Policy:	GG.1900
Title:	**Behavioral Health Services**
Department:	Medical Management
Section:	Behavioral Health Integration
CEO Approval:	*/s/ Michael Hunn 02/06/2025*
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Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes access to Behavioral Health Services for Medi-Cal Members.

II. POLICY

A. CalOptima Health shall offer the following Non-Specialty Mental Health Services (NSMHS) when they are recommended by a licensed health care professional acting within the scope of his or her license:

1. Individual/group/family mental health evaluation and treatment (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 for medication management;

5. Laboratory testing that may include tests to determine a baseline assessment before prescribing psychiatric medications, or to monitor side effects from psychiatric medications. Supplies may include outpatient laboratory, drugs, supplies and supplements;

6. Treatment for Members who are diagnosed with feeding or eating disorders;

7. Screening, Brief Interventions and Referral to Treatment (SBIRT) Services to Members ages eleven (11) years and older, including pregnant women, in accordance with CalOptima Health Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services.

8. Family therapy (composed of two (2) or more family members) for adult Members with a mental health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.

    a. Consistent with Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, the EPSDT benefit requires that

CalOptima Health is required to provide family therapy services if needed to correct or ameliorate a child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

b. Both children and adult Members can receive family therapy mental health services that are Medically Necessary. CalOptima Health must provide family therapy to the following Medi-Cal Members to improve parent/child or caregiver/child relationships and bonding, resolve conflicts, and create a positive home environment:

i. DHCS permits Members under age twenty-one (21) to receive up to five (5) family therapy sessions before a mental health diagnosis is required. CalOptima Health must provide family therapy without regard to the five (5) visit limitation for Members under age twenty-one (21) with risk factors for mental health disorders, including neo-natal or pediatric intensive care unit hospitalization, separation from a parent/caregiver due to incarceration, immigration, or military deployment, death of a parent or caregiver, foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/persistent bullying; and discrimination.

ii. Members under age twenty-one (21) who have a parent(s) or caregiver(s) with one (1) or more of the following risk factors including: A serious illness or disability, history of incarceration depression or other mood disorder, Post-Traumatic Stress Disorder or other anxiety disorder, Psychotic disorder under treatment, Substance Use Disorder (SUD), Job loss, history of intimate or is a teen parent.

iii. Any diagnostic criteria used should be age-appropriate. For example, for young children, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) should be utilized to help practitioners more accurately identify diagnosis in young children who do not have language skills or exhibit the same symptoms as older children and adults.

9. Dyadic Services

a. Dyadic Services benefit is a family and caregiver focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified and is designed to support the implementation of comprehensive models of dyadic care that works within the pediatric clinic setting to identify and address caregiver and family risk factors for the benefit of the child.

b. Dyadic Services do not require prior authorization and include, in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-029: Dyadic Services and Family Therapy Benefit. CalOptima Health will not establish unreasonable arbitrary barriers for accessing coverage.

i. Dyadic Behavioral Health (DBH) well-child visits;

ii. Dyadic Comprehensive Community Supports Services;

iii. Dyadic Psychoeducational Services;

iv. Dyadic Family Training and Counseling for Child Development; and

v. Dyadic Parent or Caregiver Services.

c. Children Members under age twenty-one (21), and their parents or caregivers shall be eligible for Dyadic Care Services. The parents or caregivers do not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

d. DBH are provided for the child and caregiver(s) or parent(s) at medical visits, providing screening for behavioral health problems, interpersonal safety, tobacco and substance misuse and social drivers of health (SDOH), such as food insecurity and housing instability, and referrals for appropriate follow-up care.

e. In accordance with the NSMHS Psychiatric and Psychological Services section of the Provider Manual, Dyadic Services may be provided by: Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician.

   i. Appropriately trained nonclinical staff, including Community Health Workers (CHW), are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the DBH visit, as long as the screening is not separately billed.

   ii. Under the supervision of a supervising Provider from one of the provider types listed above, CHWs who meet the qualifications listed in the Community Health Worker (CHW) Preventive Services section of the Provider Manual can assist a dyad to gain access to needed services to support their health, through the CHW benefit for health navigation services described in DHCS APL 22-029: Dyadic Services and Family Therapy Benefit.

f. CalOptima Health must reimburse Dyadic Comprehensive Community Supports Services as outlined in Section III.F. of this Policy, when provided by a licensed Provider.

g. CalOptima Health is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating their Network Providers on the Dyadic Services benefit.

h. Dyadic caregiver services may be provided by the medical well-child Provider, in addition to the Provider types listed above.

i. Dyadic Services benefit can occur through Telehealth or in-person with locations in any setting including, but not limited to, pediatric primary care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based-sites, or community settings. There are no service location limitations.

j. There are no restrictions as to where Dyadic Services can be performed. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) Providers should refer to the Telehealth section in Part 2 of the Provider Manual identified in APL 22-029: Dyadic Services and Family Therapy Benefit for guidance regarding providing services via Telehealth.

B. CalOptima Health shall coordinate NSMHS and SUD services considered to ameliorate, sustain, support, improve, or make more tolerable a mental health or substance use condition.

C. CalOptima Health shall be responsible for:

1. Covering and paying for all Medically Necessary Medi-Cal covered physical health care services for a Member receiving SMHS;

2. 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 CalOptima Health's Provider network; and

3. The physical health components of eating disorder treatment, and NSMHS.

4. Development and implementation of an annual outreach and education plan in compliance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-012: Non-Specialty Mental Health Services (NSMHS): Member Outreach, Education, and Experience Requirements. The purpose of the annual outreach and education plan is to ensure Members and Primary Care Providers (PCPs) are informed about covered NSMHS.

   a. The outreach and education plan shall:

      i. Meet cultural and linguistic appropriateness services standards, incorporate evidence-based best practices in stigma reduction, and provide multiple points of contact for Members to access NSMHS.

      ii. Align with population needs assessment and utilization assessment to ensure outreach efforts are targeted to specific populations needs and effectively meets the needs of our Members.

      iii. Specify how the outreach and education plan was informed by various committees including but not limited to the Member Advisory Committee (MAC), Provider Advisory Committee (PAC), and Quality Improvement Health Equity Committee (QIHEC).

      iv. Specify the coordination with Orange County Behavioral Health Plan (OCBHP) managed by the Orange County Health Care Agency (OCHCA) Behavioral Health Services (BHS) including collaboration with OCHCA Mental Health Services Act coordinator for additional guidance.

      v. Specify how CalOptima Health would coordinate with tribal liaisons to incorporate tribal partner input and address continuity of care for American Indian Members, following guidance on cultural humility and trauma-informed care, when a tribe exists in Orange County. On an annual basis, CalOptima Health shall continue to monitor tribal presence to ensure participation and inclusion of tribal communities within Orange County.

      vi. Align outreach efforts with the CalAIM No Wrong Door Policy to ensure timely access to services and uninterrupted treatment relationships.

   b. CalOptima Health shall publicly post the annual DHCS-approved Member and Provider outreach and education plan, including the utilization assessment that was used to develop the outreach and education plan on the CalOptima Health website.

   c. CalOptima Health shall review and update the DHCS-approved Member and Provider outreach and education plan annually. If there are no updates necessary, CalOptima Health shall send an email attestation to DHCS justifying why no updates are necessary.

D. A contracted Provider providing postpartum care to CalOptima Health shall cover up to twenty (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 in accordance with the DHCS APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services.

E. For Members under the age of twenty-one (21), CalOptima Health shall provide Medically Necessary NSMHS listed in Section II.A. of this Policy, regardless of the severity of the impairment.

F. CalOptima Health shall not impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by CalOptima Health, in accordance with the parity in mental health and SUD requirements in Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K.

G. CalOptima Health shall use the most current DHCS approved screening and transition of care tools to assess the Member's disorder, level of impairment, and appropriate care needed. The screening and transition of care tools consist of:

   1. For Members under twenty-one (21) years of age, the Youth Screening Tool will be used.

   2. For Members over age twenty-one (21) years of age, the Adult Screening Tool will be used.

   3. The Transition of Care Tools will be used for all Members, including adults aged twenty-one (21) and older and youth under twenty-one (21) years of age.

H. Through a network of licensed mental health care Providers, CalOptima Health shall provide Behavioral Health Services to Members with mild to moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual , individual, family and group mental health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a mental health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

I. CalOptima Health and Health Network contracted Providers within their scope of practice shall provide SBIRT Services to Members in accordance with DHCS APL 21-014: Alcohol and Drug Screening, Assessment, Brief interventions and Referral to Treatment and the CalOptima Health Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services.

J. CalOptima Health shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with CalOptima Health Policies HH.3006: Tracking and Reporting Disclosures of Protected Health Information, HH.3010: Protected Health Information Disclosures Required by Law, and HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations.

K. CalOptima Health shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with CalOptima Health Policies HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

L. CalOptima Health shall maintain and monitor Network Providers to ensure timely access to Behavioral Health Services as set forth by DHCS, the Department of Managed Health Care (DMHC), and CalOptima Health Policy GG.1600: Access and Availability Standards.

1. Network Providers can deliver Behavioral Health Services in person or by telehealth, in accordance with DHCS APL 23-007: Telehealth Services Policy, and CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, GG.1304: Continuity of Care During Health Network or Provider Termination, GG.1508: Authorization and Processing of Referrals, and GG.1665: Telehealth and Other Technology-Enabled Services.

M. Behavioral Health Services that are the responsibility of CalOptima Health that are unavailable to the Member within the network, CalOptima Health shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

N. CalOptima Health shall not require a referral from a PCP or medical Provider, or Prior Authorization for an initial mental health assessment performed by a network mental health Provider.

1. If there are no Network Providers that can complete the necessary service within the applicable timely and access requirements, then CalOptima Health shall cover the cost of an initial mental health assessment completed by an out-of-network Provider.

2. CalOptima Health shall notify Members through Member-informing materials that referral and Prior Authorization are not required for a Member to seek an initial mental health assessment from a mental health Network Provider.

O. Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with CalOptima Health Policies GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services, and GG.1549: Psychological Testing for Mental Health Conditions. Prior Authorization requirements shall be in compliance with the requirements for parity in mental health and SUD benefits in Title 42 CFR section 438.910(d).

P. CalOptima Health shall maintain a twenty-four (24) hours per day/seven (7) days per week direct telephone line for emergencies during non-business hours for Members to access and for Providers to coordinate care with the CalOptima Health Behavioral Health Line or emergency room personnel during a crisis.

1. CalOptima Health shall ensure:

a. Timely access to screening of Members for Behavioral Health Services;

b. Appropriate staffing levels of the call center; and

c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

2. CalOptima Health shall ensure its call center staff have relevant knowledge to:

a. Provide information regarding Covered Services;

b. Identify the location, qualifications, and availability of Network Providers;

c. Inform Members of their rights and responsibilities, in accordance with CalOptima Health Policy DD.2001: Member Rights and Responsibilities;

d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with CalOptima Health Policies HH.1102: Member Grievance and GG.1510: Member Appeal Process;

e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and GG.1510: Member Appeal Process;

f. Access oral interpretation services and written materials in Threshold Languages for Members;

g. Provide information on other community services or resources available to Members; and

h. Educate the Member regarding the procedure and department at CalOptima Health to contact if the Member would like to change their Health Network or has questions about Health Network options.

Q. CalOptima Health shall identify and refer an eligible Member to the OCMHP OCHCA BHS for the provision of Medi-Cal Specialty Mental Health Services. OCHCA shall provide Specialty Mental Health Services to a Member, in accordance with Title 9, California Code of Regulations (CCR), and the Memorandum of Understanding between CalOptima Health and OCHCA.

R. CalOptima Health shall have a Memorandum of Understanding (MOU) with OCHCA which includes:

1. The division of financial responsibility;

2. A process for resolving a service delivery dispute between OCHCA and CalOptima Health 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, and complies with the requirements of DHCS APL 21-013: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans in accordance with Section III.F.6. of this Policy;

3. Inclusive of details about the responsibility for establishing contracts detailing payment mechanisms with Providers;

4. A requirement that any Medically Necessary service requiring shared responsibility requires coordinated case management and concurrent review by both CalOptima Health and OCHCA;

5. Specification of procedures to ensure timely and complete exchange of information by both CalOptima Health and OCHCA for the purposes of medical and behavioral health care coordination to ensure the Member's medical record is complete and CalOptima Health can meet its care coordination obligations; and

6. Maintain collaboration among the parties to the MOU including monitoring and assessing the effectiveness of MOUs. MOUs will be reviewed annually for any needed modifications or renewal of responsibilities and obligations.

S. CalOptima Health shall identify and refer an eligible Member to the OCHCA Drug Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

T. CalOptima Health shall ensure compliance with all applicable State requirements related to dispute resolutions between CalOptima Health and OCHCA, in accordance with DHCS APL 21-013: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans and CalOptima Health Policy GG.1103: Specialty Mental Health Services.

III. PROCEDURE

A. Medical Provider Responsibilities for Screening, Referral and Intervention for Behavioral Health and SUD Services

1. For SUD services, Providers within their scope of practice :

    a. Administer a DHCS most recent approved screening tool for identifying unhealthy alcohol and drug use in accordance with DHCS APL 21-014: Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment;

    b. Provide behavioral counseling intervention on identified issue(s);

    c. Provide Member referral for SBIRT Services for Members whose provider does not offer SBIRT Services. Prior Authorization is not required;

    d. Provide Member referral to SUD treatment when there is a need beyond SBIRT Services. Prior Authorization is not required;

    e. Refer a Member to the OCHCA DMC-ODS for additional assessment and counseling;

        i. If the OCHCA DMC-ODS does not have treatment slots available CalOptima Health will coordinate with the medical Provider and OCHCA to assist a Member with placement outside the Service Area;

    f. Refer a Member to additional community resources when needed and/or services are not available through OCHCA DMC-ODS;

    g. Refer a Member to outpatient heroin detoxification Providers through the OCHCA DMC-ODS , for appropriate services; and/or

    h. A PCP or medical Provider can access the CalOptima Health Behavioral Health Line for any coordination of care or assistance needed.

2. For mental health, a PCP or other medical Provider shall:

    a. Screen and provide mental health services within the scope of their practice; and/or

    b. Refer the Member for further mental health services through CalOptima Health's Behavioral Health Line, or the OCHCA OC MHP for SMHS as needed.

B. Accessing CalOptima Health Behavioral Health Services

1. A Member may access Behavioral Health Services through the CalOptima Health Behavioral Health Line for assistance with obtaining a mental health assessment from a licensed mental health Provider within the CalOptima Health's Provider network at any time.

2. A Member may be referred to the CalOptima Health Behavioral Health Line from the following:

    a. OCHCA's Orange County Behavioral Health Plan (OCBHP) Access Line or DMC-ODS;

    b. Self-referral;

    c. Authorized Representative or caregiver;

    d. PCP or other medical Provider;

    e. Specialty Care Provider;

    f. Behavioral health specialist;

    g. Long-Term Support Services (LTSS) Provider;

    h. Community-based agency;

    i. Internal CalOptima Health Departments including Population Health Management, Case Management, and Customer Service staff or discharge planner;

    j. External Enhanced Care Management (ECM) or other Community Support (CS) Providers; and

    k. Other Member identified health care team Providers.

C. CalOptima Health Behavioral Health Integration Call Center

1. CalOptima Health Behavioral Health Line Number: (855) 877-3885

2. CalOptima Health Behavioral Health Line requirements shall include:

    a. Available 24/7 complying with telephone access standards in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards;

    b. Utilizing linguistic interpreter services, or the California State Relay (711) for Members, as necessary to ensure effective communication;

    c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;

        i. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Orange County Social Services Agency for enrollment information and assistance. Staff also provides Members with any additional community resources.

    d. Identifying and triaging callers based on their initial reason for contacting the CalOptima Health Behavioral Health Line;

    e. Screening and determination for routine, Urgent or Emergent needs. If determined Urgent or Emergent, call center staff shall immediately complete safety screening;

i. If a Member needs are indicated as requiring Emergent or Urgent Services, call center staff shall make a referral to OCHCA's Centralized Assessment Team (CAT) and/or other appropriate emergency agencies;

ii. Call center staff will link Emergent calls immediately and/or not more than two (2) hours after determining the call is Emergent;

iii. Call center staff will link Urgent calls for services within twenty-four (24) hours after making the determination that the call is Urgent; and

iv. Call center staff will obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to services and/or the appropriate emergency agencies.

3. Screening and Assessment

a. If the Member is determined to be a Medi-Cal beneficiary assigned to CalOptima Health with a mental health need, the CalOptima Health Behavioral Health Line staff shall conduct a clinical screening with the DHCS most recent approved screening tool to verify appropriate level of services.

b. Adult and Youth Screening Tools are:

i. Not required or intended for use with Members who are currently receiving mental health services;

ii. Not required for use with Members who contact mental health Providers directly to seek mental health services; and

iii. Must be used by CalOptima Health when a Member, or a person on behalf of a Member under age twenty-one (21), who is not currently receiving mental health services, contacts CalOptima Health seeking mental health services.

c. Adult and Youth Screening Tools do not replace:

i. CalOptima Health Policies that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;

ii. CalOptima Health protocols that address clinically appropriate, timely, and equitable access to care;

iii. CalOptima Health clinical assessments, level of care determinations and service recommendations; and

iv. CalOptima Health requirements to provide EPSDT services.

d. The Adult Screening Tool includes screening questions that are intended to elicit information about the following:

i. Safety: information about whether the Member needs immediate attention and the reasons a Member is seeking services.

ii. Clinical Experiences: information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.

iii. Life Circumstances: information about challenges the Member may be experiencing issues related to school, work, relationships, housing, or other circumstances.

iv. Risk: information about suicidality, self-harm, emergency treatment, and hospitalizations.

v. Questions related to SUD.

a) If a Member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan for SUD assessment. The Member may decline this referral without impacting their mental health delivery system referral.

e. The Youth Screening Tool screening questions are intended to elicit information about the following:

i. Safety: information about whether the Member needs immediate attention and the reasons a Member is seeking services.

ii. System Involvement: information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.

iii. Life Circumstances: information about challenges the Member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.

iv. Risk: information about suicidality, self-harm, harm to others, and hospitalizations.

v. SMHS access and referral of other services, including but not limited to SUD services.

f. Scoring Methodology

i. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the Member must be referred to CalOptima Health or the OCHCA's OCMHP for clinical assessment and Medically Necessary services.

a) CalOptima Health must use the scoring methodology and follow the referral determination generated by the score.

b) For all referrals, the Member must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.

ii. The adult and youth screening tools:

a) Can be administered by clinicians or non-clinicians in alignment with CalOptima Health protocols, and may be administered in a variety of ways, including in person, by telephone, or by video conference.

b) Questions must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is

able to respond. Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.

4. Referral and Coordination

    a. If it is determined the Member meets mild to moderate need for Behavioral Health Services, the CalOptima Health Behavioral Health Line staff will provide the Member with referrals to appropriate Behavioral Health Services. The staff will ensure the Member is directed to Network Providers that are currently accepting CalOptima Health Medi-Cal Members, that can provide appropriate cultural and linguistic services, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services, and can offer a first appointment, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

    b. If it is determined the Member meets SMHS, the licensed clinician shall complete a warm transfer to OCHCA's OCMHP where the Member will be assessed for SMHS services and provided appropriate linkage.

    c. If further assessment and treatment for alcohol and/or substance use is determined, the CalOptima Health Behavioral Health Line staff shall warm transfer the Member to the OCHCA's DMC-ODS for services.

    d. Referral coordination must include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the Member. Members must be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.

    e. CalOptima Health Behavioral Health Line staff will provide ongoing assistance when needed and/or requested with Member or authorized representative to coordinate with OCHCA's OCMHP as needed to ensure proper linkage and support.

5. Transitions of Care

    a. CalOptima Health is required to administer the transition of care tool to facilitate transitions of care to OCHCA's OCMHP for all Members, including adults aged twenty-one (21) and older and youth under age twenty-one (21), when their service needs change.

    b. The transition of care tool is used by both adults and youth and intended to document the Member's information and provide information from the entity making the referral to the receiving delivery system to begin the Member's care transition.

    c. Transition of care tools may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure Members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.

    d. Transition of care tools are not considered an assessment and does not replace:

        i. CalOptima Health's Policies that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;

        ii. CalOptima Health's protocols that address clinically appropriate, timely, and equitable access to care;

iii. CalOptima Health's clinical assessments, level of care determinations, and service recommendations; and

iv. CalOptima Health's requirements to provide EPSDT services.

e. The transition of care tool includes specific fields to document the following elements:

i. Referring plan contact information and care team;

ii. Member demographics and contact information;

iii. Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications; and

iv. Requested services and plan contact information.

f. The contents, including the specific wording and order of fields in the adult and youth screening tools and transition of care tool, must remain intact and unchanged.

g. The determination to transition services to and/or add services from the OCHCA's OCMHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with CalOptima Health's protocols.

i. Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician.

ii. Members must be engaged in the process and appropriate consents must be obtained, in accordance with accepted standards of clinical practice.

h. Following the completion of the Transition of Care Tool, CalOptima Health shall:

i. Refer the Member to the OCHCA's OCMHP; and

ii. Coordinate Member care services with OCHCA's OCMHP to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the Member has been connected with a Provider in the new system, the new Provider accepts the care of the Member, and Medically Necessary services have been made available to the Member. All appropriate consents must be obtained in accordance with accepted standards of clinical practice.

D. No Wrong Door

1. Clinically appropriate and covered NSMHS delivered by CalOptima Health Providers are covered during the assessment process prior to the determination of a diagnosis or a determination that the Member meets criteria for NSMHS.

a. CalOptima Health will 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. CalOptima Health will coordinate with the OCHCA for ongoing appropriate level of care and ensure no duplication of services.

2. NSMHS Not Included in an Individual Treatment Plan

    a. Clinically appropriate and covered NSMHS delivered by CalOptima Health Providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan.

3. Concurrent NSMHS and SMHS

    a. Members may concurrently receive NSMHS from a CalOptima Health Provider and SMHS via OCHCA's OCMHP when the services are clinically appropriate, coordinated and not duplicative.

    b. When a Member meets criteria for both NSMHS and SMHS, the Member shall receive services based on the individual clinical need and established therapeutic relationships.

    c. Members with established therapeutic relationships with a CalOptima Health Provider may continue receiving NSMHS from the Provider (billed to CalOptima Health), even if the member simultaneously receives SMHS from an OCHCA's OCMHP Provider (billed to OCHCA), as long as the services are coordinated between the delivery systems and are non-duplicative.

    d. CalOptima Health must 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.

    e. CalOptima Health and OCHCA OCMHP shall coordinate any concurrent NSMHS and SMHS for adults, as well as children under twenty-one (21) years of age, to ensure Member choice and the appropriate ongoing level of care and supports are in place. In addition, CalOptima Health and OCHCA OCMHP 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.

E. Co-occurring Substance Use Disorder (SUD) Services:

1. Clinically appropriate and covered NSMHS delivered by CalOptima Health Providers are covered whether or not the Member has a co-occurring SUD.

2. CalOptima Health 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 CalOptima Health Providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment including Medication Assistant Treatment-MAT) are covered whether or not the Member has a co-occurring mental health condition in accordance with CalOptima Health Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services.

3. CalOptima Health will use the current DHCS most recently approved transition of care tool for coordinating care with OCHCA OCMHP.

4. Clinically appropriate, and covered SMHS are covered by OCHCA OCMHP, whether or not the Member has a co-occurring SUD. Similarly, clinically appropriate, and covered DMC services delivered by OCHCA's DMC-ODS services are whether or not the Member has a co-occurring mental health condition.

F. Care Coordination

1. CalOptima Health and its Health Networks shall coordinate care for Members enrolled in Enhanced Care Management (ECM) and/or Community Supports under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Service Delivery, GG.1354: CalAIM Enhanced Care Management - Eligibility and Outreach, and GG.1355: CalAIM Community Supports.

    a. CalOptima Health and its Health Networks shall ensure compliance with all applicable State and federal requirements related to ECM requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 23-032: Enhanced Care Management Requirements.

    b. CalOptima Health and a Health Network shall ensure Members are receiving appropriate and coordinated services.

2. CalOptima Health's Behavioral Health Integration (BHI) department shall ensure behavioral health care coordination with OCHCA OCMHP is addressed at the bimonthly interagency CalOptima Health/OCHCA Collaboration Meeting to ensure:

    a. Provision of all Medically Necessary Covered Services; and

    b. When CalOptima Health is determined to be responsible for covered Behavioral Health Services, CalOptima Health shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the OCHCA OCMHP.

    c. Transition of care is provided for Members transitioning to or from CalOptima Health or OCHCA OCMHP for mental health services. OCHCA's OCMHP clinical consultation, including consultation on medications, shall be provided to CalOptima Health's PCPs who are treating Members with mental illness.

3. Coordination of care for inpatient mental health treatment:

    a. OCHCA OCMHP requires that inpatient hospital Providers notify a Member's PCP within twenty-four (24) hours of admission and discharge from an inpatient mental health treatment to arrange for appropriate follow-up services.

    b. To facilitate transition of care for Members transiting to or from OCHCA OCMHP for mental health services, CalOptima Health's PCPs and the outpatient behavioral health Providers treating Members with mental illness shall receive clinical consultation, including consultation on medication from OCHCA OCMHP.

    c. CalOptima Health and contracted Health Network PCPs and the outpatient behavioral health Provider shall review and update the care plan of the Member as clinically indicated.

4. CalOptima Health and its Health Networks must coordinate costs and services for all Medically Necessary care for Members, including locating, arranging, and following up to ensure services

were rendered for medical services for partial hospitalization and residential eating disorder programs, when such treatment is Medically Necessary for a Member.

a. CalOptima Health and its Health Networks shall ensure compliance with all applicable State and federal requirements related as determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 22-003: Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders requirements.

5. Emergency Services

a. CalOptima Health shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission.

b. CalOptima Health shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's mental health or medical condition.

c. As the OCMHP, OCHCA provides emergency assessment of the Member's mental health condition.

d. CalOptima Health 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.

6. Information Exchange

a. CalOptima Health shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS)
B. CalOptima Health Policy DD.2001: Member Rights and Responsibilities
C. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Health Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services
E. CalOptima Health Policy GG.1103: Specialty Mental Health Services

F. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
G. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
H. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
I. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management - Eligibility and Outreach
J. CalOptima Health Policy GG.1355: CalAIM Community Supports
K. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
L. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Health Policy GG.1510: Member Appeal Process
N. CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
O. CalOptima Health Policy GG.1549: Psychological Testing for Mental Health Conditions
P. CalOptima Health Policy GG.1600: Access and Availability Standards
Q. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
R. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
S. CalOptima Health Policy HH.1102: Member Grievance
T. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
U. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Required by Law
V. CalOptima Health Policy HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
W. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information
X. CalOptima Health Non-Specialty Mental Health Services (NSMHS): Member and Provider Outreach and Education Plan
Y. Department of Health Care Services (DHCS) All Plan Letter (APL): 21-013: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (Supersedes APL 15-007)
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Supersedes APL 18-014)
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-003: Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders
BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005: No Wrong Door for Mental Health Services Policy
CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
DD. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-028: Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services
EE. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-029: Dyadic Services and Family Therapy Benefit
FF. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
GG. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
HH. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032: Enhanced Care Management Requirements (Supersedes APL 21-012)
II. Memorandum of Understanding with the Orange County Health Care Agency (OCHCA)
JJ. Title 9, California Code of Regulations (CCR), §§1810.370(a)(3), 1830.205 1830.210, and 1850.530
KK. Title 22, California Code of Regulations (CCR), §51337, and 53855

LL. Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K
MM. Title 42, Code of Federal Regulations (CFR), §438.910(d)
NN. Welfare and Institutions Code (WIC), §§14132.03, and 14189

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/04/2018	Department of Health Care Services (DHCS)	Approved As Submitted
06/29/2021	Department of Health Care Services (DHCS)	Approved As Submitted
06/20/2022	Department of Health Care Services (DHCS)	Approved As Submitted
07/15/2022	Department of Health Care Services (DHCS)	Approved As Submitted - AIR
07/29/2022	Department of Health Care Services (DHCS)	Approved As Submitted - AIR
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
05/17/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use
01/27/2025	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2014	GG.1900	Behavioral Health Services	Medi-Cal
Revised	07/01/2016	GG.1900	Behavioral Health Services	Medi-Cal
Revised	01/01/2018	GG.1900	Behavioral Health Services	Medi-Cal
Revised	11/01/2018	GG.1900	Behavioral Health Services	Medi-Cal
Revised	10/01/2019	GG.1900	Behavioral Health Services	Medi-Cal
Revised	03/01/2020	GG.1900	Behavioral Health Services	Medi-Cal
Revised	06/03/2021	GG.1900	Behavioral Health Services	Medi-Cal
Revised	01/01/2022	GG.1900	Behavioral Health Services	Medi-Cal
Revised	04/01/2023	GG.1900	Behavioral Health Services	Medi-Cal
Revised	10/01/2023	GG.1900	Behavioral Health Services	Medi-Cal
Revised	01/01/2024	GG.1900	Behavioral Health Services	Medi-Cal
Revised	12/31/2024	GG.1900	Behavioral Health Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Behavioral Health Services	Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorder (SUD) treatment.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with or without Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
CalOptima Health Behavioral Health Phone Line	Toll-free telephone number that Providers, Members, or individuals acting on behalf of Members can call at any time (twenty-four (24) hours per day/seven (7) days a week) to obtain referrals for all CalOptima Health Covered Outpatient Mental Health Services. This line has a live operator at all times and telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 2. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section

Term	Definition
	1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);

Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Dyadic Services	A family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.

Term	Definition
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Level of Care (LOC)	Criteria for determining admission to an LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.
Long Term Services and Supports (LTSS)	Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered 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 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered 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. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima Health for Medi-Cal Members that are delivered via managed care and include the following: 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 purposes of monitoring drug therapy 4. Psychiatric consultation. 5. Outpatient laboratory, drugs, supplies and supplements.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

Term	Definition
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Quality Improvement Health Equity Committee (QIHEC):	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Screening, Brief Intervention and Referral to Treatment (SBIRT) Services	Comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.
Serious Emotional Disturbance (SED)	Persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills
Service Area	The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services (SMHS)	A 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.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.

Term	Definition
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.
Unhealthy Alcohol Use	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. (Source: USPSTF)
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely mental health intervention that shall be appropriate to the severity for the condition.