Health Systems (KHS) must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the KHS must follow up with the member to understand barriers and make adjustments to the referrals if warranted. KHS should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to

necessary treatment tool. Coordination of services will follow guidelines outlined in the Memorandum of Understanding (MOU).

(In the Documentation Requirement section)
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.

(Included in section SABIRT requirements)
Chemical dependency services are provided by and are the responsibility of KCBRS. KHS must ensure that members who, upon screening and evaluation, meet the criteria for an AUD as defined by the current DSM (DSM-5, or as amended), 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 a DHCS-certified treatment program.

2.6 Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument (unless the
- screening tool is embedded in the electronic health record);
- The name of the assessment instrument (when indicated) and the score on the assessment (unless
- the screening tool is embedded in the electronic health record); and
- If and where a referral to an AUD or SUD program was made.

Kern Health Systems (KHS) must ensure that PCPs maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. Additionally, KHS must include information about SABIRT services in their member-informing materials. (See above)

3.0 Tobacco Cessation

KHS covers comprehensive tobacco cessation services including Federal Drug Administration (FDA) approved medication and individual, group and telephone counseling.

3.1 FDA-Approved Tobacco Cessation Medication (for non-pregnant adults of any age)

All FDA-approved tobacco cessation medications for adults who use tobacco products. 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.

Magellan is their Pharmacy Benefits Manager Customer Service telephone number 800-977-2273. Prior Authorization Request Fax number 800-869-4325

- While counseling is encouraged, KHS will not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication.
- Effective 1/1/2022 medications are carved out to Medi-Cal and members will be instructed to contact DHCS' Pharmacy Benefits Manager's Customer Service telephone number at 1-800-977-2273. Prior Authorization Request must be Faxed to1-800-869-4325.

3.2 Individual, Group, and Telephone Counseling for Members of Any Age Who Use Tobacco Products

KHS covers individual, group and telephonic counseling for Members of any age who use tobacco products by*:*

- Collaborating with the county tobacco control program to identify other local group tobacco cessation counseling resources.
- Ensuring that individual, group, and telephone counseling is offered to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications;
- Ensuring that providers review the SHA's questions on tobacco use with members which will constitute individual counseling when the conditions in Policy Letter (PL) 13-001 are met;
- Encouraging that providers or other office staff use the "5 A's" (**A**sk, **A**dvise, **A**ssess, **A**ssist, and **A**rrange), the "5 R's" (**R**elevance, **R**isks, **R**ewards, **R**oadblocks, and **R**epetition), or other validated behavior change models when counseling members;
- Ensuring that a minimum of four (4) counseling sessions of at least ten (10) minutes in duration are covered for at least two separate quit attempts per year without prior authorization. KHS must offer individual, group, and telephone counseling without cost to the members;
- Ensuring that providers refer members to the Kick It California (formerly the California Smokers' Helpline), a free statewide quit smoking service operated by the University of California San Diego (see below) or other comparable quit line services; and
- Encouraging providers to refer members to the Health Education department through the provider portal, use the Kick It California web referral, or if available, the e-referral systems.

3.3 Services for Pregnant Women

Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant members should be offered tailored, one-on-one counseling exceeding minimal advice to quit smoking.

KHS will require that providers will, at a minimum:

- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. Pregnant members who smoke should get assistance with quitting throughout their pregnancy.
- Offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law.
- Refer pregnant members who use tobacco to a tobacco cessation quit line, such as the Helpline. These tobacco cessation counseling services are covered for 60 days after delivery, plus any additional days needed to end the respective month.
- Refer to the tobacco cessation guidelines provided by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy. KHS shall post ACOG guidelines on the KHS website for providers.

3.4 Prevention of Tobacco Use in Children and Adolescents

KHS will cover medically necessary tobacco cessation services to members, including counseling and pharmacotherapy, as required for children up to age 21 under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Coverage includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

KHS requires that primary care providers provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-age children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

4.0 COORDINATION OF CARE

KHS continues to cover and provide primary care and other services unrelated to the alcohol and substance abuse treatment.[4] KHS coordinates services between the PCP and the treatment programs.[5]

4.1 PCP and KCBRS Chemical Dependency Provider Responsibilities

KHS PCPs forward pertinent medical records/documentation to KCBRS. KCBRS providers are responsible for communicating with the member's PCP as needed and appropriate and for supplying the PCP with appropriate medical records/documentation.

KHS PCPs are responsible to monitor that the member is following up with chemical dependency appointments. KHS Case Mangers assist PCPs who are encountering difficulty referring members for services or who are having difficulty with non-compliant members, by contacting the member/KCBRS to determine the nature of the difficulty and intercede/facilitate

as needed.

KHS Providers continue to provide care for the physical health of the member, and the PCP communicates with the member's chemical dependency provider as needed and appropriate.

After consultation with the member's PCP, the KCBRS chemical dependency provider refers the member back to the PCP for ongoing care at such time that it is determined that the member no longer requires care from the KCBRS provider. The PCP provides ongoing medical care and refers back to KCBRS for chemical dependency follow-up as needed.

4.2 Hospitalization of a Member

If a member is hospitalized for chemical dependency services and requires medical treatment, the admitting chemical dependency Provider will contact the PCP for consultation and development of treatment plan. Members who require transfer to a medical bed for treatment of a medical condition are transferred by the PCP to the appropriate level of acute care. The chemical dependency provider continues to consult with the PCP regarding treatment of the member. When medically stable, the member is either discharged by the PCP with appropriate follow-up by KCBRS chemical dependency provider and the PCP or transferred back to the inpatient treatment facility by the chemical dependency provider. Upon discharge, the member is instructed to follow-up with the KCBRS chemical dependency provider and the PCP, as appropriate.

Medical criteria for inpatient admission for VID must include one or more of the following:

1. Delirium tremens, with any combination of the following clinical manifestations with cessation or reduced intake of alcohol/sedative:

- Hallucinations
- Disorientation
- Tachycardia
- Hypertension
- Fever
- Agitation
- Diaphoresis

2. Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) form score greater than 15.

3. Alcohol/sedative withdrawal with CIWA score greater than 8 and one or more of the following high-risk factors:

- Multiple substance abuse
- History of delirium tremens
- Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care
- Medical co-morbidities that make detoxification in an outpatient setting unsafe
- History of failed outpatient treatment
- Psychiatric co-morbidities
- Pregnancy

- History of seizure disorder or withdrawal seizures

4. Complications of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following factors:
- Persistent vomiting and diarrhea from opioid withdrawal
- Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care

Detoxification of cannabinoids, stimulants, or hallucinogens alone does not require an inpatient level of medical intervention; however, multiple substance abuse with components of alcohol, opiates, or sedatives may be considered for inpatient admission.

To receive VID services, KHS will refer members to VID service providers in general acute care hospitals. The VID provider facility must not be a Chemical Dependency Treatment Facility or an Institution for Mental Disease. The VID service provider must submit a Treatment Authorization Request (TAR) to local Medi-Cal field offices for authorization. KHS will provide care coordination with the VID service provider as needed. Documentation that is submitted with the TAR should verify that admission criteria as outlined above are met as well as demonstrate the medical necessity for the inpatient stay.

4.3 KHS and KCBRS Liaisons

There is a designated liaison for KHS who serves as the liaison for KCBRS. Issues which require resolution are directed to these individuals for discussion and problem resolution.

4.4 Identifying Tobacco Users

PCP's are responsible for identifying and tracking tobacco users. KHS will monitor provider compliance for identifying tobacco users and will utilize track tobacco users for better coordination of tobacco cessation benefits as required through the review of:

- PM160's
- The SHA during chart reviews
- The NME program

All reviews resulting in identified tobacco users are forwarded to the Health Education Department.

4.4.1 Tracking Treatment Utilization of Tobacco Users

KHS will track treatment utilization of tobacco use through the review of utilization data from the *Tobacco Registry Report* (See Attachment A) that includes internal data from provider and pharmacy claims encounters.

5.0 Medical Necessity for Non-Specialty Mental Health

In accordance with 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 EPSDT

standard set forth in Section 1396d(r)(5) of Title 42 of the USC.
The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that could be covered under a Medicaid State Plan (as described in 42 USC 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.

Consistent with federal guidance from CMS, 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 and are thus medically necessary and are 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.

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

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies, and supplements.

KHS must provide or arrange for the provision of NSMHS 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 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.

In addition to the above requirements, KHS must provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder. KHSs are also required to 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.

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.

Consistent with state law, clinically appropriate and covered NSMHS are covered by KHS 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 substance use disorder (SUD); or
- NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

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 is obligated to 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 must cover outpatient laboratory tests, drugs, supplies, and supplements prescribed by mental health providers in the KHS 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 the KHS provider network, subject to a medical necessity determination.

Consistent with APL 21-006 or subsequent guidance, KHS must ensure that its network is adequate to provide the full range of covered NSMHS to its members. KHS must also cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). 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 medically necessary to stabilize the member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

6.0 Case Management

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 MHP. 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 14184.402KHS 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.

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 network provider. KHS will notify beneficiaries 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 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 policies 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. Including voluntary inpatient detoxification as a benefit available to KHS members through the Medi-Cal fee-for-service program,

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.

7.0 CO-OCCURRING SUBSTANCE USE DISORDER

Clinically appropriate and covered NSMHS delivered by Kern Health Systems 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 Kern Health Systems 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.

8.0 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 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.

9.0 PROVIDER AND MEMBER EDUCATION

9.1 Chemical Dependency Provider Education

KHS providers are educated regarding chemical dependency carve-outs, PCP responsibilities, and referral procedures through Provider Orientations and the *Provider Administrative Manual.*

9.2 Tobacco Cessation Member Education

KHS will provide information to members who use tobacco about the availability of tobacco cessation services and identify those that are provided at no cost. Members are given the option of choosing which services to use. Additionally, KHS coordinates with the agency providing the tobacco cessation services to pay for the cost of the member to receive those services.

9.3 Tobacco Cessation Provider Education

KHS will use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update," for provider training on tobacco cessation treatments. This document informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women. KHS will encourage providers to implement the USPHS' comprehensive tobacco use treatment recommendations.

KHS will include tobacco cessation training with other provider trainings as required in DHCS contracts. These trainings must include:

- Requirements for comprehensive tobacco cessation member services included in this policy in accordance with APL 16-014;
- Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008";
- How to use and adopt the "5 A's", the "5 R's", or other validated model for treating tobacco use and dependence in the provider's clinic practice;
- Special requirements for providing services for pregnant tobacco users; and
- Advising providers about available online courses in tobacco cessation. These resources are posted on the KHS website.

10.0 CONFIDENTIALITY

KHS and KHS contracted providers will maintain and protect the confidentiality of members' medical information regarding inpatient and outpatient alcohol and drug services. Confidentiality of member information is described in *KHS Policy and Procedure* # 14.03-I , Protected Health Information.

11.0 DELEGATION OVERSIGHT

The KHS Clinical Intake Coordinator or Social Worker 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.

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

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.

ATTACHMENTS

- Attachment A: Tobacco Registry Report

REFERENCE:

Revision 2022-07 to 2022-05: Policy revised to comply with APL 22-005; APL 22-006 by Director of Utilization Management and CHSO. Policy received DHCS approval on 7/26/2022 and DMHC approval on 11/16/2022, Filing No. 20223759.
DHCS approved revisions for APL 21-014 on 3/8/22. **Revision 2021-11:** Policy revised to comply with APL 21-014 by Director of Utilization Management [1] USPSTF, Kris et al., Screening for Unhealthy Drug Use: US Preventive Services Task Force Recommendation Statement (June 9, 2020) 323 (22) JAMA 2301, is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening. [2] USPSTF, Curry et al., Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement (November 13, 2018) 320 (18) JAMA 1899, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions. [3] For information about the EPSDT benefit, see APL 19-010. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx. [4] Information about the AAP/Bright Futures initiative and the most recent periodicity schedule and guidelines is available at: https://brightfutures.aap.org/Pages/default.aspx.
Revision 2019-10: Policy revised to comply with APL 18-001 by Senior Director of Health Services. **Revision 2018-10:** Policy revised to comply with APL 18-014 by Administrative Director of Health Services. [1] **Revision 2018-02:** DHCS Approved 2/28/2018. Policy revised to comply with MIT 19K for the provision of Alcohol Misuse Screening and Counseling (AMSC). **Revision 2017-04:** Policy revised to comply with ALP 16-014. Titles updated. **Revision 2014-08:** Policy submitted as part of DMHC Mental Health Carve-In(12-2013) Material Modification. DMHC

approval pending as of 08/2014. **Revision 2009-03:** Routine revision. **2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).

[2] DHS Contract A-11 (6)

[3] DHS Contract A-11 (6)

[4] DHS Contract A-11 (6)

[5] DHS Contract A-11 (6)

Attachment A

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16

Member Source ID	Tobacco User	Pregnant Tobacco User	Prior Tobacco User	Cessation Product	Cessation Counseling	Tobacco Exposure	Newborn Tobacco Exposure	New Member Question	Number of Conditions Met
[redacted]									

KERN HEALTH SYSTEMS

Generated Reporting System

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16