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| Policy: | MA.7020 |
| Title: | **Behavioral Health Services** |
| Department: | Medical Management |
| Section: | Behavioral Health Integration |
| *CEO Approval:* | */s/ Michael Hunn 12/20/2024* |
| Effective Date: | 04/06/2023 |
| Revised Date: | 12/01/2024 |
| Applicable to: | ☐ Medi-Cal<br>☒ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy defines the scope of Behavioral Health Services for OneCare Members.

## II. POLICY

A. CalOptima Health shall offer the following Behavioral Health Services:

1. Inpatient mental health services
2. Outpatient mental health services:
    a. Clinic services;
    b. Day treatment including Partial hospitalization program (PHP) and Intensive outpatient program (IOP)
    c. Psychosocial rehab services;
    d. Individual/group mental health evaluation and treatment;
    e. Psychological testing;
    f. Electroconvulsive Therapy (ECT);
    g. Transcranial Magnetic Stimulation (TMS);
    h. Opioid Treatment Program (OTP);
    i. Outpatient services for the purposes of monitoring drug therapy;
    j. Outpatient laboratory, drugs, supplies and supplements; and
    k. Psychiatric consultation
3. Assessment screenings including mental health and substance use disorder (SUD) screenings

B. 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 in accordance with the parity in mental health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), section 438.900.

C. CalOptima Health and its Health Networks contracted Primary Care Practitioner/Physicians (PCPs) shall be responsible for screening and providing Behavioral Health Services within the scope of their practice.

D. CalOptima Health and its Health Networks 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 standards, when applicable, in accordance with CalOptima Health Policies HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI), HH.3010: Protected Health Information (PHI) Disclosures Required by Law, and HH.3011: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

E. CalOptima Health and its Health Networks 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.

F. CalOptima Health shall ensure timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and CalOptima Health Policy MA.7007: Access and Availability.

G. If Behavioral Health Services that are the responsibility of CalOptima Health are unavailable to the Member, CalOptima Health shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals, and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

H. CalOptima Health shall not require a referral from a Primary Care Practitioner/Physician (PCP) or Prior Authorization for an initial outpatient mental health assessment performed by a contracted mental health Provider.

I. CalOptima Health shall ensure that all contracted and non-contracting mental health Providers are informed of the Prior Authorization and referral process. Prior Authorization requirements for services covered by CalOptima Health shall be in compliance with the requirements for parity in mental health and substance use disorder benefits in Title 42 Code of Federal Regulations (CFR) section 438.910(d).

J. CalOptima Health shall follow authorization guidelines in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, GG.1508: Authorization and Processing of Referrals and GG.1501: Inpatient Length of Stay Assignment, when authorizing Behavioral Health Services.

K. CalOptima Health shall maintain a twenty-four (24) hour/seven (7) day week direct telephone line for emergencies and assistance during non-business hours.

L. CalOptima Health and its Health Networks shall identify and refer an eligible Member to the county behavioral health agency managed by the Orange County Health Care Agency (OCHCA) Behavioral Health Services (BHS) for the provision of Medi-Cal Specialty Mental Health Services (SMHS).

1. The county behavioral health agency, OCHCA shall provide SMHS to a Member, in accordance with Title 9, California Code of Regulations (CCR), sections 1820.205, 1830.205 and, and in accordance with CalOptima Health and OCHCA Coordination and Provision of Behavioral Healthcare Services Contract.

M. CalOptima Health and its Health Networks shall identify and refer an eligible Member to the Orange County Health Care Agency's Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

N. CalOptima Health and its Health Networks shall coordinate for all Medically Necessary physical health care services, emergency, and Non-Emergency Medical Transportation (NEMT) in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical, and for all covered psychotropic drugs for Members referred by OCHCA and Drug Medi-Cal Providers as per the Contract between CalOptima Health and OCHCA.

O. CalOptima Health and its Health Networks shall request and facilitate the participation of OCHCA in Interdisciplinary Care Team (ICT) conference.

P. CalOptima Health shall require interagency meetings occur at least quarterly to review the Care Coordination process and implement interventions to improve performance, where opportunities for improvement are identified.

Q. CalOptima Health and its Health Networks shall implement a mechanism for the identification and referral of quality of care and service delivery issues to CalOptima Health's Quality Improvement (QI) Department.

## III. PROCEDURE

A. Medical Provider Responsibilities for Screening, Referral and Intervention for Behavioral Health and Substance Use Disorder (SUD) Services include:

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

a. Administer an approved screening tool for identifying unhealthy alcohol or drug use;

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

c. Provide Member referral to SUD treatment when there is a need beyond screening or counseling interventions;

d. Refer a Member to the OCHCA DMC-ODS for additional assessment and counseling, if necessary;

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

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

f. A PCP or medical provider can access the CalOptima Health Behavioral Health Line for any Care Coordination 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 a Member for further mental health services through the CalOptima Health Behavioral Health Line, OCHCA 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 BHS Access Line or DMC-ODS;

b. Self-referral;

c. Authorized Representative or caregiver;

d. PCP or another medical provider;

e. Specialty Care provider;

f. Behavioral health provider , including clinical psychologist, clinical social worker, marriage and family therapists, mental health counselors/clinical professional counselors, Opioid Treatment Program (OTP) providers, community mental health centers, and those of the following who regularly furnish or will regularly furnish behavioral health counseling or therapy services;

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

h. Community-based agency;

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

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

k. Other Member's 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. 24/7 availability in compliance with telephone access standards in accordance with CalOptima Health Policy MA.7007: Access and Availability;

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

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

   i. If the caller is not a One Care Member and not in crisis, call center staff shall refer the caller to his/her primary health insurance and suggest a community resource for treatment of their described symptoms.

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 caller's needs are indicated as requiring Emergency or Urgent Services, call center staff shall make a referral to OCHCA's Centralized Assessment Team (CAT) and/or contact the other appropriate emergency agencies;

   ii. Call center staff must link emergent calls immediately, and/or not more than two (2) hours after the determination that the call is emergent;

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

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

f. If the caller is determined to be a beneficiary assigned to CalOptima Health with a mental health need, the call center licensed behavioral health clinicians shall conduct a clinical screening to determine the appropriate level of service.

3. Screening and Assessment:

   a. If it is determined the Member needs Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the CalOptima Health behavioral health network, are currently accepting CalOptima Health OneCare Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to CalOptima Health Policy MA.7007: Access and Availability.

   b. If CalOptima Health's screening suggests a Member qualifies for SMHS provided by the county behavioral health agency, then CalOptima Health will make a referral to the OCHCA for referral of services via secure protocol.

   c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to the OCHCA DMC-ODS for DMC services.

d. CalOptima Health and OCHCA, per the No Wrong Door Initiative, shall coordinate any concurrent services to ensure Member choice and the appropriate ongoing level of care and supports are in place. In addition, CalOptima Health facilitates care transitions ensuring that the referral loop is closed.

D. Prior Authorization

1. CalOptima Health shall process requests for Prior Authorization within the timeframes specified in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. CalOptima Health shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

   a. General Standards

      i. If CalOptima Health does not take action by approving, denying, deferring, or modifying services, on a routine written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service is sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

      ii. CalOptima Health shall maintain a system for tracking all referrals for Provider and Member-requested health care services and supplies. The system, at a minimum, must track:

         a) Referral turnaround time for issuing a determination;

         b) Criteria used in making the determination. If denied, deferred, or modified a copy of the Integrated Denial Notice (IDN) and

         c) Specific services approved, denied, deferred, or modified.

      iii. A Practitioner or Provider shall request Prior Authorization for services for a Member, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

      iv. Services Excluded from the Prior Authorization Process

         a) Emergency Services and emergency care do not require Prior Authorization, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

            1) CalOptima Health shall not require notification for Emergency Services and does not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

            2) CalOptima Health shall not refuse to cover Emergency Services based on the emergency room provider, or hospital or fiscal agent not notifying the Member's PCP or CalOptima Health of the Member's screening and treatment.

            3) CalOptima Health shall not require Prior Authorization for emergency care, following the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint is an emergency.

4) CalOptima Health shall treat a mental health emergency as an Emergency Medical Condition, under which the use of Prior Authorization would be prohibited for a minimum ninety (90) day transition period for any active course(s) of treatment when a Member has enrolled in CalOptima Health after starting a course of treatment.

v. Hospital Services

a) A contracted hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

b) All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

c) A decision will be made on an initial request within seventy-two (72) hours of the request.

d) Concurrent review will be completed every forty-eight (48) to seventy-two (72) hours during the inpatient stay.

vi. Provider

a) The Hospital/Provider shall provide Care Coordination with the Member's PCP and behavioral health specialist as appropriate.

b) The Hospital/Provider shall admit the Member to the appropriate Provider or Specialist Physician, based on the instructions from the Member's Health Network.

c) Hospital/Provider shall coordinate timely Discharge Planning so that the Member's anticipated needs are met, and discharge plan is continued to the next appropriate level of care following facility discharge.

vii. Additional Assistance After Discharge

a) CalOptima Health shall outreach to Members after discharge to assist with Care Coordination needs including but not limited to benefits, services, and community resources.

viii. Out-of-Network Services

a) CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

b) CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

ix. Prior Authorization Procedure

a) CalOptima Health's Behavioral Health (BH) Utilization Management (UM) unit shall provide Members, or potential Members, and/or Providers access to information, about the BH UM process, and the process for authorizing care, in the OneCare Evidence of Coverage and Provider Manual, available in-print and on the CalOptima Health website at www.caloptimahealth.org.

x. Denials, Dismissals, and Modifications of Prior Authorization Requests

a) CalOptima Health shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage.

b) In the event a Prior Authorization request is denied, dismissed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify in writing the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. Care Coordination and Case Management

1. Enhanced Care Management (ECM)

a. CalOptima Health and its Health Networks shall provide Care Coordination for Members enrolled in Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative in accordance with GG.1354: CalAIM Enhanced Care Management Eligibility and Outreach.

b. Members with Original Medicare, a Medicare Advantage Plan or a Dual-Eligible Special Needs Plan shall be authorized for ECM if they are referred, meet criteria for (1) one or more of the Populations of Focus (POF) and agree to participate.

2. SMHS

a. CalOptima Health and its Health Networks shall coordinate a Member's care with OCHCA to ensure:

i. The provision of all Medically Necessary Covered Services;

ii. The provision of care management while Members are receiving SMHS, in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process;

iii. Identification and referral of eligible Members to LTSS, community-based services and benefits, and Behavioral Health Services;

iv. OCHCA Provider or representative participate in the Member's ICT;

v. PCP provides copy of Member's Individual Care Plan (ICP) to OCHCA Provider;

vi. OCHCA updates PCP of changes; and

vii. PCP updates OCHCA Provider of changes.

3. SUDs

   a. CalOptima Health and its Health Networks shall ensure provision of care management while Members are receiving services from OCHCA DMC-ODS.

      i. The OCHCA DMC-ODS Provider, or representative, shall be invited to participate in the Member's ICT;

      ii. When the member is identified as actively receiving services with OCHCA and OCHA participates in the Interdisciplinary Care Team (ICT) meeting, CalOptima Health and/or the PCP shall provide a copy of the ICP to OCHCA.

      iii. The OCHCA DMC-ODS Provider shall provide updates to the PCP; and

      iv. The PCP shall provide updates to the OCHCA DMC-ODS.

F. Exchange of Protected Health Information (PHI)

   1. All Providers rendering services to the Member shall ensure that only the minimum information necessary will be exchanged in accordance with the terms and conditions of this policy and CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls, in order to protect the Member's privacy to the fullest extent. This information will be exchanged in an effort to provide coordination between medical and behavioral health services.

   2. CalOptima Health and its Health Networks or the OCHCA shall ensure that there is a Release of Information signed by the Member. The form shall:

      a. Be signed within the current Episode of Care (EOC), established either upon the opening of a new Member case or if currently under OCHCA Provider care, as discovered during Member's annual medical visit;

      b. Identify CalOptima Health, OCHCA, OCHCA Drug Medi-Cal, and/or other program(s) providing services in which information should be shared;

      c. Identify which types of information can be shared;

      d. Be placed in the Member's chart along with other Releases of Information; and

      e. Be void at the end of the current EOC and require renewal upon each new EOC.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. Coordination and Provision of Behavioral Healthcare Services Contract/MOU between CalOptima Health and OC MHP
B. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management Eligibility and Outreach
C. CalOptima Health Policy GG.1501: Inpatient Length of Stay (LOS) Assignment
D. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical

E. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
H. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
I. CalOptima Health Policy GG.1900: Behavioral Health Services
J. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
K. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)
L. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Required by Law
M. CalOptima Health Policy HH.3011: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
N. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
O. CalOptima Health Policy MA.6009: Care Management and Coordination Process
P. CalOptima Health Policy MA.6042: Integrated Organization Determinations
Q. CalOptima Health Policy MA.7007: Access and Availability
R. CalOptima Health Utilization Management Program
S. Title 9, California Code of Regulations (CCR), §§ 1820.205, 1830.205, and 1830.210
T. Title 22, California Code of Regulations (CCR), §§ 51159, 51303, and 54301
U. Title 42, Code of Federal Regulations (CFR), Section 438.900

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 04/06/2023 | Regular Meeting of the CalOptima Health Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 04/06/2023 | MA.7020 | Behavioral Health Services | OneCare |
| Revised | 02/01/2024 | MA.7020 | Behavioral Health Services | OneCare |
| Revised | 12/01/2024 | MA.7020 | Behavioral Health Services | OneCare |

## IX. GLOSSARY

| Term | Definition |
|---|---|
| Appeal | As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. |
| Authorized Representative | A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. |
| Behavioral Health Services | Services which encompass both mental health and substance use disorder services, as covered by CalOptima Health. |
| CalOptima Health Behavioral Health Line | Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/ 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:<br><br>1. Have authority to approve Covered Services;<br>2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or<br>3. 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 may be a Grievance or an Appeal, or a single Complaint could include both. |
| Care Coordination | A collaborative process of assessment, planning facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes. |
| Covered Services | Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under Center for Medicare & Medicaid Services (CMS). |
| Department of Managed Health Care (DMHC) | The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended. |

| Term | Definition |
|---|---|
| Drug-Medi-Cal Organized Delivery System (DMC-ODS) | Program under which each county enters into a contract with the Department of Health Care Services (DHCS) for the provision of a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. |
| Grievance | An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. |
| Emergency Medical Condition | A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:<br><br>1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;<br>2. Serious impairment to bodily function; and/or<br>3. Serious dysfunction of any bodily organ or part. |
| Emergency 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. |
| Episode of Care (EOC) | The set of services provided to treat a clinical condition or procedure. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network. |
| Individual Care Plan (ICP) | A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of their disease process, and lifestyle choices. |
| Interdisciplinary Care Team (ICT) | A team comprised of the Primary Care Provider and Care Coordinator, and other Providers at the discretion of the Member, that work with the Member to develop, implement, and maintain the Individual Care Plan (ICP). |
| Long Term Services and Supports (LTSS) | A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following:<br><br>1. In-Home Supportive Services (IHSS);<br>2. Community-Based Adult Services (CBAS);<br>3. Multipurpose Senior Services Program (MSSP) services; and<br>4. Skilled Nursing Facility services and subacute care services. |
| Medically Necessary / Medical Necessity | The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. |

| Term | Definition |
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| Medi-Cal Specialty Mental Health Services (SMHS) | Specialty mental health services are provided through a Mental Health Provider, in accordance with Chapter 11 of Division 1 of Title 9 of the CCR and include:<br><br>1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;<br>2. Psychiatric inpatient hospital services;<br>3. Targeted Case Management;<br>4. Psychiatrist services; and<br>5. Psychologist services. |
| Member | A beneficiary enrolled in the CalOptima Health OneCare program. |
| Mental Health Plan (MHP) | Pursuant to California Code of Regulations, Title 9 section 1810.226, an MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity. |
| Minimum Necessary | The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment, or Health Care Operations. |
| Non-Emergency Medical Transportation (NEMT) | 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. |
| Primary Care Practitioner/Physician (PCP) | A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, “Primary Care Practitioner” or “PCP” shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic. |
| Prior Authorization | A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. |

| 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.<br><br>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:<br><br>1. The past, present, or future physical or mental health or condition of a Member;<br>2. The provision of health care to a Member; or<br>3. Past, present, or future Payment for the provision of health care to a Member. |
| Provider | Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. |
| Prudent Layperson | A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to their health in an emergency. |
| Specialist Physician | A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Physician. |
| Specialty Care | Refers to higher-level medical services that require a referral from a primary care provider. Physicians who provide specialty care undergo extensive training to “specialize” in a given area of medicine, for example, oncology, cardiology, etc. |
| Threshold Languages | A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program. |
| 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. |