PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3028 (previously UP100328)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Mental Health Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1995</td><td colspan="4">Next Review Date: 01/08/2026
Last Review Date: 01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/08/2025</td></tr>
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I. **RELATED POLICIES**:
   A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
   B. ADM52 – Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services
   C. CMP36 – Delegation Oversight and Monitoring
   D. MCUG3024 – Inpatient Utilization Management
   E. MCUP3014 – Emergency Services
   F. MCUP3101 – Screening and Treatment for Substance Use Disorders
   G. MCUG3118 – Prenatal & Perinatal Care
   H. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
   I. MCQG1015 – Pediatric Preventive Health Guidelines

II. **IMPACTED DEPTS**:
   A. Health Services
   B. Claims
   C. Member Services
   D. Behavioral Health

III. **DEFINITIONS**:
   A. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
   B. Dyad: A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad.
   C. 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 work within the pediatric clinic setting to identify and address caregiver and family risk factors for the benefit of the child.
   D. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's delegated managed behavioral healthcare organization is Carelon Behavioral Health.
   E. (MCP) Managed Care Plan: Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.
   F. (MHP) Mental Health Plan: A county Mental Health Plan in Partnerships' service area. MHPs are

required to provide and cover all medically necessary SMHS in accordance with their contracts with DHCS.

G. Medical Necessity: Medically necessary services are reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

H. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: (California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

I. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*
Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:
1. Mental health evaluation and treatment, including individual, group and family psychotherapy
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

J. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*
County Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.

I. Wellness & Recovery Program: Partnership's regional Drug Medi-Cal Organized Delivery System waivered program (substance use treatment services) in seven counties within Partnership's service area.

IV. ATTACHMENTS:
A. Adult Screening Tool
B. Youth Screening Tool
C. Transitions of Care Tool

V. PURPOSE:
To describe the means for providing mental health services to Members of Partnership HealthPlan of California (Partnership).

VI. POLICY / PROCEDURE:
A. Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:
1. Members determined to require Non-Specialty Mental Health Services (NSMHS) are served by Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health at (855) 765-9703.
2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County Mental Health Plan in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.

[1] As per APL 22-012 *Revised*, this does not include medications dispensed from pharmacies and covered under Medi-Cal Rx. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: *https://medi-calrx.dhcs.ca.gov/home/education/*

3. DHCS requires MCPs and MHPs to use the Screening and Transition of Care Tools (Attachments A, B & C) for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. 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
   a. The Screening Tools (Attachments A & B) identify initial indicators of Member needs in order to make a determination for referral to either the Member's MCP (Partnership) for a clinical assessment and medically necessary NSMHS or the MHP for a clinical assessment and medically necessary SMHS.
      1) The Adult Screening Tool includes screening questions that are intended to elicit information about the following topics:
         a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
         b) 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.
         c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
         d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
         e) Questions related to substance use disorders (SUD): If a Member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan or Partnership (for Members residing in one of the 7 counties participating in the Wellness and Recovery regional DMC-ODS program administered by Partnership) for SUD assessment. (*See also policy MCUP3101 Screening and Treatment for Substance Use Disorders*) The Member may decline this referral without impacting their mental health delivery system referral.
      2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
         a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
         b) 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.
         c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
         d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
         e) SMHS access and referral of other services
   b. Adult and Youth Screening Tool 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.
   c. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the Member must be referred to the MCP or the MHP for clinical assessment and medically necessary services.
      1) Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.
      2) MCPs must use the scoring methodology and follow the referral determination generated by the score.
         a) 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.

b) 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.

c) The MCP must coordinate Member referrals with MHPs or directly to MHP providers delivering SMHS. MCPs may only refer directly to an MHP provider of SMHS if policies and procedures have been established and MOUs are in place with the MHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the Member.

d. The Adult and Youth Screening Tools are administered by Partnership's MBHO, Carelon Behavioral Health, and may be administered in a variety of ways, including in person, by telephone, or by video conference.
   1) The Screening Tools can be administered by clinicians or non-clinicians.

e. The Screening Tools are not required or intended for use with Members who are currently receiving mental health services.

f. The Screening Tools are also not required for use with Members who contact mental health providers directly to seek mental health services. Contracted mental health providers who are contacted directly by Members seeking mental health services may begin the assessment process and provide services during the assessment period without using the Screening Tools.

g. The Adult and Youth Screening Tools do not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations and service recommendations.
   4) MCP requirements to provide EPSDT services.

h. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a Member is referred to the MCP or MHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.

i. During the assessment period for both youth and adult Members, provision of and payment for NSMHS remain the responsibility of Partnership, even if Member is found to meet criteria for SMHS.

4. MCPs are required to administer the Transition of Care Tool (Attachment C) to facilitate transitions of care to MHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change. When there is a need to refer a Member between levels of care (SMHS and NSMHS), the Transition of Care Tool shall be completed by the treating clinical provider and submitted as part of the referral.

   a. The Transition of Care Tool is used for both adults and youth and is 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.

   b. The Transition of Care Tool 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.

   c. The Transition of Care Tool includes specific fields to document the following elements:
      1) Referring plan contact information and care team
      2) Member demographics and contact information
      3) Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications
      4) Requested services and plan contact information

d. Following the completion of the Transition of Care Tool, Partnership or its delegate, Carelon Behavioral Health, shall:
   1) Refer the Member to the MHP, or directly to an MHP provider delivering SMHS if appropriate processes have been established in coordination with MHPs.
   2) Coordinate Member care services with MHPs 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.
   3) All appropriate consents must be obtained in accordance with accepted standards of clinical practice.
   4) When Closed Loop Referrals (see section III.A.) are made for behavioral health services between NSMHS, SMHS or county level SUD treatment services, Partnership or its delegate, Carelon, will ensure that that there is an appointment in the other system of care, along with tracking the outcome of that appointment. If Partnership is unable to confirm with the other system of care or provider that the appointment was fulfilled, Partnership or its delegate, Carelon, will seek to confirm with the member or to further understand what barriers to care the member may experience. At all times, parties involved will adhere to relevant privacy regulations for the sharing of mental health and SUD information. Obtaining appropriate releases of information (with appropriate Member consent) is recommended to allow information exchange for facilitating exchange of pertinent clinical information.
   5) Outcomes of referrals are monitored through monthly referral trackers between Partnership (and/or its delegate) and each MHP.

e. The determination to transition services to and/or add services from the MHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols?
   1) 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.
   2) Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice

f. The Transition of Care Tool is not considered an assessment and does not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations, and service recommendations
   4) MCP requirements to provide EPSDT services

B. Members may self-refer for mental health services to an appropriate mental health provider. Members do not need a referral from their Primary Care Provider (PCP) to receive mental health services.

C. In an effort to coordinate medical and mental health care, providers should ask Members to sign a release of information so that the Member's providers can best coordinate care. However, the release of information is not a condition for services to be provided.

D. The County Mental Health Plan's (MHP's) role in providing mental health services:
   1. County MHPs provide crisis assessments, SMHS and authorizations for acute in-patient psychiatric care for Members in their counties who meet access criteria as described in Behavioral Health Information Notice (BHIN) 21-073.
      a. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider.
      b. The County crisis stabilization service acts as a backup after hours and on weekends as well as at other times of provider unavailability.
      c. Members may call the County crisis line directly, without a referral.

d. Members eligible for mental health services from Partnership delegated managed behavioral health organizations will be re-directed to appropriate County crisis services as needed.
e. Should services be rendered concurrently in both the NSMHS and SMHS systems for both Members who are under the age of 21 and those 21 years and older, Partnership and County Mental Health Plans shall coordinate care as mutually agreed upon, while ensuring Member's choice is considered. This collaboration shall continue through transitions between systems of care.

E. The PCP's role in providing mental health services:
1. A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or Partnership's delegated managed behavioral health organization, Carelon Behavioral Health, for telephone consultation. For detailed screening, referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines.
   a. If a Member's screening is positive and indicates further assessment, the assessment may be performed either by the PCP or by referral to a network mental health provider.
   b. If the Member's PCP cannot perform the mental health assessment, they must refer the Member to the appropriate provider and ensure referral to the appropriate delivery system for mental health services, either in the MCPs provider network or the county MHP's network
   c. Members may then be treated by the PCP within the PCP's scope of practice; or
   d. When the condition is beyond the PCP's scope of practice, the PCP must refer the Member to a mental health provider, first attempting to refer within the MCP network
   e. At any time, Members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCPs provider network.

F. Managed Care Plan's responsibility for providing NSMHS:
1. Partnership is responsible for the delivery of NSMHS (as defined in III.F.) for the following populations:
   a. Members who are 21 year of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
   b. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;
   c. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy; and
   d. Members of any age with potential mental health disorders not yet diagnosed.
2. NSMHS may be delivered by PCPs within their scope of practice, or through Partnership's provider network which shall provide a full range of covered NSMHS to its pediatric and adult Members.
3. In accordance with California Welfare and Institutions Code (WIC) sections 14059.5 and 14184.402, services that are "medically necessary" or a "medical necessity" (see III.F.) to correct or ameliorate health conditions for Members under the age of 21 shall be in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS. These services are covered by Partnership as Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services (per policy MCCP2022) regardless of whether the services are covered in the state's Medicaid State Plan.
   a. Consistent with federal guidance from Centers for Medicare & Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make

more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

4. Consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS are covered by Partnership even when:
   a. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
   b. Services are not included in an individual treatment plan;
   c. The Member has a co-occurring mental health condition and substance use disorder (SUD); OR
   d. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

G. Partnership provides or arranges for the provision of NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs as follows:
   1. Partnership covers physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions
   2. Partnership does not cover pharmacy benefits and services pursuant to APL 22-012 *Revised* and the Medi-Cal Rx program. All medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/

H. Partnership covers up to 20 individual and/or group counseling sessions for pregnant and postpartum Members with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. (*see also policy MCUP3118 Prenatal & Perinatal Care*)

I. Partnership provides medical case management and covers and pays for all medically necessary Medi-Cal- covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries receiving SMHS. Partnership coordinates care with the MHP, and is responsible for the appropriate management of a Member's mental and physical health 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 MCPs provider network.

J. Partnership covers family therapy under Medi-Cal's NSMHS benefit, including for Members ages 20 or below who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated, but may not have a mental health diagnosis. Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.
   1. All family members do not need to be present for each service.
   2. Members ages 20 or below may receive up to five family therapy sessions before a mental health diagnosis is required.
   3. Family therapy is delivered without regard to the five session limit for Members under age 21 with any of the following risk factors:
      a. mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death
      b. foster care placement
      c. food insecurity
      d. housing instability
      e. exposure to domestic violence or trauma
      f. maltreatment

g. severe/persistent bullying
h. discrimination

K. Partnership is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the Member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

L. Partnership is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as well as for emergency services necessary to stabilize the Member. *(see also policy MCUP3101 Screening and Treatment for Substance Use Disorders)*

M. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers whether delivered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) model or the DMC State Plan model are covered by the counties respectively, whether or not the Member has a co-occurring mental health condition. *(See also policy MCUP3101 Screening and Treatment for Substance Use Disorders.)*

N. The Parity in Mental Health and Substance Use Disorder Benefits requirements of Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) stipulate that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Therefore, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network, and no referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.
   1. Partnership provides information regarding mental health services for Members in the Partnership Medi-Cal Member Handbook as well as through Partnership's website www.partnershiphp.org. Applicable Member informing materials state that referral and prior authorization are not required for a Member to seek an initial mental health assessment from a network mental health provider.
   2. Partnership covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.
   3. Pursuant to DHCS requirements and the Memorandums of Understanding (MOU) template, Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). To the extent permitted by law, Partnership will exchange with county partners, member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health.

O. Dyadic Services Benefit
Partnership reimburses for all medically necessary mental health services pursuant to the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual. Dyadic Services is a new benefit pursuant to the Medi-Cal Provider Manual, APL 22-029 *Revised* and California Welfare and Institutions Code section 14132.755. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from the plans if Dyadic Care services are provided by a billable Provider.
   1. Dyadic Services Provider Requirements and Qualifications
      a. Provider Types:
      Dyadic caregiver services may be provided by the medical well-child provider in addition to the provider types listed below.

1) 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.
2) Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician.
3) Appropriately trained nonclinical staff, including Community Health Workers (CHWs), are not precluded from screening Members for issues related to Social Drivers of Health (SDOH) or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

b. Provider Requirements:
1) Providers of Dyadic Services must be enrolled as a Medi-Cal provider AND
2) Possess a National Provider Identifier (NPI) number that is entered in the 274 Network Provider File.

c. Reimbursement for Services:
1) The delivery of these services and family therapy are considered non-specialty mental health services and are billable to Partnership's contracted MBHO (Carelon Behavioral Health).
2) There are no prior authorization requirements nor will there be any unreasonable barriers to access and services.
3) All Dyadic Services must be billed under the Medi-Cal ID of the Member ages 20 or below.

2. Member Eligibility Criteria for Dyadic Services
   a. Children (Members ages 20 or below) and their parent(s)/caregiver(s) are eligible for Dyadic Behavioral Health (DBH) well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
      1) Under EPSDT standards, a diagnosis is not required to qualify for services.
      2) DBH well-child visits are intended to be universal per the Bright Futures periodicity schedule for behavioral/social/emotional screening assessment. The DBH well-child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.
      3) The family is eligible to receive Dyadic Services so long as the child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does 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.
3. Covered Dyadic Services
   a. MCPs may offer the Dyadic Services benefit 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.
   b. Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.
   c. Multiple Dyadic Services are allowed on the same day and may be reimbursed at the fee-for-service (FFS) rate.
   d. Dyadic Services rendered by behavioral health staff are reimbursed when they have not been previously completed as part of the medical well child visit.
   e. Dyadic Caregiver Services, including screening, assessment, and brief intervention, may be billed either by the medical well child provider or the DBH provider, but not by both when rendered on the same day.
   f. Covered Dyadic Services are behavioral health services for children (Members ages 20 or below)

and/or their parent(s) or caregiver(s), and include:

1) DBH Well-Child Visits
   a) DBH well-child visits are provided for the child and caregiver(s) or parent(s) at medical visits. The DBH portion of the well-child visit must be limited to those services not already covered in the medical well-child visit.
   b) When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, MCPs must ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements.
   c) MCPs may deliver DBH well-child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:
      i. Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.
      ii. Developmental history of the child.
      iii. Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).
      iv. Mental status assessment of parent(s) or caregiver(s).
      v. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.
      vi. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.
      vii. Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:
         a. Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences (ACEs) impact their child's development and their parenting.
         b. Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., (ACEs) impact their child's development.
         c. Information and resources to support the child through different stages of development as indicated.
      viii. Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.
2) Dyadic Comprehensive Community Supports Services, separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (Member ages 20 or below) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:
   a) Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.
   b) Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.
   c) Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.
   d) Communication and coordination of care with the child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies.
   e) Outreach and follow-up of crisis contacts and missed appointments.
   f) Other activities as needed to address the dyad's identified treatment and/or support

needs.

3) Dyadic Psychoeducational Services for psychoeducational services provided to the child age 20 or below and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience.
4) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the child age 20 or below and parent(s) or caregiver(s). These services include brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and other related issues.
5) Dyadic Parent or Caregiver Services: Dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (Member ages 20 or below) as appropriate:
   a) Brief Emotional/Behavioral Assessment
   b) ACEs Screening
   c) Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
   d) Depression Screening
   e) Health Behavior Assessments and Interventions
   f) Psychiatric Diagnostic Evaluation
   g) Tobacco Cessation Counseling

P. Dispute Resolution
   1. If a dispute occurs between the local County Mental Health Plan (MHP) and Partnership HealthPlan of California (Partnership) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the MHP and Partnership will participate in a dispute resolution process as defined in Partnership Policy ADM52 Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services.
      a. Partnership does not delegate the responsibility of MCP and MHP dispute resolution to any Subcontractor.

Q. Delegation Oversight and Monitoring
   1. Partnership delegates the administration of certain mental health services to a managed behavioral health organization.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
   4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 10, Section 10.8.D
B. Medi-Cal Provider Manual/ Guidelines: Non-Specialty Mental Health Services: Psychiatric and Psychological Services *(non spec mental)*
C. Title 9 of the California Code of Regulations (CCR) Chapter 11
D. Title 9 CCR Sections 1820.205, 1830.205, 1830.210, 1850.505, 1850.515, 1850.525, 1850.535
E. Title 22 CCR Section 53855
F. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)
G. Title 42 United States Code (USC) § 1396d(r)(5)

H. Welfare and Institutions Codes (WIC) § 14059.5, 14132.03, 14184.402 § 14189
I. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
   a. Specialty Mental Health Services Memorandum of Understanding Template
   b. Substance Use Disorder Treatment Services Memorandum of Understanding Template
J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (04/08/2022)
M. DHCS APL 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)
N. DHCS, APL 22-029 *Revised* Dyadic Services & Family Therapy Benefit (03/20/2023)
O. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
P. Behavioral Health Information Notice (BHIN) 21-073
Q. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 08/11/95; 10/10/97 (name change only); 06/21/00; 12/19/2001; 08/20/03, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 04/21/10; 03/16/11; 08/15/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 10/12/22; 06/14/23; 04/10/24; 08/14/24; 01/08/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.