



State of California—Health and Human Services Agency  
**Department of Health Care Services**



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## **MEDICAID MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT COMPLIANCE PLAN**

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## 1. EXECUTIVE SUMMARY

### 1.1 Medicaid Mental Health Parity Final Rule Background

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On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Parity Final Rule<sup>1</sup> (Parity Rule) to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid and applied parity requirements to the coverage provided by Medicaid managed care organizations (MCOs), Alternative Benefit Plans (ABPs), and the Children’s Health Insurance Programs (CHIP). Specifically, the Parity Rule included the following requirements:

- Aggregate lifetime and annual dollar limits;
- Financial requirements (FR);
- Quantitative treatment limitations (QTLs);
- Non-quantitative treatment limitations (NQTLs); and
- Information requirements.

A key objective of the Parity Rule is to ensure that restrictions or limits on mental health and substance use disorder services are not more substantively applied as compared to medical surgical services. Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary’s lifetime or on an annual basis. These limits cannot be applied to mental health or substance use disorder (MH/SUD) benefits unless the limits apply to at least one third of all medical/surgical (M/S) benefits. In addition, such limits must either be applied to both medical/surgical and mental health and substance use disorder benefits as a whole or the limits applicable to mental health or substance use disorder benefits must be no more restrictive than those applicable to medical/surgical benefits. FRs and QTLs applied to MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL that applies to substantially all medical/surgical benefits in that classification.

A non-quantitative treatment limitation (NQTL) may not apply to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.

Further, the Parity Rule added requirements to make certain information pertaining to mental health and substance use disorder benefits available, specifically the criteria for medical necessity determinations and reason for denial of reimbursement or payment.

Certain parity requirements also apply to the Alternative Benefit Plan (ABP). The Parity Compliance Toolkit<sup>2</sup> provides that an ABP that provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits is deemed compliant with parity requirements for beneficiaries entitled to EPSDT benefits.

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<sup>1</sup> Medicaid Mental Health Parity Final Rule, Federal Register Vol. 81 No. 61, published March 30, 2016: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

<sup>2</sup> Parity Compliance Toolkit, dated January 17, 2017: <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>

Parity requirements apply when a beneficiary is enrolled in a Managed Care Organization (MCO). At such point, the beneficiary's entire benefit package is subject to parity standards regardless of delivery system, which includes the medical/surgical benefits and non-specialty mental health benefits through the Medi-Cal managed care plans (MCP) and fee-for-service (FFS), pharmacy benefits through the MCP and FFS, specialty mental health benefits through the county mental health plans (MHP), substance use disorder benefits through the Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, and waiver services. California's delivery system structures are described in greater detail in [Section 2](#) below.

In California where some mental health and substance use disorder services for MCP enrollees are provided through a combination of MCPs and MHPs, the State has the responsibility of undertaking the parity analysis within the plans and across the delivery systems to determine if the benefits and any financial requirements or treatment limitations are consistent with the Parity Rule.

## 1.2 Compliance Plan Overview

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The purpose of this Compliance Plan is to describe the comprehensive parity analysis that the California Department of Health Care Services (DHCS) has undertaken, resulting outcomes of the parity analysis, and solutions to rectify the findings. The Parity Compliance Toolkit outlined key steps in the parity analysis process. DHCS ensures required compliance with the Parity Rule by addressing such steps as described within this document.

This Compliance Plan is divided into six (6) sections:

[Section 1](#) is the Compliance Plan overview that provides the background of the Parity Rule requirements and purpose of the Compliance Plan.

[Section 2](#) provides the background on California's service delivery, which provide context on the intricacy of the parity analysis.

[Section 3](#) describes the State's approach to conducting the comprehensive parity analysis.

[Section 4](#) discusses the outcomes of the parity analysis.

[Section 5](#) provides system-level changes that DHCS implemented and/or is in the process of operationalizing to come into compliance with the identified parity issues.

[Section 6](#) describes the ongoing monitoring at the State and plan level when parity reassessment is required.

## 2. CALIFORNIA'S SERVICE DELIVERY SYSTEMS

The California Department of Health Care Services (DHCS) is the single state agency responsible for the administration of the State's Medicaid program, called Medi-Cal. DHCS administers programs to support the vital health care needs of nearly 14 million Californians, about one-third of the State's population.

DHCS contracts with MCPs for the provision of medical/surgical services, pharmacy benefits, preventative substance use disorder services, and non-specialty mental health services delivered in the primary care setting to beneficiaries with mild to moderate mental health functional impairment.

In California, specialty mental health and substance use disorder services are carved-out of the Managed Care Organization (MCO) delivery system through CMS-approved Medicaid Waivers. DHCS administers specialty mental health services (SMHS) through county mental health plans (MHPs) that are responsible for the provision, or arrangement of, specialty mental health services.

DHCS administers theDMC, DMC-ODS, and Substance Abuse Prevention and Treatment Block Grant (SABG) programs through a community-based system for SUD services through counties or through direct contracts with service providers. MCPs refer beneficiaries to MHPs for SMHS and/or SUD services. MHPs and MCPs have developed memoranda of understanding (MOUs) that include agreements for coordinating beneficiary care.

As a result of the carve-outs, DHCS examined each of the delivery system's governing laws, State Plan, Waiver requirements, funding methodologies, administrative requirements, contractual agreements, and other complexities. Moreover, CMS required states to demonstrate parity within long-term care services and supports.

### 2.1 Managed Care Plans

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#### ***Service Delivery***

DHCS administers health care services through two delivery systems – managed care and fee-for-service (FFS). Medi-Cal managed care plans are required to offer services in an amount no less than what is offered to beneficiaries under Medi-Cal FFS. MCPs provide State Plan services in accordance with State statutes and regulations, Medi-Cal Provider Manual, DHCS Medi-Cal contract, and All Plan Letters (APLs).

Approximately 80 percent of Medi-Cal beneficiaries receive health care services through a MCP. In California, there are six models of managed care within the 58 counties:

- County Organized Health Systems (COHS)
- Two-Plan
- Geographic Managed Care (GMC)
- Regional
- Imperial
- San Benito

[Attachment A](#) in the Appendix illustrates the plan models by county.

Senior Care Action Network (SCAN) Health Plan is a Medicare Advantage Special Needs Plan that contracts with DHCS to provide services for the dual eligible Medicare/Medi-Cal population subset in certain geographic areas. Since CMS has defined SCAN as a MCO per the Medicaid Managed Care Final Rule, SCAN is included in areas where there is applicability to MCPs for parity.

MCPs cover most acute, primary and specialty care, pharmacy, and some long-term services and supports, although coverage of certain benefits can vary by plan models and individual plans in certain circumstances. Managed long-term services and supports (MLTSS) covered by MCPs include long-term health care facilities (i.e., Skilled Nursing Facilities/Nursing Facilities (SNF/NF), subacute facilities, and Intermediate Care Facilities), Multipurpose Senior Services Program (MSSP), and In-Home Supportive Services. MCPs also cover Community-Based Adult Services (CBAS) under the auspice of California’s Section 1115 Waiver, *Medi-Cal 2020*. California provides additional long-term care services under Home and Community-Based Services (HCBS) Waivers. These are discussed in the [Waiver Services](#) section.

Starting on January 1, 2014, California expanded its benefits for Medi-Cal beneficiaries with mental health conditions who do not meet the SMHS medical necessity criteria, and carved these benefits into managed care, thus providing access to a limited scope of primary care-based, non-emergency mental health and substance use disorder services through the MCPs. Pursuant to the State Plan, MCPs provide non-specialty mental health services included in the essential health benefits package.<sup>3</sup>

Outpatient non-specialty mental health services include:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purpose of monitoring drug therapy;
- Outpatient laboratory, drugs, supplies and supplements (excluding antipsychotics); and
- Psychiatric consultation.

MCPs do not provide specialty mental health or substance use disorder services, but are responsible for referral and coordination with the local county office for these services. DHCS ensures that all contracts with MCPs include a process for screening, referral, and coordination with MHPs, as set forth in Welfare and Institutions Code Section 14681<sup>4</sup>. Further, memoranda of understanding (MOU) are in place between MCPs and MHPs to coordinate physical and mental health care, provide for a dispute resolution process, describe the Department’s responsibility for reviewing the disputes, and outline the provision of medically necessary services pending resolution of dispute.

MCPs are responsible for providing substance use disorder preventative services, which include Alcohol Misuse Screening and Counseling (AMSC) for misuse of alcohol, tobacco cessation services and office visits associated with alcohol and substance use disorder services when provided by a network provider acting within their scope of practice. MCPs are required to provide United States Preventative Services Taskforce (USPSTF) recommended covered tobacco cessation services, including: initial and annual assessment of tobacco use; FDA-approved tobacco cessation medications; individual, group and telephone counseling for beneficiaries who use tobacco products; services for pregnant tobacco users; and prevention services of tobacco use in children and adolescents.

***Governing Laws and Authority***

MCPs in California are governed by many different statutes and regulations set forth by both the Federal and State government, which include the Code of Federal Regulations (CFR), California Code of Regulations (CCR), California Health and Safety Code (H&S), California Welfare and Institutions Code (W&IC), and Knox-Keene

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<sup>3</sup> Welfare & Institutions Code Sections 14132.03 and 14189.

<sup>4</sup> Welfare & Institutions Code Section 14681: <http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14681.html>



Health Care Service Plan Act of 1975 (Knox Keene). DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements, whichever is more prescriptive.

DHCS operates its Medicaid managed care program under the authority of the Section 1115 Waiver. The waiver authority was granted under the *Bridge to Reform Demonstration*, which was renewed on December 30, 2015 as *Medi-Cal 2020*. The Section 1115 Waiver allowed California to phase in coverage in individual counties through the mandatory enrollment of the population into Medi-Cal managed care plans.

### ***Funding Mechanism***

DHCS pays MCPs monthly actuarially sound capitation rates as defined in 42 CFR 438.6(c) and 42 CFR 438.4 and those rates are developed in accordance with standards specified in 42 CFR 438.5 per beneficiary in addition to potential supplemental capitation for specific services. Capitation rates generally are flat fees that are paid for each member that covers all included costs of health care for a defined population group. The capitation rates are calculated based on methods that are determined in part by CMS, which oversee the Medicaid program. In turn, MCPs negotiate rates and contract with providers to ensure services are rendered<sup>5</sup>.

## 2.2 Mental Health Plans

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### ***Service Delivery***

California's specialty mental health services (SMHS) are provided under the 1915(b) Freedom of Choice Waiver. The 1915(b) SMHS Waiver provides California with the opportunity to deliver Rehabilitative Mental Health Services<sup>6</sup> to children and adults through a managed care delivery system, with MHPs designated as Prepaid Inpatient Health Plans. DHCS contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to beneficiaries who meet medical necessity criteria<sup>7</sup> in a manner consistent with the beneficiary's mental health treatment needs and goals as documented in the beneficiary's treatment plan.

The county MHPs provide outpatient SMHS in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries. The SMHS covered under the 1915(b) SMHS Waiver are defined in California's Medicaid State Plan and include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges. These services are as follows:

- Mental Health Services;
- Medication Support Services;

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<sup>5</sup> MCPs pay providers in a variety of ways, which may include some form of capitation, FFS, or other types of arrangements.

<sup>6</sup> Rehabilitative Mental Health Services are services recommended by a physician or other licensed mental health professional within the scope of his or her practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level. Rehabilitative Mental Health Services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention. Rehabilitative Mental Health Services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past. Rehabilitative Mental Health Services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. (Medi-Cal State Plan, Supplement 3)

<sup>7</sup> SMHS medical necessity criteria is outlined in Title 9 CCR Chapter 11, Sections 1820.205, 1830.205, and 1830.210.

- Day Treatment Intensive;
- Day Rehabilitation;
- Crisis Intervention;
- Crisis Stabilization;
- Adult Residential Treatment;
- Crisis Residential Treatment Services;
- Psychiatric Inpatient Hospital Services;
- Targeted Case Management; and
- EPSDT Services.

### ***Governing Laws and Authority***

MHPs in California are governed by many different statutes and regulations set forth by both the Federal and State government. State governance include the California Code of Regulations (CCR) and California Welfare and Institutions Code (W&IC). MHPs are classified as Prepaid Inpatient Health Plans (PIHP) under the Federal Medicaid Managed Care regulations, and as such, are also governed by Title 42 and the Code of Federal Regulations (CFR) part 438. DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements.

The State's enabling legislation for the 1915(b) Waiver is set forth in Welfare and Institutions Code Sections 14680-14685.1 and 14700-14726.

### ***Funding Mechanism***

The 1915(b) Waiver program is administered locally by each county’s MHP, and each county’s MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries. MHPs are not paid on a capitated basis, but rather, are reimbursed through a claims-based FFS payment structure based on their actual expenditures for services. MHPs negotiate rates and contract with providers to ensure services are rendered. California funds SMHS through multiple dedicated revenue sources. In addition to FFP, these sources include 1991 Realignment<sup>8</sup>, 2011 Realignment<sup>9</sup>, Mental Health Services Act<sup>10</sup>, SAMHSA Block Grants and locally-generated matching funds for 1991 Realignment<sup>11</sup>, or other local revenues. **Attachment B** in the [Appendix](#) illustrates the map of California’s counties by mental health regions.

## 2.3 Substance Use Disorder Services

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### ***Service Delivery***

Beneficiaries enrolled in Medi-Cal receive substance use disorder services through DMC, which is a carve-out of the MCPs’ benefits. Treatment is offered on demand (i.e., no referral necessary) for all Medi-Cal beneficiaries when medically necessary.

For SUD services, California’s State Plan authorizes the DMC program to provide the following five treatment modalities:

- Outpatient Drug Free Treatment (group and/or individual counseling);
- Intensive Outpatient Treatment;
- Residential Treatment (limited to pregnant and perinatal clients);
- Naltrexone Treatment; and
- Narcotic Replacement Therapy (methadone).

The DMC system establishes a structure for providing State Plan SUD services. In addition, SABG funding supports a significant portion of California’s SUD treatment services. The SABG includes funding for outpatient and residential treatment designed to augment the DMC program’s SUD services.<sup>12</sup> SABG-funded providers are required to adhere to a hierarchy of priority populations and all beneficiaries must indicate active substance use

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<sup>8</sup> 1991 Realignment was a legislatively-driven effort initiated in 1991 that approved a half-cent increase in state sales tax and dedicated a portion of vehicle license fees to fund local community mental health services.

<sup>9</sup> 2011 Realignment codified the Behavioral Health Services Subaccount that currently funds SMHS, DMC, residential perinatal drug services and treatment, drug court operations, and other non-DMC programs. See AB 109 (Chapter 15, Statutes of 2011) and SB 1020 (Statutes of 2012) for more information.

<sup>10</sup> MHSAs revenues, established by Proposition 63, which passed in 2004 and is generated through a 1% surtax on personal income over \$1 million, are allocated directly to counties and have helped to significantly fund rehabilitative and preventive mental health services to underserved populations.

<sup>11</sup> A portion of local revenue generated from property taxes, patient fees, and some payments from private insurance companies is used to fund mental health services, referred to as a Maintenance of Effort (MOE).

<sup>12</sup> Title 42, USC §300x-21(b) authorizes the use of SABG funds only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse, and for related activities contained in 42 USC §300x-24, which applies to tuberculosis and human immunodeficiency services.

within the previous 12-months to be eligible for SABG funded treatment services. This also includes individuals who were incarcerated and reported using while incarcerated.

The current DMC delivery system places emphasis on state-wideness, resulting in SUD treatment facilities spread unevenly across California. Challenges arising from this approach include difficulty targeting the needs of specific populations and issues with ensuring quality across providers. To address these challenges, in 2015 CMS approved the DMC-ODS waiver amendment to the Medi-Cal 2020 Demonstration Waiver<sup>13</sup>.

By opting into the DMC-ODS and executing the DMC-ODS Intergovernmental Agreement, the county agrees to provide or arrange for the provision of DMC-ODS services through a PIHP. The county makes DMC-ODS services available as a Medi-Cal benefit for all individuals who reside within its county borders, have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a substance use disorder, and meet the medical necessity to receive that particular service based on American Society of Addiction Medicine (ASAM) criteria for SUD treatment services. The county may make these DMC-ODS services available by selectively contracting with DMC certified providers, a managed care plan, or offer county-operated services.

DMC-ODS services include:

- Outpatient drug free services;
- Intensive outpatient services;
- Withdrawal management (detoxification) services;
- Narcotic replacement therapy;
- Medication-assisted treatment;
- Residential treatment services; and
- Recovery services

### ***Governing Laws and Authority***

The statutes that govern the DMC Program are established in Welfare and Institutions Code Section 14021, 14124, and 14043.38, as well as Health and Safety Code Sections 11750-11975. The primary regulations that govern DMC are contained in the California Code of Regulations Title 22, Sections 51341.1 (program requirements), 51490.1 (claim submission requirements), and 51516.1 (reimbursement rates and requirements). Other regulations pertaining to the DMC program are in Title 9 CCR Section 9533. DMC-ODS counties are also governed by the Code of Federal Regulations (CFR). DHCS adheres to both legislation and regulations set forth by the State of California and Federal requirements.

DHCS operates DMC under the State Plan and the California Code of Regulations Title 9 and 22. The DMC-ODS Waiver is under the authority of the Section 1115 Waiver entitled *Medi-Cal 2020*.

### ***Funding Mechanism***

The DMC-ODS Pilot program is authorized and financed under the authority of the State's Section 1115 Waiver. Funding for SUD services in DMC and DMC-ODS is allocated to the counties from State and Federal funding, and is also supplemented by county and local funding, the Substance Abuse Prevention and Treatment Block Grant, discretionary grants, and the Behavioral Health Subaccount that was codified by the 2011 County Realignment (Senate Bill 1020). Similar to the SMHS, SUD services are reimbursed through the claims-based FFS

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<sup>13</sup> Medi-Cal 2020 Demonstration Waiver: <http://www.dhcs.ca.gov/provgovpart/Documents/MediCal2020STCs06-01-17.pdf>

payment structure based on the county’s actual expenditures. DMC-ODS counties pay providers the agreed-upon rates between the county and its providers. Counties receive quarterly payments of one-fourth of their annual allocation of SABG funding.

## 2.4 Waiver Services

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### ***Service Delivery***

In addition to MCP-covered MLTSS services, California provides long-term care services through Home and Community Based Services (HCBS) waivers. The Social Security Act lists specific services that may be provided in HCBS programs, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. The array of services, which are approved by CMS through the Waiver application, differ significantly in the populations they serve, their size and complexities, and their statutory and regulatory structures, among other differences. HCBS Waivers allow states flexibility to offer different types of services to individuals with chronic disabilities in community-based settings as an alternative to institutionalized care.

California currently administers seven (7) 1915(c) HCBS Waivers:

- Multipurpose Senior Services Program (MSSP) Waiver
- HIV/AIDS Waiver
- Developmental Disabilities (DD) Waiver
- Assisted Living Waiver (ALW)
- Nursing Facility/Acute Hospital (NF/AH) Waiver
- In-Home Operations (IHO) Waiver
- Pediatric Palliative Care (PPC) Waiver

### ***Governing Laws and Authority***

DHCS is the Single State Agency responsible for the administration of CMS approved Waiver services. The Federal government authorized the 1915(c) HCBS Waiver programs under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, codified in section 1915(c) of the Social Security Act. Governing State statutes are established in Welfare and Institutions Code Section 14137.

### ***Funding Mechanism***

LTSS benefits provided by MCPs are included in their capitation rate. LTSS benefits provided under the HCBS Waivers and 1915(i) State Plan are paid for under the FFS structure.

## 2.5 Pharmacy Services

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### ***Service Delivery***

DHCS refers to drugs as capitated or carved-out. A drug that is capitated is covered by MCPs and included in their capitation rates. When dispensed, the pharmacy bills the MCP for the covered drug, not Medi-Cal FFS. A complete list of carved-out or non-capitated drugs is maintained by the DHCS Pharmacy Benefits Division and is

distributed to the MCPs on a regular basis. This list is also posted in the Medi-Cal Provider Manual<sup>14</sup> and providers are notified of any updates via Provider Bulletins.

A carved-out drug is a drug that is not covered by the MCPs and is not included in the MCPs' capitation rates. Although a MCP provider may write a prescription for a carved-out drug, when dispensed, the pharmacy provider bills Medi-Cal FFS rather than the MCP. Certain categories of drugs are currently carved-out, or non-capitated, unless otherwise specified in the MCP's contract with DHCS, or in the Medi-Cal Provider Manual. Drugs are carved-out by categories or classes as well as by ingredients and by the generic name, not by individual brand name, dose form, or indications for treatment.

Medi-Cal FFS has selected certain categories of medications and carved them out from the calculation of MCP capitation. The selection of carved-out drugs is determined based on the general cost factor of the class of drugs in the aggregate, the introduction of new and costly medications into the class, and the degree of difficulty in determining a capitation rate that would appropriately compensate the MCPs accordingly. The classes of selected drugs that are carved-out include:

- Drugs to treat HIV/AIDS (these medications are exempt from the 6 Rx limit)
- Alcohol and opioid detoxification and dependency treatment drugs
- Blood factors
- Psychiatric (antipsychotic) drugs
- Erectile dysfunction (ED) drugs when indicated for the treatment of ED

### ***Governing Laws***

The laws governing California's prescription drug program are Section 1927(K) that defines Covered Outpatient Drugs (COD) and Section 1927(d) of the Social Security Act that allows state Medicaid programs to apply prior authorization and/or imposition of utilization limitations with respect to all drugs. These governing laws provide the prior authorization process that outlines requirements for response timeframes of a phone response within 24 hours of request for prior authorization and a 72-hour supply of a covered prescription drug in emergency situations. It further provides guidelines for utilization restrictions, which include, but are not limited to, the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals. Utilization control methods utilized by the State are further described in [Section 4.2.7](#).

### ***Payment Mechanism***

Like other MCP services, payment for capitated drugs is negotiated by the health plans.

FFS provider reimbursement is statutorily set at the lowest of: acquisition cost of the drug plus a professional dispensing fee, the Federal Upper Limit, the Maximum Allowable Ingredient Cost, or the usual and customary price charge by the provider to the general public.

### ***Authority***

The authority to include pharmacy benefits in the State's Medicaid program is established in the Social Security Act. Prescription drugs are an optional benefit. Therefore, the State Plan is the source that documents that

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<sup>14</sup> Medi-Cal Provider Manual: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp)

prescription drugs will be included in the California Medicaid program, and it provides the parameters of the types of prescription drug services covered.

### 3. PARITY ANALYSIS APPROACH

DHCS conducted a mandatory assessment of Medicaid benefits across the delivery systems to ensure the State’s compliance with the Parity Rule. DHCS adhered to the Parity Compliance Toolkit that outlined key steps to conducting the parity analysis and examined benefits across delivery systems for parity compliance:

- Medi-Cal managed care plans
- Mental health plans
- Drug Medi-Cal
- Drug Medi-Cal Organized Delivery System
- Waivers
- FFS

To gain perspectives on current practices across delivery systems, as well as to identify parity concerns, DHCS utilized three methods to collect information. These methods included: (1) a survey administered to the MCPs, MHPs, DMC-ODS Counties, and counties providing SUD services through DMC to better understand operations at the local level, (2) review of policies and guidance at the State level, and (3) rigorous Department-wide deep dive discussions to draw comparisons between the delivery systems.

The scope of the parity analysis included benefits mapping and classification; identification, analysis, and determination of FRs, QTLs, and NQTLs; and review of notice and disclosure requirements in the four classifications of benefits by benefit package. The following sections provide greater detail on the extent of review in these areas.

#### 3.1 Benefits Definition, Classification, and Mapping

##### 3.1.1 Defining Benefit Types

In order to determine whether mental health and substance use disorder benefits are provided in parity with medical/surgical benefits, it was essential to identify which benefits are considered mental health and substance use disorder benefits and which are medical/surgical benefits for the purpose of this parity analysis. DHCS utilizes the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, a generally recognized independent standard of current medical practice, as a basis for defining benefits as mental health and substance use disorder services. DHCS referred to the Parity Rule for the definitions for mental health and substance use disorder benefits and developed the following benefits definitions:

Table 1. Benefits Definitions	
Benefit Type	Definition
<b>Mental Health</b>	Mental health benefits, for the purposes of Parity, mean benefits for medically necessary services provided to eligible Medi-Cal beneficiaries who are being evaluated for or have an ICD mental health diagnosis based upon criteria established in the Diagnostic and Statistical Manual. Medically necessary mental health services are services provided for the purpose of assessment, diagnosis, treatment, and rehabilitation to alleviate psychological or emotional illness, symptoms, conditions, or disorders and may be provided in inpatient, residential, outpatient or other permitted settings as clinically indicated.



Table 1. Benefits Definitions	
Benefit Type	Definition
Substance Use Disorder	A Substance Use Disorder is the recurrent use of alcohol and/or drugs that has caused clinically and functionally significant impairment in life activities. SUD treatment services are services, inpatient and outpatient, provided to treat a beneficiary enrolled in Medi-Cal who has at least one diagnosis for an SUD based on the criteria established by the <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM). SUD treatment services are outpatient drug free, intensive outpatient, withdrawal management (detoxification), narcotic replacement therapy, medication-assisted treatment, residential treatment, and recovery services.

### 3.1.2 Defining Classifications and Mapping Benefits to Classifications

The Parity Rule specifies that financial requirements and treatment limitations apply by benefit classification. Moreover, in order to conduct the parity analysis, each medical/surgical, mental health, and substance use disorder benefit must be mapped to one of four classifications of benefits: Inpatient, Outpatient, Prescription Drugs, and Emergency Care. Further, when mental health and substance use disorder benefits are provided in any one classification in a benefit package, then mental health or substance use disorder benefits must also be provided in every classification in which medical/surgical benefits are provided for that benefit package.

DHCS assigned each service to one of four classifications. This required the State to compare medical/surgical services to mental health services and medical/surgical services to substance use disorder services per benefit classification. For example, comparing inpatient medical/surgical services to inpatient mental health services, as well as inpatient medical/surgical services to inpatient substance use disorder services.

DHCS selected the setting as the basis of organizing the services into the benefit classifications. The basis of the setting helped to better align and organize available services by benefits classification. Inpatient settings that included hospital settings, acute care settings, and psychiatric health facilities all provide beneficiaries access to an array of inpatient services. Settings for outpatient services include outpatient clinics, and outpatient hospitals, and community-based settings. Prescription drug services included all medications and associated supplies, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment. Lastly, emergency care includes all covered medications or items delivered in an emergency department setting other than an inpatient setting.

For purposes of mapping benefits in each classification during the parity analysis, DHCS utilized the following classification definitions:

Table 2. Classification Definitions	
Classification	Definition
<b>Inpatient</b>	All covered services furnished in a hospital, acute care setting, or psychiatric health facility.
<b>Outpatient</b>	All covered services in an outpatient clinic, outpatient hospital, or community-based setting.
<b>Prescription Drugs</b>	All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment.
<b>Emergency Care</b>	All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.

Please refer to **Attachment C** in the [Appendix](#) for the Medi-Cal benefits mapped to the four classifications.

Once the four classifications were defined and all medical/surgical, mental health, and substance use disorder benefits were mapped to a classification, DHCS moved on to the next part of the parity analysis, which entailed the statewide policy review for identification of financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations applied to specific benefits in each classification.

### 3.2 State-Level Policy Review

Parity compliance requires an analysis of financial requirements (FR), quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL) imposed on mental health and substance use disorder benefits to ensure they are no more restrictive than those that apply to medical/surgical benefits in the same classification. To review potential state-imposed FRs, QTLs, and NQTLs in each classification, DHCS organized a Mental Health Parity Workgroup (Workgroup) that included the applicable programs from within the Department: Managed Care Quality and Monitoring Division (MCQMD), Mental Health and Substance Use Disorder Services (MHSUDS), Pharmacy Benefits Division (PBD), Benefits Division (BD), Long Term Care Division (LTCD), and the Office of Legal Services (OLS). This Workgroup was comprised of program, clinical, and executive staff, and included legal representation to ensure that there was a multidisciplinary approach to the parity analysis.

The Workgroup reviewed State policies and guidance within the Medicaid State Plan, waiver programs, State and Federal statutes and regulations, All Plan Letters (APL) and County Information Notices, DHCS contracts with the MCPs and MHPs, Medi-Cal Provider Manual, and the DMC and SMHS Billing Manual for potential FRs, QTLs, and NQTLs. This provided DHCS with a standard of State and Federal guidance by which to gauge local level policies when they are more restrictive than State requirements. Established requirements and limitations within State policies set the floor for minimum standards that must be met. It is these requirements and limitations by which comparisons were drawn between delivery systems.

### 3.3 Surveys and Technical Assistance

To obtain knowledge and information on local level policies, processes, and standards, DHCS administered plan surveys to MCPs, MHPs, DMC, and DMC-ODS counties. DHCS sought input from the California Department of Managed Health Care (DMHC) on their commercial plan experience with MHPAEA compliance. The DMHC

regulates and monitors licensed private health plans in California under the Knox-Keene Health Care Services Plan Act (Knox-Keene), which includes monitoring compliance with MHPAEA. DHCS adapted the MHPAEA survey administered by DMHC and reviewed the guidance in the Toolkit to develop its own surveys for the MCPs and MHPs. DHCS also completed the survey from the State’s perspective on pharmacy services since the State carves out high-cost medications and some antipsychotics to FFS.

### 3.3.1 Medi-Cal Managed Care Plan Survey

On January 9, 2017, DHCS administered a survey to the 22 MCPs, which focused on the following areas: authorization and referral process, pharmacy and drug formulary, provider network, credentialing and contracting, case management and care coordination, treatment restriction and/or exclusions, and financial requirements. Please refer to **Attachment D** in the [Appendix](#) for the MCP survey template.

DHCS requested each MCP respond to the survey on current FRs, QTLs and NQTLs within each benefit classification. Following the issuance of the survey, DHCS conducted a webinar on January 9, 2017 to encourage MCP engagement, respond to questions, and provide assistance with completing the survey. Additionally, DHCS conducted technical assistance calls with each individual plan between January 9, 2017 and January 20, 2017 to provide further guidance and assistance with survey questions.

The Department also requested policies and procedures for each question that applied to the plan. The survey responses were analyzed for parity concerns. Once the initial results were analyzed, a follow-up survey was sent out to gather additional information on a case-by-case basis.

### 3.3.2 County Mental Health Plan, DMC, and DMC-ODS Counties Survey

DHCS administered a similar survey to the 56 MHP, DMC, and DMC-ODS counties on January 20, 2017. The survey was tailored to better align with the SMHS delivery system. It focused on gaining information about potential FRs, QTLs and NQTLs in eight areas: authorization and referral process; medication prescribing, authorization, and monitoring practices; progressive therapy/step therapy; provider network credentialing and contracting; case management and care coordination; client treatment plans; ; financial requirements; and, disclosure requirements. MHPs and DMC-ODS counties were required to complete the survey and submit supporting documentation (i.e., plan policies and procedures).

DHCS conducted a webinar on January 20, 2017 to provide MHPs, DMC, and DMC-ODS counties with an introduction to the parity requirements and an overview of the parity survey. DHCS also held a technical assistance call with the MHPs, DMC, and DMC-ODS counties on January 26, 2017 to provide further guidance and assistance with completion of the survey questions. Throughout the survey response period, DHCS provided technical assistance and guidance to MHPs, DMC, and DMC-ODS counties requesting additional support.

DHCS analyzed the survey responses and supporting documentation to identify potential areas of concern and engaged in focused deep dive reviews through its Workgroup.

Please refer to **Attachment E** in the [Appendix](#) for the MHP and DMC-ODS counties survey template.

## 3.4 Deep Dive Sessions

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The Workgroup utilized dedicated deep dive sessions to get a better understanding of each program’s policies and limitations. Between March and June 2017, the Workgroup met two to three times weekly in person to

discuss existing policies and operations for considering comparability and stringency across the programs. These face-to-face meetings were critical to identifying potential parity concerns, as well as determining the State’s compliance and steps for resolution. The Workgroup continues to meet weekly in order to ensure regular communication and provide implementation progress updates with the entire team.

#### 4. PARITY ANALYSIS OUTCOMES

The Workgroup utilized the findings from the surveys, State-level policy review, and deep dive meetings to identify the areas where there were potential parity concerns by FRs, QTLs, and NQTLs. A summary of the parity concerns resulting from the parity analysis are outlined in the table below. The results of the parity analysis are described in greater detail within this section.

Table 3. Summary of Parity Concerns
• Share of cost statutes (FR)
• AMSC quantitative limits on screenings and brief interventions (QTL)
• Authorization processing and timeframes (NQTL)
• Non-specialty mental health prior authorization processes (NQTL)
• AMSC provider training requirements (NQTL)
• Statewide credentialing policy (NQTL)
• Statewide continuity of care policy (NQTL)
• Transportation policy for non-MCP covered services (NQTL)
• Statewide Network Adequacy Proposal (NQTL)
• Standardized Notice of Action (NQTL)

##### 4.1 Financial Requirements (FRs)

The parity regulations describe financial requirements as fees charged to beneficiaries for services, including copayments, deductibles and co-insurance. The regulations provide that no financial requirement be applied to mental health or substance use disorder benefits “in any classification that is more restrictive than the predominant financial requirement ... of that type applied to substantially all medical/surgical benefits in the same classification ....” (42 C.F.R. § 438.910(b)(1)). Generally, the purpose of this requirement is to prevent beneficiaries from being charged more for mental health or substance use disorder services than for medical/surgical services, which would create a barrier to beneficiaries accessing those services.

The Workgroup evaluated the financial requirements applicable to mental health and substance use disorder benefits to ensure that they are no more restrictive than the financial requirements that apply to medical/surgical benefits in the same classification. The State complies with these financial requirements because no financial requirements apply to mental health or substance use disorder services. For this reason, DHCS did not need to perform the two-part test for FRs (i.e., Substantially All, Predominant Level).

#### 4.1.1 Share of Cost

Share of cost (SOC) is the amount a beneficiary is required to pay, or obligates to pay, towards their medical expenses in a particular month before services can be billed to Medi-Cal. SOC is structured similarly to a private insurance plan's out-of-pocket deductible, but on a monthly, rather than annual basis. The beneficiary's SOC is calculated by the county during the eligibility process, and is based on the beneficiary's countable income. Medi-Cal eligibility rules, including income requirements for the various Medi-Cal programs are established by Federal and State law.

The Workgroup found during the State-level policy review that each of the MCP, MHP, and SUD contracts have provisions that indicate that income is used to determine program eligibility, among other factors. SOC, which is based on income, is applied consistently across California's delivery systems.

In addition to providing SMHS through a MHP, counties are required to provide community mental health services (which are not Medi-Cal reimbursable) to their residents. Historically, counties have charged residents fees, based on ability to pay, for community mental health services. Previous share of cost statutes pertaining to Uniform Method of Determining Ability to Pay (UMDAP) required counties to charge beneficiaries for SMHS (Welfare & Institutions Code sections 5709). However, this is inconsistent with current practice; county MHPs do not charge any fees to Medi-Cal beneficiaries. The Department amended Welfare & Institutions Code sections 5709 to conform state law with current practice.

#### 4.1.2 Cost-Sharing

Cost sharing is prohibited by regulation. California Code of Regulations, title 22, section 51341.1, subsection (h), paragraph (7) that states in part, "Providers shall not charge fees to beneficiaries for access to DMC substance use disorder services or for admission to a DMC treatment slot." DHCS SUD County Monitoring Unit through its annual monitoring process, which includes a review of compliance with DMC or DMC-ODS contract terms and conditions, will continue to verify that counties do not collect any type of cost sharing from SUD treatment beneficiaries. In addition, DHCS contacted counties to ensure that cost-sharing practices for Medi-Cal beneficiaries are discontinued immediately.

#### 4.1.3 Other Financial Requirements

##### ***Copayments***

DHCS does not require beneficiaries to pay a copay to receive Medi-Cal services, including specialty mental health or SUD services. The Workgroup determined that there are no compliance steps needed for this requirement.

##### ***Coinsurance, Deductibles, and Out-of-Pocket Maximums***

There are no coinsurance requirements, deductibles, or out-of-pocket maximums in the Medi-Cal program. The Workgroup determined that there are no compliance steps needed for these requirements.

##### ***Aggregate Lifetime and Annual Dollar Limits***

Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary's lifetime or on an annual basis. These limits cannot be applied to mental health or substance use disorder benefits unless the limits apply to at least one third of all medical/surgical benefits. In addition, such limits must either be applied to both medical/surgical and mental health and substance use disorder benefits as a whole or the limits applicable to mental health or substance use disorder

benefits must be no more restrictive than those applicable to medical/surgical benefits. The Medi-Cal program does not place aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits; therefore, the Workgroup determined that there are no compliance steps needed for these requirements.

## 4.2 Quantitative Treatment Limitations (QTL)

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Quantitative treatment limitations (QTLs) are limits on the scope or duration of a benefit that are expressed numerically, such as limits on the number of covered visits, days of coverage or frequency of covered treatment. The general parity rule is that no QTL may apply to mental health or substance use disorder benefits in a classification if the QTL is more restrictive than the predominant treatment limitation of that type that applies to substantially all medical/surgical benefits in the same classification. The Workgroup reviewed State regulations and policies for MCPs, MHPs, and counties providing substance use disorder services and evaluated for potential QTLs discussed below.

### 4.2.1 Specialty Mental Health Discharge Planning Targeted Case Management

MHPs provide targeted case management (TCM) services for purposes of discharge planning. This specialty mental health TCM service is provided solely for the purpose of coordinating placement of the beneficiary on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, during the 30 calendar days immediately prior to the day of discharge, for a maximum of three (3) nonconsecutive periods of 30 calendar days or less per continuous stay in the facility. The TCM service is billed separately than the inpatient stay. Further, the beneficiary can receive additional TCM services upon discharge. The Workgroup concluded that the QTL does not limit the benefit, but rather, defines the timeframe for when the service can be billed. As such, the Workgroup determined that there is not a QTL issue with the SMH Discharge Planning TCM service.

### 4.2.2 DMC-ODS Residential Services

#### 4.2.2.1 DMC-ODS Residential Treatment Services

DMC-ODS residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the results of a clinical assessment for determining the most appropriate level of care based on American Society of Addiction Medicine (ASAM) criteria. Residential treatment services are provided in a continuum of care as per the five (5) levels of ASAM residential treatment levels. Residential treatment services are required in all counties that contract to participate in the DMC-ODS Program.

Counties that opt into DMC-ODS provide residential treatment services pursuant to the limitations and requirements set forth in the Medi-Cal 2020 Demonstration Waiver and the DMC-ODS Intergovernmental Agreement<sup>15</sup> with the State. Section (X)(134) of the Medi-Cal 2020 Demonstration Waiver and Part III(H) of the DMC-ODS Intergovernmental Agreement require counties that opt into the DMC-ODS provide residential treatment services in accordance with the following limitations:

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<sup>15</sup> Executed DMC-ODS contracts: <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

- Adults – up to two 90-day periods with a one-time 30-day extension in a 365-day period;
- Adolescents – up to two 30-day periods, with a one-time 30-day extension in a 365-day period; and
- Perinatal beneficiaries for the duration of their pregnancy and 60 days postpartum.

The DMC-ODS residential benefit is only authorized when delivered according to the quantitative limitations set forth in the Medi-Cal 2020 Demonstration Waiver and accompanying expenditure authority. This expenditure authority is the exclusive basis upon which DHCS can claim Federal financial participation for the benefit notwithstanding the Institutions for Mental Diseases (IMD) prohibition in Medicaid. Authorizing the counties to provide DMC-ODS residential services without these quantitative limitations would exceed the expenditure authority and thus preclude provision of the DMC-ODS residential benefit by virtue of the Federal statutory IMD prohibition. Because these quantitative limitations are a prerequisite for providing the benefit itself in Medi-Cal, it is not appropriate to evaluate parity compliance in this specific DMC-ODS context. For this reason, the Workgroup determined that there are no QTL concerns with DMC-ODS residential treatment services.

#### 4.2.2.2 Residential Treatment Services for Adolescents

Residential treatment services for adolescents are provided through DMC-ODS and may be authorized for up to 30 days in one continuous period. There is a limitation on reimbursement for two non-continuous 30-day regimens in any one-year period (365 days), and one extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period (365 days). However, the Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate overrides these quantitative limitations. Thus, the Workgroup determined that there are no QTL concerns with residential services for adolescents.

#### 4.2.3 DMC Narcotic Treatment Program

The Narcotic Treatment Program (NTP) component of California’s substance use disorder program through DMC includes a 200 minutes per month limit on narcotic treatment counseling. Additionally, NTP beneficiaries must have medical necessity reevaluated by the Medical Director or Licensed Practitioner of the Healing Arts at least annually to determine that those services are still clinically appropriate for that individual.

In December 2013, DHCS submitted State Plan Amendment (SPA) 13-038 with the goal of providing additional substance use disorder services under the DMC program effective January 1, 2014. SPA 13-038 added language based upon an agreement with CMS that allowed the soft limit of 200 minutes per month to be exceeded and reimbursed in cases of medical necessity. As described in the [Medical Management Standards](#) below, DHCS applies the overarching principles of medical necessity equally to mental health and substance use disorder services as to medical/surgical services, thereby not presenting a QTL parity concern.

#### 4.2.4 Medication Supply Limits

Medi-Cal FFS pharmacy benefits policy currently allows six (6) prescription medications to be filled per beneficiary per month without prior authorization. This limitation applies to all prescriptions, regardless of the drug type or category, except in the following cases:

- Nursing facility patients
- Adult and pediatric subacute care patients
- Family planning drugs (for example, oral contraceptives)
- Claims that must be submitted on paper (claims with required attachments)

- Claims for newborns, where the baby uses the mother’s identification number
- Some Managed Care Plans (verify with specific plan)
- Drugs for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, as identified by a specific symbol in the Contract Drugs List.
- Cancer drugs, as identified by a specific symbol in the Contract Drugs List.

Section 1927 of the Social Security Act allows state Medicaid programs to apply prior authorization and/or may impose limitations with respect to all drugs. Restrictions include, but are not limited to, the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this Act. Accordingly, out of concern regarding the risk of over-medication, misuse of medication, as well as fraud and abuse potential involved in the dispensing of medications, Medi-Cal FFS has imposed a limit of six (6) prescriptions filled per beneficiary per month without prior authorization.

Carved-out drugs are determined on various factors, including the:

- General cost factor of the class of drugs in the aggregate
- Introduction of new and costly medications into the class, and
- Degree of difficulty in determining a capitation rate that would appropriately compensate the MCPs accordingly

DHCS currently carves out the following classes of drugs:

- Drugs to treat HIV/AIDS (these medications are exempt from the 6 prescription limit)
- Alcohol and opioid detoxification and dependency treatment drugs
- Blood factors
- Psychiatric (antipsychotic) drugs

Carved-out drugs claims are submitted to Medi-Cal FFS for reimbursement and are thus subject to the six (6) prescription utilization control. This limitation is applied across all carved-out prescriptions in the FFS system, not just mental health and substance use disorder prescriptions. Although there is a potential that mental health and substance use disorder medications could exceed six prescriptions per member per month, the probability of over six carved-out prescriptions for an individual member per month is extremely low. Additionally, each MCP is able to establish utilization controls on all medications, including non-carved out mental health drugs. Plan utilization controls may be equally or more restrictive than the six prescription limit in FFS. Therefore, the FFS utilization control does not create an issue of parity for the mental health or SUD drugs due to the six (6) prescription limit or any other FFS utilization control restriction.

#### 4.2.5 Alcohol Misuse Screening and Counseling Limits

On January 1, 2014, California began offering the Alcohol Misuse Screening and Counseling (AMSC) benefit (formerly known as Screening, Brief Intervention, and Referral to Treatment) to adult Medi-Cal beneficiaries under the Affordable Care Act, which required that preventive services be offered to all Medi-Cal beneficiaries 18 years and older in primary care settings. Medi-Cal-funded primary care practitioners must provide AMSC, which includes a brief behavioral counseling intervention provided by a health care professional to include feedback and advice aimed to reduce alcohol misuse and/or make appropriate referrals to mental health and/or



alcohol use disorder services. DHCS issued APL 14-004 to provide policy guidance to the MCPs and added the benefit to the Medi-Cal Provider Manual.

DHCS classified AMSC as a substance use disorder benefit, thereby drawing the comparison of QTLs with other medical/surgical preventative services. The Medi-Cal Provider Manual and APL 14-004 provides for one (1) full screen and three (3) brief interventions per year to be provided and reimbursed. This limit is based on recommendation from the United States Preventative Services Task Force (USPSTF) that three brief interventions are the most effective at reducing alcohol abuse in adults when conducted in the primary care setting. The USPSTF is an independent panel of experts in primary care and prevention that systematically review the evidence of effectiveness of, and develops recommendations for, clinical preventive services.

After providing the brief intervention and upon identifying a possible alcohol use disorder, MCPs are required to refer the beneficiary to the county alcohol and drug program for evaluation and treatment. The referral to treatment process consists of assisting a patient with accessing specialized alcohol abuse treatment and selecting treatment facilities, which allows the beneficiary access to a higher level of care. However, despite the referral to a higher level of care, the Workgroup determined that the AMSC limitation is still a QTL.

The Workgroup reviewed the current AMSC process and were concerned that although the beneficiary has access to a continuum of care, the limitations posed issues with appropriateness of needed services. The Workgroup was concerned about the potential for the beneficiary to not be allowed to return to the lower level of care after review by the county program determines that the beneficiary does not meet medical necessity for the higher level of care. Additionally, the Workgroup was concerned that after going through the continuum of care, the beneficiary may be in need of the lower level of care within the same year. Lastly, after referral to a higher level of treatment beyond the primary care setting, due to the quantitative limit, the primary care provider would not be able to provide additional services beyond the one (1) screening and three (3) brief interventions.

Therefore, the Workgroup determined that DHCS would need to clarify policy to state that limitations can be exceeded due to medical necessity. In order to operationalize this policy, DHCS will clarify in the APL and Medi-Cal Provider Manual that additional AMSC services beyond the one (1) screening and three (3) brief interventions can be provided on the basis of medical necessity. This clarification would help to ensure that beneficiaries have access to needed AMSC services in the primary care setting when medically necessary. This change would also align with other Medicaid benefits with quantitative limits (i.e., optional benefits) which can be exceeded if medically necessary. This is further explained in the [Medical Necessity](#) section.

#### 4.3 Non-Quantitative Treatment Limitations (NQTL)

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NQTLs are non-numerical limits on the scope or duration of benefits. The general parity rule is that NQTLs must not be imposed on mental health and substance use disorder benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification. For this reason, the Workgroup approached the NQTL analysis differently from the review of financial requirements and QTLs. The NQTL analysis required that the Workgroup review survey findings and local-level policies and procedures to determine how State-issued policy and federal guidance was implemented and operationalized in practice.

As described in the Parity Toolkit, the NQTL analysis does not focus on whether the final result is the same; instead, compliance is based upon parity in application of the underlying processes, strategies, evidentiary standards, or other factors, both in writing and in operation. The Workgroup evaluated each potential NQTL through the lens of two approaches: (1) comparability of the benefit structure by benefit classification and (2) stringency in which the limit is applied.

Although the Parity Rule provided an illustrative, non-exhaustive list of NQTLs, the Workgroup broadened its scope of review to other policies if there were potential disparity in processes among delivery systems. The following is a discussion of the NQTLs that the Workgroup determined required further analysis.

### 4.3.1 Medical Management Standards

#### 4.3.1.1 Medical Necessity

Medical necessity is a medical management standard that can potentially limit or exclude benefits on the basis of medical necessity or medical appropriateness. In California, medical necessity is defined in State statutes.<sup>16</sup> The Workgroup analyzed the application of medical necessity by evaluating the comparability and stringency between medical/surgical and mental health benefits and between medical/surgical and substance use disorder benefits. As part of the NQTL review, the Workgroup requested policies and procedures from the MCPs, MHPs, DMC, and DMC-ODS counties to verify that evidence-based clinical guidelines were being used consistently. MCPs, MHPs, DMC, and DMC-ODS counties, and consequently each of their network providers, must base their medical necessity determinations in accordance with the generally recognized clinically appropriate standards of care.

Further, the Workgroup evaluated how soft limits were applied by delivery system and determined that all Medicaid services that are eligible to exceed the quantitative limits set forth in the State Plan, Alternative Benefit Plan, and Medi-Cal Provider Manual are permitted to exceed the stated limit if it medically necessary, regardless of the type of service. The Workgroup ascertained that this principle is applied consistently irrespective whether the service is intended to treat a medical/surgical, mental health, or substance use disorder condition.

The Parity Rule also imposes information requirements with respect to medical necessity. The availability of criteria for medical necessity determinations and the reason for denial of coverage for mental health and substance use disorder benefits are further discussed in this document in the [Information Requirements](#) section.

#### 4.3.1.2 Authorizations

Authorization of services may take place prospectively, prior to the service being rendered; concurrently, while the services are being rendered; or retrospectively, after the services have already been rendered. The Workgroup reviewed authorization policies and procedures to ensure consistent application of authorization decisions across medical/surgical, mental health, and substance use disorder services by benefit classification. In

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<sup>16</sup> Medical necessity definitions: Medical/surgical services – Title 22 CCR Section 51303(a) and the DHCS-MCP Contract; SMHS – Title 9 Sections 1810, 1820.205 1830.205, and 1820.210 (for EPSDT); DMC – Title 22 CCR Section 51303.1 and Section 51341.1(h)(1)(A)(v)(a-b); DMC-ODS requires at least one diagnosis from the DSM Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders and must meet the ASAM Criteria definition of medical necessity for services.

reviewing for comparability and stringency across delivery systems, the Workgroup considered the following factors as part of the NQTL analysis:

- Definition of authorizations in each program
- Circumstances in which authorizations are applied
- Authorization process
- Requirements and timeframes
- Consequences/penalties when requirements are not met
- Benefits that are subject to the authorization requirements
- Frequency and appropriateness of reviews
- Triggers for reassessment

Through the Workgroup’s review of State and local policies, it was determined that both MCPs and MHPs utilize clinical standards along with regulatory guidance from DHCS to authorize and reimburse medically necessary services delivered by providers to beneficiaries. However, existing State statutes and regulations establish different standards for MCPs and MHPs. State statutes governing the MCPs are more prescriptive than Federal guidelines, while State regulations governing the MHPs align with the Federal requirements in the Medicaid Managed Care Final Rule<sup>17</sup> regulations. As such, the Workgroup utilized the more restrictive State statutes governing the MCPs as the threshold for determining standardization across delivery systems.

California Health and Safety Code Section 1367.01<sup>18</sup> describes the following key policy elements that the plan must have:

- Written policies and procedures, reviewed and approved by DHCS, on authorization processes, including the manner in which plans approve, modify, delay or deny based on medical necessity
- Defined criteria and guidelines for purposes of authorizing services based on medical necessity
- Disclose authorization policies and procedures to providers and beneficiaries upon request
- Employed or designed medical director that holds an unrestricted license in the state of California to practice medicine
- Telephone access for providers to request authorizations
- A quality assurance program that specifically looks at authorizations
- Communicate the decision of the review request to the provider
- A licensed physician or licensed health care professional deny or modify requests for authorizations
- Communications to the beneficiary regarding decisions must be in writing and initially to the providers via telephone or facsimile, which must include the reason of the plan decision, the description of the criteria or guidelines used, and the clinical reasons decision including medical necessity
- Notification to the beneficiary and provider must be provided in writing if the authorization review timelines cannot be met, which would include the additional information that is needed to make the determination, the additional expert that needs to be consulted and the additional exams or tests that are required

The systemic changes for the SMHS delivery system described within this section are in response to the adaptation of the key policy elements described above. To further comport with the aforementioned policy

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<sup>17</sup> Medicaid Managed Care Final Rule, Federal Register, Vol. 81, No. 88, May 6, 2016: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

<sup>18</sup> Health and Safety Code Section 1367.01: <http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1367-01.html>

elements, DHCS will communicate and enforce the following overarching authorization principles through the parity contract amendment and State policy guidance:

Overarching Authorization Principles Applicable to MCPs and MHPs

A plan shall disclose the utilization management or utilization review policies and procedures that the plan, its contracting provider groups, or any entity that the plan contracts with, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits provided by the plan. These policies and procedures shall ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration: service type; appropriate service usage, cost and effectiveness of service and service alternatives; contraindications to service and service alternatives; potential fraud, waste and abuse; patient and medical safety; and other clinically relevant factors. The policies and procedures shall be consistently applied to medical/surgical, mental health and substance use disorder benefits. The plan shall notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

**Prior Authorization**

Prior authorization policies for MCPs are specifically defined in State statutes. Statutes prescribe authorization timeframes and require that the list of services that require prior authorization be provided to providers and beneficiaries. In addition, State and federal requirements, as per the Medicaid Managed Care Final Rule, dictate notice content and process requirements for decisions that deny, modify, or terminate mental health or substance use disorder benefits.

The Workgroup identified an area of concern in the SMHS delivery system with respect to processing timeframes to respond to prior authorization requests. State statutes require that MCPs respond to prior authorization requests within five (5) business days. MHP timeframes allow for 14 calendar days per Federal regulations, which is more restrictive from the beneficiary’s perspective as compared to medical/surgical service requests. The Workgroup concluded that there were no parity concerns with prior authorization timeframes for substance use disorder services since DMC-ODS counties must respond to prior authorization requests by providers for residential treatment services within 24 hours, which is less restrictive than the five (5) business days utilized in MCPs.

Additionally, the Workgroup identified some key differences with regard to the method in which MCPs and MHPs utilized the prior authorization process and the requirement to provide a defined list of services that need prior authorization. Prior authorization requirements for MCPs are clearly delineated in State statutes. Specifically, MCPs are required to identify and list services that require prior authorization. The MCPs are also required to make this list available to providers and beneficiaries. Conversely, while the MHPs were required, per the MHP contract and Title 9 regulations, to have in place procedures for authorization of services and notification to beneficiaries, it was allowable for MHPs to authorize services retrospectively. For outpatient SMHS, the State guidance on authorizations did not specify whether authorizations should be done prior to service delivery, concurrently, or retrospectively. State regulations governing the MHPs (CCR title 9, chapter 11, sections 1830.215 and 1820.220) permit, but do not mandate, prior authorization of outpatient specialty mental health services although requirements for retrospective authorization of inpatient psychiatric hospital services

are explicitly outlined. For reasons that regulatory and State guidance was silent on prior and concurrent review of authorizations and was more explicit in allowing retrospective review, MHPs did not consistently utilize prior authorizations in the same manner as MCPs.

In order to address the disparity between the requirements for MCPs and MHPs, DHCS adopted new requirements for prior authorization of SMHS, including the identification of services requiring prior authorization and timeframes for making authorization decisions. To align the prior authorization timeframes between MCPs and MHPs, DHCS adopted the review timeframe of five (5) business days for MHPs. DHCS issued policy guidance to the MHPs and will amend the MHP contract to include guidance regarding circumstances and timeframes in which authorizations are required for specific SMHS. As this constituted a significant shift in local operations related to authorization of services, DHCS continues to work with the county MHPs to rollout the implementation of the authorization procedures. DHCS required MHPs to submit Parity policies related to authorizations by August 1, 2019.

Nevertheless, the Workgroup identified no parity concerns with prior authorization processes for substance use disorder services. According to Section 134 of the Medi-Cal 2020 Demonstration Waiver and Part III(F)(3)(i – x) of the DMC-ODS Intergovernmental Agreement, prior authorization is only required for residential treatment services. Additionally, counties must develop written processes and procedures for processing initial and continuing authorization of services. Counties are required to use DSM and ASAM criteria to confirm that the services are medically necessary. Furthermore, the services that require prior authorization are listed in the DMC-ODS Waiver and county contract, and is made available to beneficiaries and providers through the county. There are no prior authorization requirements for SUD services in State Plan DMC counties. DMC services are provided based on medical necessity and at least one SUD diagnosis from the DSM.

***Concurrent Authorization***

The purpose of concurrent review for authorization requests is to ensure the appropriateness of inpatient and outpatient admissions and determine the level of care and length of stay based upon medical necessity. MCPs utilize concurrent review after the first day of post-stabilization admission to review for medical necessity. Just as for prior authorization, the timeframe and processing requirements for concurrent review of authorizations are outlined in State statutes.

The Workgroup identified an area of concern in the SMHS delivery system with respect to concurrent authorization timeframes and processes. As an example, the Workgroup had concerns with the existing authorization policies and procedures for psychiatric inpatient hospital services. The State guidance required initial authorization by the MHP’s Point of Authorization or by the hospital’s Utilization Review Committee<sup>19</sup> (URC). If the initial authorization was determined by the hospital’s URC, MHPs were further permitted to conduct retrospective authorization of services. Specifically, the regulations required hospitals to request authorization from a beneficiary’s MHP prior to a planned admission or within 14 calendar days after the following: discharge, ninety-nine (99) calendar days of continuous service to a beneficiary, if the hospital stay

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<sup>19</sup> Hospitals are required to comply with Federal requirements for utilization control, including certification of need for care, evaluation and medical review, plans of care and utilization review plan, as well as requiring each hospital to establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care. (CCR, title 9, chapter 11, sections 1820.210 and 1820.230)

exceeded that period of time, or the date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending) (CCR, title 9, chapter 11, section 1820.220(b).)

Although State regulations allow for the use of concurrent review, the Workgroup determined that due to the ambiguity of State guidance, MHPs are not consistently conducting concurrent authorization review. Since MHPs are mainly conducting retrospective authorization reviews, a payment adjustment to the provider could occur for services already rendered if it is determined that the services were not medically necessary. In contrast, authorizations approved by the MCPs are considered assured payment to providers.

The second concern that the Workgroup had with concurrent authorization review is regarding the processes and timeframe for authorization. The regulations require the hospital's URC to approve or deny the payment authorization no later than the third working day from the day of admission. In an effort to bridge the parity concerns, DHCS issues [policy guidance](#) to align the requirements for MHP authorizations of psychiatric inpatient hospital services with the concurrent authorization review requirements used by MCPs for inpatient hospital services. Similar to MCPs, MHPs are expected to conduct concurrent review of treatment authorizations until discharge. DHCS required MHPs to submit Parity policies related to authorizations by August 1, 2019. DHCS will continue to ensure consistency in the required timeframes for concurrent review of inpatient hospital services by amending the contract and regulatory guidance for SMHS.

The Workgroup identified no parity concerns with concurrent review processes and timeframes for substance use disorder services. According to Section 134 of the Medi-Cal 2020 Demonstration Waiver and Part III(H)(iv)(b-c) of the DMC-ODS Intergovernmental Agreement, concurrent authorization is required only in residential treatment services for adults and adolescents to receive up to an additional 30 days of residential services who previously received prior authorization for up to 90 days of residential treatment services. Adults and adolescents who received authorization for residential treatment services may receive one 30-day extension per 365-day period, as long as services are determined to be medically necessary during the concurrent authorization process. In addition, the Workgroup has not identified any services in State Plan DMC that require concurrent authorization.

### ***Retrospective Authorization***

As mentioned in the *Prior Authorization* section above, the Workgroup determined that retrospective review is the main form of authorization review used by MHPs, as prior authorization and concurrent review are less common. To meet parity compliance, DHCS issues guidance and clarify requirements for authorization of SMHS, as described with subsection [4.3.1.2](#).

The Workgroup did not identify any parity concerns with retrospective review for substance use disorder services. Retrospective reviews are not conducted in DMC or DMC-ODS; rather, services are provided according to medical necessity, and in the case of residential services, services must also meet prior authorization requirements. DHCS conducts post-service post-payment utilization reviews at DMC provider sites to determine compliance with standards of care and other DMC requirements. At the conclusion of each review, DHCS issues a written report detailing any deficiencies found and identifying recovery for any payments made for units of service that are found to be out of compliance.

### **4.3.2 Non-Specialty Mental Health (Mild to Moderate Mental Health Services)**

After an analysis of the MCP survey results and review of policies and procedures, the Workgroup concluded that there were inconsistencies in processes within the MCPs. The Workgroup identified variances with the

MCPs' prior authorization processes between medical/surgical and non-specialty mental health services. Prior authorization processes appeared to vary from plan to plan; some MCPs required prior authorization to obtain an initial mental health assessment by a primary care provider or mental health provider. The Workgroup's review of State issued guidance via APL 13-021 revealed that prior authorization requirements were ambiguous. While many primary care providers (PCPs) provide the initial mental health assessments within their scope of practice, not all do. If a beneficiary's PCP does not perform a mental health assessment, and instead refers the beneficiary to another provider, this creates a barrier to access to an initial mental health assessment.

The Workgroup identified other variances in policies and procedures from plan to plan. For example, some MCP utilized a different panel of experts and committee members to review authorizations for medical/surgical services compared to mental health and substance use disorder services.

To remedy these variances, DHCS will issue guidance and clarify to MCPs that any restrictions to a beneficiary's access to an initial mental health assessment is prohibited. To add to this, DHCS will affirm the overarching principles of authorizations that provide for a comparable process for both medical/surgical, non-specialty mental health, and substance use disorder services as described in the above-mentioned [Authorizations](#) section. Taking into account that utilization management may vary between providers, the standards that will be communicated to the MCPs are that the authorization review process and evidentiary standards criteria must be based on clinical standards, applied consistently across medical/surgical and non-specialty mental health services, and communicated to providers. MCPs will be required to submit their utilization management policies and procedures to DHCS for review. The policy must demonstrate that authorizations are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits.

#### 4.3.3 Reimbursement Structures

There are fundamental differences in the financing of the delivery systems in California, which result in distinctive reimbursement arrangements. For parity across MCPs, MHPs, and SUD delivery systems, DHCS does not believe it necessary to examine potential differences in the network reimbursement methodology in the NQTL context, given the fundamental differences in the financing of the delivery systems and how those differences necessarily result in distinctive downstream reimbursement arrangements. MCPs are reimbursed via a full risk-based, capitated rate, whereas MHPs and DMC-ODS entities are reimbursed a non-risk, non-capitated cost basis, and counties in DMC are reimbursed on a fee-for-service basis.

For parity within a MCP's delivery of medical/surgical and mental health and substance use disorder benefits, DHCS does not have evidence to suggest that plans are applying different factors to network reimbursement rates for covered mental health and substance use disorder services as compared to network rates for covered medical services. For both categories, plans consider multiple factors in determining/negotiating rates, including Medicare or Medi-Cal rates for the service in question, geographic market dynamics, provider supply, and service demand.

MCPs, MHPs, and DMC-ODS counties pay their network providers rates that the plans negotiate with the providers. DHCS does not prescribe the rates plans pay their network providers. The plans and their network providers may consider a variety of factors when negotiating rates. In DMC, the reimbursement rates are set by DHCS on an annual basis in California Code of Regulations, Title 22, Section 51516.1. DHCS does not have any evidence to suggest that plans or DHCS are applying different factors when setting reimbursement rates.

#### 4.3.4 Alcohol Misuse Screening and Counseling Provider Training

The Workgroup identified conflicting statements in State guidance between the Medi-Cal Provider Manual and APL regarding the requirement that providers undergo AMSC training as a condition of reimbursement for providing AMSC services. The Medi-Cal Provider Manual included a specific requirement of a minimum of four hours of SBIRT training in order to provide and receive reimbursement for AMSC services; conversely, the APL highly encouraged training but did not require it as a condition of reimbursement. Additionally, DHCS does not require training for any other preventative services screenings prior to medical/surgical services being provided. The Workgroup considered this requirement to be a NQTL because the training requirement, and consequently payment condition, could potentially limit the number of providers that can render AMSC services.

The Workgroup determined that the APL and the Medi-Cal Provider Manual language will need to be aligned. Additionally, DHCS will issue guidance to MCPs that clarifies that rendering licensed health care providers are recommended, but not required, to take training in order to provide and receive reimbursement for AMSC services. These clarifications to the training requirement will help to ensure that providers can render the service if it is in their scope of practice and promote comparable access as a medical/surgical service.

#### 4.3.5 Network Adequacy

The Medicaid Managed Care Final Rule established network adequacy requirements but provided flexibility to states to set state-specific standards. In developing California’s network adequacy standards, DHCS was cognizant of utilizing comparable processes, strategies, and evidentiary standards across delivery systems in light of parity. Therefore, DHCS established the same network adequacy standards (time and distance and timely access) for both specialty and non-specialty mental health providers, as well as opioid treatment program providers, thus aligning the standards with specialists providing medical/surgical benefits. California’s network adequacy standards are published at <http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf>.

On February 23, 2018, DHCS issued MHSUDS [Information Notice No. 18-011](#), Federal Network Adequacy Standards for MHPs and DMC-ODS counties, which identifies network adequacy standards developed pursuant to Title 42 of the Code of Federal Regulations part 438.68, as specified in Chapter 738, Statutes of 2017 (Assembly Bill 205). DHCS developed a robust network monitoring process to annually certify the networks, per federal requirements. As a part of its network monitoring process, DHCS also monitors compliance with various Parity requirements (e.g., network adequacy and availability of services, timeliness of services, and beneficiary grievances). For example, DHCS reviews beneficiary grievances to determine if they indicate issues related to access to, and timeliness of, SMHS. During the review, DHCS is also able to monitor whether the MHP is compliance with state guidance addressing Parity requirements (as outlined in MHSUDS IN 18-010E). In addition, MHPs are required to report to DHCS, as a part of the MHPs’ quarterly network adequacy submission (beginning July 1, 2019), all requests, and approvals, for continuity of care.

For DMC-ODS, DHCS included Parity requirements and network adequacy standards in contract boilerplate agreements for State Fiscal Year (SFY) 2019-2020.

#### 4.3.6 Provider Credentialing



The Medicaid Managed Care Final Rule and 21<sup>st</sup> Century Cures Act<sup>20</sup> set forth new requirements for provider screening and enrollment. Prior to these requirements, there were no statewide credentialing standards in the SMHS delivery system; instead, county MHPs were directed to develop policies and procedures for credentialing and re-credentialing of providers. DHCS issued [policy guidance](#) for the specialty mental health and substance use disorder programs adopting a statewide credentialing policy, consistent with guidance issued to MCPs via APL 16-012. MHPs and DMC-ODS counties are already required to comply with the elements in the Managed Care Final Rule and Cures Act specific to provider screening; thus they are in compliance with those specific requirements.

DHCS requires both MCPs and MHPs to follow those policies in accordance with 42 CFR 438.214 and 438.602(b), as well as compliance with Section 1902(kk) of the Social Security Act regarding provider terminations. DHCS reviews policies and procedures that reflect these regulation changes to ensure ongoing compliance by the MCPs and MHPs.

Currently, DHCS conducts various aspects of credentialing SUD providers. According to Part II(E)(5)(a) of the DMC-ODS Intergovernmental Agreement, which is based on the Medicaid Final Rule 42 CFR §438.214, counties will align their credentialing policies and procedures with State-established requirements. The State-established guidance aligns with the requirements set forth in the Managed Care Final Rule and 21<sup>st</sup> Century Cures Act..

#### 4.3.7 Fail First, Step Therapy, and Prescription Drug Network Tiers

Prescription drugs for specialty mental health and substance use disorder services are carved out and paid for by the Medi-Cal FFS delivery system. DHCS compared the MCP pharmacy benefits structure with Medi-Cal FFS to conduct the NQTL analysis on prescription drug protocols. Medi-Cal FFS does not have fail first, step therapy, and/or network tier requirements for drugs, nor does it require labs, drug testing, or patient compliance monitoring before authorizing medications. FFS does not utilize a pre-determined set of benchmarks used in Treatment Authorization Request (TAR) adjudication. All TAR adjudication is performed based on the pharmacist adjudicator’s professional evaluation of documentation provided by the requester validating the medical necessity for the requested drug and clinically ruling out CDL alternatives. If the adjudicator finds that details or data are missing that, if provided, would potentially make the request approvable, the TAR may be deferred asking for additional information. FFS Medi-Cal does not limit medications used to treat conditions based on failure to complete prior treatment or due to patient non-compliance. Out of concern regarding the risk of over-medication, misuse of medication, as well as fraud and abuse potential involved in the dispensing of medications, Medi-Cal FFS has imposed a limit of six (6) prescriptions filled per beneficiary per month without prior authorization.

In compliance with Section 1927(d)(7), FFS covers all seven FDA-approved tobacco cessation medications. Bupropion SR, Varenicline, nicotine gum, nicotine lozenge, and the nicotine patch are available without a TAR, while a nicotine inhaler and nicotine nasal spray do require a TAR.

If a FFS drug requires a TAR, authorization may be granted when:

- The clinical condition of the patient requires the use of an unlisted drug and listed drugs have been adequately considered or tried and do not meet the medical needs of the patient.

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<sup>20</sup> 21<sup>st</sup> Century Cures Act: <https://www.congress.gov/bill/114th-congress/house-bill/34/text>

- The use of an unlisted drug results in a less expensive treatment than would otherwise occur.

Authorization for prescribed drugs is granted for a specific quantity of medication and number of refills, if any, in accordance with the beneficiary's medical need and the chronicity of the condition. Similarly, if an MCP has prior authorization requirements on medications, a clinical rationale for such an action and the criteria used to decide medical necessity must be included in the determination. The authorization requests for mental health and substance use disorder medications must be evaluated on a comparable basis, and are applied no more stringently than the clinical rationale and medical necessity criteria used for medical/surgical medications. Since MCPs cover some outpatient mental health medications, DHCS Pharmacy Benefits Division reviews all FFS and MCP drug formularies for compliance with the above requirements.

#### 4.3.8 Continuity of Care

California statutes require MCPs to provide continuity of care to beneficiaries with certain complex conditions (Health and Safety Code Section 1373.96). Per contract requirements and DHCS policy, MCPs are required to allow the services and/or treatment to continue for up to 12 months with the beneficiary's current provider if certain criteria are met, even if the provider is out-of-network.

Whereas, California's SMHS system operates under an approved 1915(b) Freedom of Choice Waiver that waives a beneficiary's freedom of choice in selecting a Medi-Cal provider. Beneficiaries that meet medical necessity criteria for SMHS are mandatorily enrolled into the MHP in their county of residence. Waiving freedom of choice in this manner does not restrict beneficiaries from choosing among providers within the MHP. MHPs are required to provide, or arrange for the provision of, SMHS to all beneficiaries that meet medical necessity criteria if they are residents of the county in which the MHP is located. This includes beneficiaries who receive physical health care from a MCP or through the FFS system.

As beneficiaries change their residence from one county to another, the beneficiary's Medi-Cal eligibility is transferred to the new county and the beneficiary can receive services from the MHP in that county. Since all MHPs are required to provide, or arrange for the provision of, all medically necessary SMHS, continuity of care is built in to the structure of the 1915(b) Waiver and the SMHS delivery system. Furthermore, the existing MHP contract required county MHPs to implement procedures to coordinate services furnished by the MHP with services that the beneficiary received from any other Medi-Cal managed care plan or MHP. It also required the MHP to ensure continuity and coordination of care with physical health care providers and other human services agencies used by its beneficiaries. The contract does not specify requirements for operationalizing a continuity of care policy at the local level.

The Workgroup identified the continuity of care policy as a NQTL concern since DHCS' continuity of care policy for MCPs includes non-participating physician providers. As such, DHCS adopted SMHS and SUD continuity of care policies consistent with the requirements in place for MCPs.

#### 4.3.9 Home and Community Based (HCBS) Waiver Services

The Workgroup evaluated the HIV/AIDS Waiver, DD Waiver, and MSSP Waiver since these waivers provide some mental health services. However, upon further review, it was determined that these waivers are not primarily intended to treat mental health and substance use disorder conditions. The Parity Toolkit states that when defining LTSS benefits, it is the condition for which the service is provided that determines the benefit type.

The HIV/AIDS Waiver provides services to individuals who are diagnosed with the human immunodeficiency virus (HIV), who are experiencing the symptoms associated with acquired immune deficiency syndrome (AIDS). The DD Waiver provides home and community-based services for developmentally disabled persons who are Regional Center consumers. Local Multipurpose Senior Service Program (MSSP) sites provide therapeutic counseling for the elderly, including treatment for severe anxiety, emotional exhaustion, loss/grief, confusion etc.

Because the primary aims of the HIV/AIDS Waiver or DD Waiver are to treat the HIV/AIDS diagnosis or developmentally disabled conditions and not primarily intended to provide services for a mental health and substance use disorder condition, the Workgroup determined that parity compliance does not apply to either of these Waivers. Likewise, the MSSP Waiver does not provide mental health services for individuals with mental illness or serious emotional disturbance, including services necessary for the diagnosis of a mental illness. Because the MSSP Waiver is not primarily intended to provide mental health services, the Workgroup determined that parity compliance also does not apply to the MSSP Waiver.

Moreover, DHCS did not check the box on the Waiver applications to include services for individuals with chronic mental illness including services necessary for the diagnosis or treatment of the individual's mental illness in the HIV/AIDS, DD, or original MSSP Waiver. While not explicit in the 2014 renewal, the MSSP Waiver renewal did not list the addition of mental health services as a major change, nor was mental illness listed as one of the target groups or subgroups of individuals that may receive services under the MSSP Waiver. This is consistent with the July 1, 2004 – June 30, 2009 application<sup>21</sup> excluding mental health services from the MSSP Waiver.

Since these HCBS waivers are not intended to treat mental health and substance use disorder conditions, and are not subject to parity, the Workgroup has determined that are no additional steps necessary for parity compliance.

#### 4.3.10 Transportation

Non-Emergency Medical Transportation (NEMT) is a covered Medi-Cal benefit when a beneficiary needs to obtain medically necessary services and is prescribed by a licensed physician, dentist, podiatrist, mental health provider, or SUD provider. Medi-Cal Managed Care Plans (MCPs) currently provide NEMT to plan-covered benefits for all eligible beneficiaries and non-medical transportation (NMT) for EPSDT services. For non-plan covered benefits, the MCP is required to refer and coordinate NEMT services for the beneficiary.

Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016) requires DHCS to clearly define NMT in the State Plan for all Medi-Cal beneficiaries in both fee-for-service (FFS) and managed care delivery systems. NMT is subject to utilization controls and federally permissible time and distance standards, consistent with a federal requirement that state Medicaid agencies provide assurances of necessary transportation for beneficiaries to and from covered services. In the FFS delivery system, NMT is an indirect benefit that may be covered administratively through programs identified in the State Plan or through local transportation resources reimbursed through Medi-Cal's County-Based Medi-Cal Administrative Activities (CMAA) program and/or the MCPs.

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<sup>21</sup> CMS approved renewal waiver for MSSP Program: <http://www.dhcs.ca.gov/services/medi-cal/Documents/MSSPWaiverApplication2004to2009.pdf>

As a result of AB 2394, DHCS expanded the NMT benefit in the managed care delivery systems, effective July 1, 2017, to include all enrolled beneficiaries, regardless of age, for covered plan services. Additionally, effective October 1, 2017, DHCS will require the MCPs to provide NMT benefits to its enrolled beneficiaries for non-MCP-covered services, including mental health and substance use disorder services, to comply with the Parity Rule.

The changes made by DHCS will result in increasing beneficiary access to transportation for medical/surgical, mental health, and substance use disorder services. DHCS issued guidance on this via the contract, APL, and the MCP's Member Handbook template.

#### 4.3.11 Federally Qualified Health Centers (FQHC) Same Day Billing

California's State Plan contains policy that disallows the billing of multiple encounters that take place on the same day in Federally Qualified Health Centers (FQHCs). The FQHC same day billing policy may appear to limit the ability of mental health providers to render and be reimbursed for services, and thus, can be viewed a NQTL. However, the policy does not actually restrict any services as all services are covered under the FQHC rate, regardless of whether medical services or mental health services are provided first. The Workgroup determined that the same day FQHC same day billing policy is applied consistently among medical/surgical, mental health, and substance use disorder benefits. Therefore, the Workgroup concluded that there is not a NQTL concern with FQHC same day billing since the policy is not more restrictive on mental health services.

#### 4.4 Information Requirements

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The Parity Rule includes two (2) information requirements related to mental health and substance use disorder benefits. The first requirement is that the criteria for medical necessity determinations for mental health and substance use disorder benefits must be made available upon request to MCO enrollees, potential enrollees, and providers. If an MCO (or other plan governed by the Parity Rule) disseminates practice guidelines (which contain the criteria for medical necessity determinations for mental health and substance use disorder benefits) to its providers and to its beneficiaries upon request it is deemed to be compliance with this requirement. MCPs and MHPs both disseminate practice guidelines and are deemed to be in compliance with this requirement. MCPs are also required to provide beneficiaries the criteria for medical necessity determinations for all benefits, including mental health and substance use disorder services, upon request, free of charge. The Workgroup reviewed policies and procedures related to criteria for medical necessity determinations, as well as the dissemination of practice guidelines. It was determined that DHCS is in compliance with the Parity Rule as it relates to the availability of medical necessity criteria and that no further action is required.

The second information requirement is the requirement to make available to beneficiaries the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits. When an MCP or MHP delays, denies, modifies or terminates a benefit it notifies the impacted beneficiary with a Notice of Action (NOA), otherwise referred to as a Notice of Adverse Benefit Determination.

State and Federal regulations define NOA requirements and timelines. (See CFR 438.228, 42 CFR Part 431, Subpart E and CA Health & Safety Code 1367.01). The Federal requirements apply to MCPs, MHPs, and DMC-ODS opt-in counties.<sup>22</sup> Per 22 CCR 51341.1(p), DMC providers are required to advise beneficiaries in writing prior

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<sup>22</sup> The Intergovernmental Agreement, Exhibit A, Attachment I (E)(4)(v)(e)(i) governs the requirements for DMC-ODS counties on issuing notices of adverse benefit determination.

to the effective date of a denial, involuntary discharge, or reduction in SUD services. Beneficiaries are also notified of their right to a State Fair Hearing at the time they are notified of the change in services.”

However, the Workgroup determined the requirements governing the MCPs and outlined in Health and Safety Code Section 1367.01 are more prescriptive than Federal guidelines. Specifically, the H&S Code requires the MCPs to notify the beneficiary, in writing, within two (2) business days of the decision to terminate, modify, or reduce services. Existing State regulations for the MHPs require written notification to the beneficiary within three (3) business days. Further, while the content of the NOA is mandated by Federal regulations, and consistent across all plan types, there were also differences in the layout and formatting of the NOA between the MCPs, MHPs, and DMC-ODS counties.

In May 2017, DHCS updated its Notice of Action (NOA) templates to ensure they contain the required elements and disclosures. The standardized templates are comprised of two components: the NOA and the “Your Rights” templates. DHCS issued the updated templates to MCPs via APL 17-006. The APL also requires MCPs to provide beneficiaries copies of all documents and records relevant to an NOA, including criteria or guidelines used to make medical necessity determinations, free of charge, upon request.

To promote statewide standards and ensure compliance with the Parity rule, DHCS will align the content and timing requirements for NOAs across delivery systems for MCPs, MHPs, and DMC-ODS counties. In addition to the standardized content, the NOA will be sent within two (2) business days after an adverse action.

## 5. COMPLIANCE ACTION PLAN

### 5.1 Contract Amendment and Deliverables

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#### 5.1.1 MCP Contract

In order for the MCPs to come into compliance with the Parity Rule, DHCS will incorporate the required language as instructed by CMS on the Parity Contract Checklist<sup>23</sup> and amend the MCP contract to address the parity findings described in **Section 4, [Summary of Parity Analysis Findings](#)**. Additionally, MCPs will be required to adjust their policies and procedures regarding the QTLs and NQTLs that were identified and submit them to DHCS for review to ensure compliance.

To demonstrate compliance, MCPs will be required to amend their applicable policies and procedures and submit them to DHCS for review and approval. DHCS will submit the amended contract in compliance with the Parity Rule along with this Compliance Plan to CMS.

MCPs will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables section of the contract and APL guidance. DHCS will provide guidance that outlines the required deliverables as well as the submission timelines. DHCS subject matter experts will review the submission of deliverables to evaluate Parity Rule compliance and to determine MCP’s contractual compliance.

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<sup>23</sup> Contract Checklist for Parity: <https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf>

### 5.1.2 MHP Contract

DHCS will incorporate the required language for parity, as instructed by CMS on the Parity Contract Checklist, into the MHP contract to ensure parity compliance. The contract amendment and policy changes will address the parity findings described in **Section 4**, [Summary of Parity Analysis Findings](#).

To demonstrate ongoing compliance, MHPs are required to amend their applicable policies and procedures and submit them to DHCS for review and approval. DHCS reviews the MHPs' policies and procedures, and other documentation, via regular monitoring and triennial reviews.

### 5.1.3 SUD Contract

CMS provided a draft tool to DHCS SUD for conducting Readiness Reviews of counties that opt into the DMC-ODS waiver after July 1, 2017. CMS will review and approve all Readiness Reviews prior to a county receiving contractual approval to provide services under a DMC-ODS Intergovernmental Agreement.

DHCS identified required changes to the current Intergovernmental Agreement (contract) boilerplate between DMC-ODS counties and the State. The parity contract amendment will include information on meeting parity requirements and the specific processes DHCS will undertake for ensuring ongoing compliance with parity requirements. The amendment will also describe the county monitoring efforts that will focus on identifying changes or restrictions that counties impose on the delivery of SUD benefits that may impact compliance with parity requirements.

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## 5.2 State Guidance

### 5.2.1 All Plan Letters

#### 5.2.1.1 Revision to APL 13-021: Non-Specialty Mental Health Services

DHCS has revised and issued an APL to supersede APL 13-021, *Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services*, to include the Parity Rule requirements and provide clarification on authorization requirements for non-specialty mental health services with respect to the initial mental health assessment. The APL also included the overarching principles of authorizations as described in the [Authorizations](#) section.

#### 5.2.1.2 Revision to APL 14-004: AMSC

DHCS has revised APL 14-004, *Alcohol Misuse Screening and Counseling*, to address the QTL by allowing providers to provide additional brief intervention sessions when medical necessary. Additionally, the APL will clarify that provider training is not required as a condition to providing AMSC in order to address the NQTL.

#### 5.2.1.3 APL 17-010: Transportation

DHCS has revised and issued APL 17-010 to add the expanded transportation benefit as a result of the parity analysis. The APL will require MCPs to provide NEMT and NMT for all Medi-Cal services, regardless whether it is a plan-covered benefit, unless it is provided through another program.

DHCS issued APL 17-010 to the MCPs on May 31, 2017.

## 5.2.2 County Information Notices

DHCS issued several Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices to provide guidance to MHPs and DMC-ODS counties regarding Parity requirements.

5.2.2.1 MHSUDS [Information Notice No. 16-042](#): Statewide Residential Treatment Services and Residential Treatment Authorizations in the DMC-ODS

5.2.2.2 MHSUDS [Information Notice No. 18-010E](#): Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates

5.2.2.3 MHSUDS [Information Notice No. 18-011](#): Federal Network Adequacy Standards for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties, which identifies network adequacy standards developed pursuant to Title 42 of the Code of Federal Regulations part 438.68, as specified in Chapter 738, Statutes of 2017 (Assembly Bill 205). The standards are detailed in the Information Notice.

5.2.2.4 MHSUDS [Information Notice No. 18-019](#): Provider Credentialing and Re-Credentialing for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

5.2.2.5 MHSUDS [Information Notice No. 18-020](#): Federal Provider Directory Requirements for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

5.2.2.6 MHSUDS [Information Notice No. 18-043](#): Beneficiary Handbook Requirements and Template

5.2.2.7 MHSUDS [Information Notice No. 18-051](#): Statewide Transition of Care (Continuity of Care) Policy

5.2.2.8 MHSUDS [Information Notice No. 18-059](#): Federal Continuity of Care Requirements for Mental Health Plans

5.2.2.9 MHSUDS [Information Notice No. 19-026](#): Authorization of Specialty Mental Health Services

DHCS monitors compliance with these policies during monthly calls with each county, as well as with monthly All MHP calls.

## 5.3 Medi-Cal Provider Manual

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The Workgroup identified areas in the Medi-Cal Provider Manual that require modification in order to meet parity compliance. DHCS will update the Preventive Services section for AMSC to incorporate the following changes:

- Add the medical necessity clause to exceed the soft limits of one (1) screen and three (3) brief interventions when medically necessary
- Eliminate the requirement for providers to obtain required training in order to provide, and be reimbursed for, AMSC services

The above changes will align with updates made to the AMSC APL and removes any potential barriers to accessing medically necessary AMSC services.

## 5.4 Alternative Benefit Plan

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Medicaid Alternative Benefit Packages (ABPs) were required to comport with MHPAEA for the Affordable Care Act implementation. DHCS assessed the ABP for comportment with MHPAEA and assured compliance by submission of ABP State Plan Amendment CA 13-035 on December 30, 2013. CMS approved the ABP effective January 1, 2014. Therefore, the State's ABP is deemed to be compliant with the parity requirements for FRs, QTLs, and NQTLs with respect to beneficiaries entitled to EPSDT benefits. The Workgroup determined that the State Plan is in alignment with the ABP benchmark plan. Therefore, DHCS recommends no revisions to the State Plan ABP.

The State Plan for Children's Health Insurance Program (CHIP) is deemed in compliance due to the provision that the State covers EPSDT for the full EPSDT population. Please refer to **Attachment G** in the [Appendix](#) for the required EPSDT documentation. Nonetheless, CMS has updated the CHIP State Plan template on September 20, 2017. DHCS may potentially need to submit a CHIP SPA to document consistency with parity regulations. DHCS will post the required public notification of the potential SPA changes and will work towards the amendment until December 29, 2017, if determined to be necessary.

## 5.5 Statutes

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The conclusion of the parity analysis necessitates an amendment to State statute in order to meet parity requirements. DHCS amended Welfare & Institutions Code sections 5709 to conform state law and current practice to clarify that MHPs shall not charge any resident's fees for Medi-Cal specialty mental health services.

## 5.6 Compliance Posting

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To demonstrate parity compliance, the State is required to provide documentation of compliance to the general public by posting a summary of the parity findings and compliance recommendation on its website by October 2, 2017. DHCS will post the Compliance Summary at <http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx>.

# 6. MONITORING AND REASSESSMENT

## 6.1 State Responsibilities

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The Parity Rule requires states to develop and implement monitoring procedures, including a process for ongoing parity reassessment, once the Compliance Summary is posted on October 2, 2017. The Workgroup will continue to meet and discuss operationalizing and refining the ongoing compliance and monitoring activities described below. DHCS is currently making necessary updates, including updating the medical audit tool.

Parity compliance will be monitored through contract renewals with MCPs, MHPs, and DMC, as well as waiver renewals with DMC-ODS, if applicable. Other triggers for parity reassessment include significant changes to the provider networks and added benefits. In instances where new benefits are added to the Medi-Cal program, DHCS will provide guidance on plan readiness, as well as audit the process to ensure that parity requirements are met. DHCS will maintain communication with its plans and interested stakeholders and provide compliance and monitoring updates through State guidance and opportunities for stakeholder feedback.



DHCS intends on leveraging existing MCP oversight and plan assessment tools to monitor parity compliance, specifically new and updated requirements for state monitoring that are a result of the Medicaid Managed Care Final Rule 42 CFR § 438.66<sup>24</sup>. These monitoring efforts include, but are not limited to:

- Grievance and Appeal Monitoring which reviews data to improve overall plan performance on an annual basis. DHCS will utilize the data to ensure that MCPs are complying with parity requirements and disseminating accurate information about parity to providers and beneficiaries.
- Customer Service Performance Monitoring utilizes data from call center reports and is reviewed on a quarterly basis. The data will be evaluated to ensure that beneficiaries are not having access issues to MH/SUD and M/S benefits.
- Utilization Management Process Monitoring tracks and validates encounter data submission and reported rates on an annual basis. Additionally they are required to submit their policies and procedures regarding their review process. The department will ensure their review criteria is comparable across medical/surgical and mental health and substance use disorder benefits
- Financial Monitoring reviews financial audit reports, financial statements, medical loss ratio summary reports, overpayments and recoveries and are reviewed on an annual basis. These will be reviewed to ensure MCPs performance.

Since these monitoring activities are required by the Medicaid Final Rule it will ensure parity as both MHPs and MCPs will be required to adhere. DHCS continually monitors MHP compliance with State and Federal requirements pursuant to the monitoring plan in its approved 1915(b) Waiver. DHCS conducts various monitoring and oversight activities to ensure compliance, including onsite triennial system reviews of the 56 county MHPs. The system review covers requirements related to network adequacy, access, authorization of services, beneficiary problem resolution, coordination of care, program integrity, provider monitoring, and quality improvement. The compliance review protocol has been updated to also include specific requirements implemented to address Parity, including:

- Continuity/Transition of Care Requirements
- Authorization Requirements
- Credentialing Requirements
- Grievance and Appeal System Requirements
- Notice of Adverse Benefit Determination (NOABD) Requirements

DHCS conducts regular monitoring, including annual reviews, of the DMC-ODS pilot counties. Beginning in SFY 2017-2018, counties that implemented the DMC-ODS were required to complete Readiness Reviews in accordance with the requirements in 42 CFR 438.66(d). As the above Information Notices were issued, the requirements of those policies were incorporated into the Readiness Review process and documented for CMS review and approval. CMS also required DHCS to certify a county's network adequacy pre-implementation. These activities required DMC-ODS pilot counties to submit policies and procedures for DHCS and CMS review and approval. During the annual county compliance monitoring for SFY 2018-2019, counties are being monitored for policy and contractual compliance to noticing of adverse benefit determination, credentialing and re-credentialing, and requirements for prior authorizations to treatment services. Identified deficiencies in county policies and procedures require counties to submit corrective action plans to remediate the deficiencies

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<sup>24</sup> Medicaid Managed Care Final Rule, Federal Register, Vol. 81, No. 88, May 6, 2016: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

in a timely manner. DMC-ODS counties are required to submit the number of Transition of Care requests in their quarterly submissions of grievance and appeals for CMS reporting. Beginning in SFY 2019/20 and going forward, the compliance review will include the following Parity requirements:

- Currently, DHCS is completing the annual certification of network adequacy process for nineteen DMC-ODS counties to submit to CMS by July 1, 2019. County policies and procedures regarding timeliness to services, time and distance standards, and pre-authorization to services are being analyzed for compliance with state and federal requirements.
- DHCS will continue to evaluate county adherence to statewide Parity requirements as outlined by the information notices listed on page three of this document through the review of county policies and procedures.
- DHCS will monitor and follow up on regularly submitted county data and all complaints or public information related to Parity such as limiting access to covered medically necessary services, not meeting timely access to services or limiting beneficiary rights to appeal an adverse benefit determination or filing a grievance.

Annual monitoring for State Plan DMC counties includes:

- Policy and contract monitoring;
- On-site compliance reviews;
- Provider utilization reviews with results forwarded to the County for follow-up; and,
- Technical assistance to counties to support county and provider compliance.

Finally, DHCS will use its External Quality Review Organization (EQRO), Behavioral Health Concepts (BHC), Inc., to conducting monitoring of MHP and DMC-ODS county compliance with Medicaid Parity requirements. DHCS will collaborate with BHC to develop and implement review tools and checklists that will validate the Plans' compliance with the Parity requirements, including the MHP contract and various Information Notices (e.g., authorization, continuity of care). Since EQRO reviews are annual, this will ensure that all counties receive the same monitoring each year.

Prior to the annual EQRO review, the EQRO will conduct a county document review. The document reviews may include reviews of various county policies and procedures, beneficiary handbooks, and provider manuals. Document reviews will be used to identify potential MH and SUD treatment limitations, as well as compliance with the statewide policies addressing Parity. The results of the document reviews will be cross referenced with questions for counties at the on-site reviews and for beneficiaries during focus groups. When discrepancies between policies and practice, or other areas of non-compliance are determined, the EQRO will make recommendations for the county to come into compliance.

DHCS may also use the EQRO for targeted chart reviews if monitoring suggests that a county is not accurately applying its policies for authorizing and providing MH or SUD services consistent with Parity requirements.

Finally, the EQRO will validate counties' provider network adequacy data and information. In developing California's network adequacy standards, DHCS used comparable processes, strategies, and evidentiary standards across delivery systems in light of parity. Therefore, DHCS established the same network adequacy

standards (time and distance and timely access) for both specialty and non-specialty mental health providers, as well as opioid treatment program and outpatient substance use disorder providers, and aligned the standards with specialists providing medical/surgical benefits. The EQRO will be instrumental to ensure that counties will meet these standards and are in compliance with Parity requirements. The department is working with the EQRO to establish initial protocol items for parity compliance.

## 6.2 MCP Responsibilities

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MCPs will be responsible for parity compliance between medical/surgical and non-specialty mental health benefits and ongoing assessment as well. The Department will issue any necessary guidance and updates through APLs and weekly plan operation calls. MCPs will be required to meet contractual requirements and submit deliverables if reassessment is initiated, such as grievance and appeal and call center data. Moreover, MCPs will be required to submit their Evidence of Coverage template that describes covered benefits when applicable. DHCS provides technical assistance when MCP deliverables and submissions do not meet requirements. If identified deficiencies are not corrected within appropriate timeframes, DHCS may administer a corrective action plan or sanctions, respectively, until the issue is resolved.

## 6.3 MHP Responsibilities

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MHPs are responsible for demonstrating compliance with all applicable state and Federal requirements. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements during onsite triennial reviews of each MHP. If, at any time, DHCS determines the MHP to be out of compliance with requirements, the MHP is required to submit a Plan of Correction, as well as evidence of correction, to the Department. If an MHP does not adequately address the findings of non-compliance, the MHP is subject to enhanced monitoring activities, including, but not limited to, the imposition of administrative and financial sanctions.

## 6.4 County SUD Services Responsibilities

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Counties are responsible for adhering to the state and federal requirements of either the DMC-ODS Intergovernmental Agreement or the DMC state-county contract. Counties must demonstrate compliance during annual DHCS monitoring reviews. Evidence of compliance can be through policies and procedures, support documents, written reports and interviews with county staff. If DHCS determines a county is non-compliant with contract requirements, the county must develop a corrective action plan and submit evidence of correction. DHCS can withhold funds should the county fail to remediate deficiencies.

## 7. GLOSSARY OF TERMS

Term	Definition
AMSC	Alcohol Misuse Screening and Counseling
APL	All Plan Letter
ASAM	American Society of Addiction Medicine
COD	Covered Outpatient Drugs
COHS	County Organized Health Systems
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSM	Diagnostic and Statistical Manual of Mental Disorders
FFP	Federal Financial Participation
GMC	Geographic Managed Care
HCBS	Home and Community-Based
H&S	Health and Safety Code
MCP	Medi-Cal Managed Care Plan
MHP	Mental Health Plan
MHPAEA	Mental Health Parity Addiction and Equity Act
SABG	Substance Abuse Block Grant
SMHS	Specialty Mental Health Service
SUD	Substance Use Disorder
TCM	Targeted Case Management
USPSTF	United States Preventative Services Taskforce
WIC	Welfare and Institutions Code

## **8. APPENDICES**

8.1 Medi-Cal Managed Care Models (Attachment A)

8.2 California Counties by Mental Health and DMC-ODS Region (Attachment B)

8.3 Benefits Mapping, Classification, and Definitions (Attachment C)

8.4 Medi-Cal Managed Care Plan Survey (Attachment D)

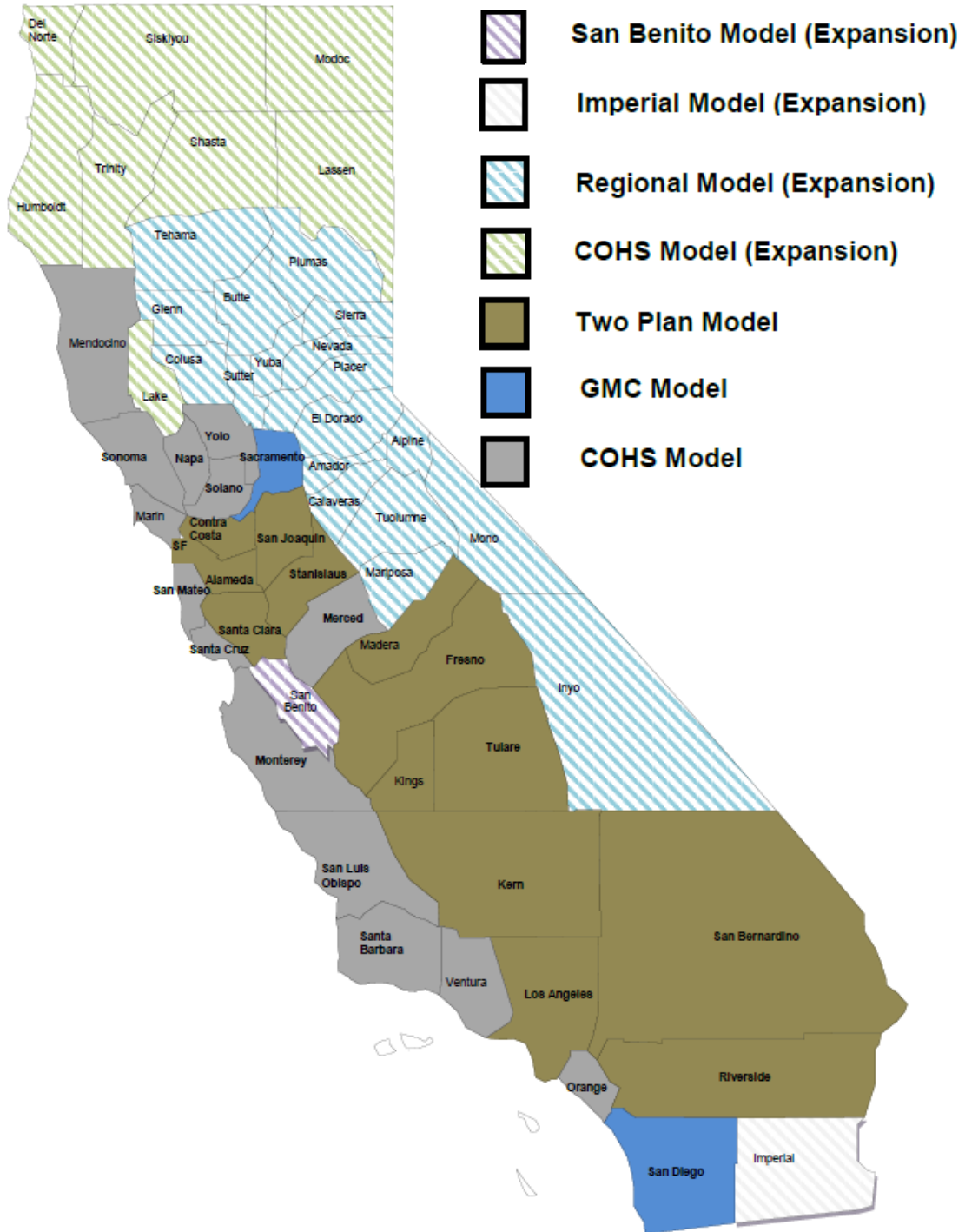
8.5 County Mental Health Plan Survey (Attachment E)

8.6 Medicaid Alternative Benefit Plan (ABP) State Plan Amendment (Attachment F)

8.7 EPSDT Documentation (Attachment G)

Attachment A  
Medi-Cal Managed Care Models

**MEDI-CAL MANAGED CARE MODELS**



**Attachment B**  
**California Counties by Mental Health and DMC-ODS Region**



Table 1. Medical/Surgical Benefits to the Four Classifications				
Inpatient <sup>1</sup>	Outpatient <sup>2</sup>		Prescription Drugs <sup>3</sup>	Emergency Care <sup>4</sup>
<ul style="list-style-type: none"> <li>▪ Anesthesiology services</li> <li>▪ Breastfeeding education</li> <li>▪ Diagnostic services</li> <li>▪ Labor and delivery</li> <li>▪ Laboratory</li> <li>▪ Medications administered during admission</li> <li>▪ Physician services</li> <li>▪ Nurse midwife services</li> <li>▪ Radiology</li> <li>▪ Surgery</li> <li>▪ Transplant (organ and tissue)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Acupuncture</li> <li>▪ Ambulatory surgery</li> <li>▪ Anesthesiology services</li> <li>▪ Audiology</li> <li>▪ Behavioral Health Treatment</li> <li>▪ Blood and blood derivatives</li> <li>▪ CBAS Services</li> <li>▪ Case management services</li> <li>▪ Chiropractic</li> <li>▪ Dental services</li> <li>▪ Diagnostic services</li> <li>▪ Dialysis</li> <li>▪ DME and other medical supplies</li> <li>▪ Eyeglasses and other eye appliances</li> <li>▪ Family planning services</li> <li>▪ Federally Qualified Health Center (FQHC) services</li> <li>▪ Health education services</li> <li>▪ Hearing aids</li> <li>▪ Home health services</li> <li>▪ Hospice services</li> <li>▪ Hospital outpatient and outpatient clinic services</li> <li>▪ Indian health services</li> <li>▪ Laboratory services</li> <li>▪ Local Education Agency (LEA) services</li> <li>▪ Long term care services (unless LTC services are under waivers exclusively)</li> <li>▪ Orthotics and prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medications administered during an outpatient visit</li> <li>▪ Nurse midwife services</li> <li>▪ Occupational therapy</li> <li>▪ Ophthalmology</li> <li>▪ Pediatric subacute services</li> <li>▪ Personal care services</li> <li>▪ Physical therapy</li> <li>▪ Physician services</li> <li>▪ Preventive services</li> <li>▪ Podiatry</li> <li>▪ Primary care services (general medicine, OB/GYN)</li> <li>▪ Psychological testing</li> <li>▪ Radiology</li> <li>▪ Rehabilitative services</li> <li>▪ Respiratory Care</li> <li>▪ Rural Health Clinic (RHC) services</li> <li>▪ Skilled nursing facility</li> <li>▪ Specialty care</li> <li>▪ Speech therapy</li> <li>▪ Treatment therapies (chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/infusion therapy, medication management)</li> <li>▪ Tuberculosis services</li> <li>▪ Transportation</li> <li>▪ Vision services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Enteral and nutrition formulas</li> <li>▪ Medications (generic and brand name)</li> <li>▪ Pharmacy supplies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ambulance</li> <li>▪ Emergency services</li> <li>▪ Laboratory</li> <li>▪ Radiology provided in an emergency department</li> <li>▪ Triage and physician services delivered in the emergency visit</li> <li>▪ Diagnostic services</li> <li>▪ Medications administered during emergency visit</li> <li>▪ Minor surgical procedures</li> </ul>

<sup>1</sup> **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.

<sup>2</sup> **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.

<sup>3</sup> **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medications-assisted treatment.

<sup>4</sup> **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.



**Table 2. Mental Health Services to the Four Classifications**

Inpatient <sup>1</sup>	Outpatient <sup>2</sup>	Prescription Drugs <sup>3</sup>	Emergency Care <sup>4</sup>
<ul style="list-style-type: none"> <li>▪ Administrative day services</li> <li>▪ Psychiatric Health Facility services</li> <li>▪ Acute Psychiatric Hospital services</li> <li>▪ Psychiatric hospital professional services in a FFS hospital</li> </ul>	<p><i>Non- Specialty Mental Health:</i></p> <ul style="list-style-type: none"> <li>▪ Psychotherapy (individual and group)</li> <li>▪ Outpatient services for the purposes of monitoring medication therapy</li> <li>▪ Psychiatric consultation</li> <li>▪ Laboratory</li> <li>▪ Mental health services (CBAS)</li> </ul> <p><i>Specialty Mental Health:</i></p> <ul style="list-style-type: none"> <li>▪ Adult Residential Treatment Services</li> <li>▪ Crisis Intervention</li> <li>▪ Crisis Stabilization</li> <li>▪ Crisis Residential/Treatment</li> <li>▪ Day Rehabilitation</li> <li>▪ Day Treatment Intensive</li> <li>▪ Intensive Care Coordination*</li> <li>▪ Intensive Home Based Services*</li> <li>▪ Medication Support Services</li> <li>▪ Mental Health Services               <ul style="list-style-type: none"> <li>○ Assessment</li> <li>○ Plan development</li> <li>○ Therapy</li> <li>○ Rehabilitation</li> <li>○ Collateral</li> </ul> </li> <li>▪ Targeted Case Management</li> <li>▪ Therapeutic Behavioral Services*</li> <li>▪ Therapeutic Foster Care*</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medications (generic and brand name)</li> <li>▪ Supplies and supplements</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ambulance</li> <li>▪ Emergency services</li> <li>▪ Laboratory</li> <li>▪ Radiology provided in an emergency department</li> <li>▪ Triage and physician services delivered in the emergency visit</li> <li>▪ Diagnostic services</li> <li>▪ Medications administered during emergency visit</li> <li>▪ Minor surgical procedures</li> </ul>

<sup>1</sup> **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.

<sup>2</sup> **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.

<sup>3</sup> **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder mediations-assisted treatment.

<sup>4</sup> **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.

\* EPSDT services.

**Table 3. Substance Use Disorder (SUD)\*\* Benefits to the Four Classifications**

Inpatient <sup>1</sup>	Outpatient <sup>2</sup>	Prescription Drugs <sup>3</sup>	Emergency Care <sup>4</sup>
<p><i>DMC-ODS:</i></p> <ul style="list-style-type: none"> <li>ASAM Level 3.7 Medically Monitored Intensive Inpatient Service (Adult) and Medically Monitored High-Intensity Inpatient Services (Adolescents)</li> <li>ASAM Level 4.0 Medically Managed Intensive Inpatient Services</li> </ul>	<p><i>Managed Care:</i></p> <ul style="list-style-type: none"> <li>SBIRT (Screening, Brief Intervention, and Referral to Treatment)</li> <li>Tobacco prevention and cessation services</li> </ul> <p><i>DMC:</i></p> <ul style="list-style-type: none"> <li>NTP Group Counseling</li> <li>NTP Individual Counseling</li> <li>Intensive Outpatient Treatment</li> <li>Outpatient Drug Free Group Counseling</li> <li>Outpatient Drug Free Individual Counseling</li> <li>Perinatal Residential Treatment</li> </ul> <p><i>DMC-ODS:</i></p> <ul style="list-style-type: none"> <li>ASAM Level 1 Outpatient Services</li> <li>ASAM Level 2.1 Intensive Outpatient Services</li> <li>ASAM level 2.5 Partial Hospitalization</li> <li>ASAM Level 3.1 Clinically-Managed Low-Intensity Residential Services</li> <li>ASAM Level 3.3 Clinically-Managed Population-Specific High-Intensity Residential Services</li> <li>ASAM Level 3.5 Clinically-Managed High-Intensity Residential Services</li> <li>Withdrawal Management Levels 1, 2 and 3.2</li> </ul>	<p><i>DMC:</i></p> <ul style="list-style-type: none"> <li>Naltrexone</li> <li>Methadone</li> </ul> <p><i>DMC-ODS:</i></p> <ul style="list-style-type: none"> <li>Additional Medication Assisted Treatment (ASAM OTP Level 1)</li> <li>Buprenorphine</li> <li>Disulfiram</li> <li>Naloxone</li> <li>Acamprosate</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance</li> <li>Emergency services</li> <li>Laboratory</li> <li>Radiology provided in an emergency department</li> <li>Triage and physician services delivered in the emergency visit</li> <li>Diagnostic services</li> <li>Medications administered during emergency visit</li> <li>Minor surgical procedures</li> </ul>

<sup>1</sup> **Inpatient** – All covered services furnished in a hospital, acute care setting, or psychiatric health facility.

<sup>2</sup> **Outpatient** – All covered services in an outpatient clinic, outpatient hospital or community-based setting.

<sup>3</sup> **Prescription Drugs** – All covered medications and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder mediations-assisted treatment.

<sup>4</sup> **Emergency Care** – All covered medications or items delivered in an emergency department (ED) setting other than an inpatient setting.

\*\*Drug Medi-Cal (DMC); Drug Medi-Cal Organized Delivery System (DMC-ODS)

# Attachment D - Medi-Cal Managed Care Plan Survey

## Medicaid Mental Health Parity Guidance

MEDICAID MENTAL HEALTH PARITY OVERVIEW	
<p>DHCS is conducting an analysis on the mental health parity regulations for managed care health plans (MCP); across all delivery systems. Under the final rule, CMS applies certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to the coverage provided to the enrollees of Medicaid managed care plans to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs.</p> <p>As required by the parity regulations, DHCS is evaluating treatment limitations which limit the scope or duration of the benefits for treatment. Treatment limitations may be non-quantitative treatment limitations (NQTL) which are non-numerical limits on benefits (such as pre authorization requirements) or quantitative treatment limitations (QTL) which are numeric (such as limit on visits).</p>	
NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTL) and QUANTITATIVE TREATMENT LIMITS (QTL) SURVEY	
<p>To assist these efforts, DHCS requests MCPs respond to the survey questions. MCPs must also incorporate responses from each MCP's subcontractors. The information gathered in this survey will help to ensure compliance with Medicaid Mental Health Parity by reviewing benefit limitations and restrictions between medical, mental health and substance use disorder benefits and ensuring MHSUD benefits are no more restrictive than medical benefits.</p> <p>Please respond to each survey question within the benefit classification if it applies. For questions that only apply to specific benefit classifications, a response is not needed for the other benefit classifications and may be "greyed out".</p> <p>Questions that are Yes or No response require additional information if the response is "yes". Please include additional detail about your response as requested by the survey question.</p>	
QUANTITATIVE TREATMENT LIMITS (QTL) AND FINANCIAL REQUIREMENTS	
<p>QTLs reference limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period or other similar limits on the scope of duration of treatment. QTLs are expressed numerically. Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Types of QTLs include annual, episode, lifetime and visit limits.</p>	
NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTL)	
<p>Under mental health parity regulations, a plan may not impose a NQTL on Mental Health/Substance Use Disorder (MH/SUD) benefits that are more stringent than medical or surgical benefits. The NQTL analysis will not focus on whether the final result is the same; instead, compliance depends on parity in application of the underlying process, strategies, evidentiary standards, or other factors (must be both written and in operation) as to the differences between the different limitations.</p> <p>Other factors that may be considered when developing NQTLs include but are not limited to cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion related to diagnosis and treatment, clinical efficacy of a proposed treatment or service, licensure and accreditation of providers, and claim types with a high percentage of fraud.</p>	
<p>Below is a list of NQTL examples that are both included in 42 CFR § 438.910(d)(2) and mentioned elsewhere in CMS guidance:</p>	
Illustrative list of NQTLs as listed in 42 CFR § 438.910(d)(2)	Other NQTLs included in mental health parity but not specifically included in the illustrative list
<ul style="list-style-type: none"> <li>-Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);</li> <li>-Formulary design for prescription drugs;</li> <li>-Plans with multiple network tiers (such as preferred providers and participating providers, network tier design);</li> <li>-Standards for provider admission to participate in a network, including reimbursement rates;</li> <li>-Plan methods for determining usual, customary, and reasonable charge;</li> <li>-Fail-first policies or step therapy protocols;</li> <li>-Exclusions based on failure to complete a course of action;</li> <li>-Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage; or</li> <li>-Standards for providing access to out-of-network providers.</li> </ul>	<ul style="list-style-type: none"> <li>-Limitations of in-patient services for situations where a participant is a threat to self or others;</li> <li>-Exclusions for court-ordered and involuntary holds when the included care would otherwise be considered medically necessary;</li> <li>-Concurrent review requirements and policies;</li> <li>-Retrospective review requirements and policies;</li> <li>-Service coding; or</li> <li>-Exclusions for services provided by clinical social workers.</li> </ul>
<p><b>CMS issued Examples that may be for reference when completing the survey:</b></p>	
<p><b>Example 1.</b> Facts. A MCO requires prior authorization that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient MH/SUD benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for 7 days, after which a treatment plan must be submitted by the patient's attending provider and approved by the MCO. Conversely, for inpatient MH/SUD benefits, routine approval is given only for 1 day, after which a treatment plan must be submitted by the beneficiary's attending provider and approved by the MCO.</p>	
<p><b>Example 2.</b> Facts. A MCO applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of MH/SUDs, but only 30 percent of medical/surgical conditions.</p>	
<p><b>Example 3.</b> Facts. A MCO requires prior approval that a course of treatment is medically necessary for outpatient medical/surgical and MH/SUD benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. For MH/SUD treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, providers will only receive a 25 percent reduction in payments for these treatments from the MCO.</p>	
<p><b>Example 4.</b> Facts. A MCO generally covers medically appropriate treatments. For both medical/surgical benefits and MH/SUD benefits, evidentiary standards used in determining whether a treatment is medically appropriate are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.</p>	
<p><b>Example 5.</b> Facts. Training and state licensing requirements often vary among types of providers. An MCO applies a general standard that any provider must meet the minimum requirement related to supervised clinical experience under applicable state licensure laws to participate in the MCO's provider network. State law requires master's level general medical providers to have post-degree, supervised clinical experience; therefore the MCO requires all master's level providers in its network (including mental health providers) to have post-degree, supervised clinical experience. State law does not require master's level mental health therapists to have post-degree, supervised clinical experience; therefore the MCO requirement to participate in the network is effectively higher than state law for master's level mental health therapists.</p>	
<p><b>Example 6.</b> Facts. A state contracts with an external contractor to review inpatient admissions for an ABP. The contractor considers a wide array of factors in designing medical management techniques for both MH/SUD and medical/surgical inpatient benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensure and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) inpatient MH/SUD benefits, as well as for some (but not all) medical/surgical benefits. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the state's utilization review organization.</p>	
<p><b>Example 7.</b> Facts. A MCO provides coverage for medically appropriate medical/surgical benefits, as well as MH/SUD benefits. The MCO excludes coverage for inpatient SUD services when obtained outside of the state. There is no similar exclusion for medical/surgical benefits within the same classification.</p>	
<p><b>Example 8.</b> Facts. A state's CHIP program requires prior authorization for all outpatient MH/SUD services after the ninth visit and will only approve up to 5 additional visits per authorization. For outpatient medical/surgical benefits, the state's CHIP program allows an initial visit without prior authorization. After the initial visit, benefits must be pre-approved based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.</p>	
<p><b>Example 9.</b> Facts. A state provides an ABP that is compliant with EHB requirements, including the provision of MH/SUD services. The state aligns its ABP's outpatient benefits with those described in the state plan and applies the same prior authorization requirements. For outpatient MH/SUD services, prior authorization is required for each individual treatment session. In contrast, for outpatient medical/surgical services, a series of treatments is provided under a single authorization.</p>	
<p><b>Example 10.</b> Facts. A state's ABP requires preauthorization for all outpatient substance use disorder services. The state ABP does not require preauthorization for any medical/surgical services.</p>	
<p><b>Example 11.</b> Facts. In cases where an MCO is unable to provide necessary outpatient services to a particular enrollee, the MCO requires that the enrollee must get prior approval in order to see any outpatient out-of-network provider. The MCO approves the use of an out-of-network provider for medical/surgical outpatient services if there is not an in-network provider within 10 miles of the person's residence. Approval of an out-of-network provider for outpatient MH/SUD services is only authorized if there is not an in-network provider within 30 miles of a person's residence.</p>	
<p><b>Useful Links:</b></p> <p>Press Release from CMS on finalizing the Medicaid Mental Health Parity  <a href="https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html">https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html</a></p>	
<p><b>Fact Sheet</b>  <a href="https://www.medicaid.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf">https://www.medicaid.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf</a></p>	
<p><b>Mental Health Parity and Addiction Equity Act Webpage</b>  <a href="https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html">https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html</a></p>	

MCP Name:

\*include Subcontractors

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

Prior Authorization and Referral Process		Inpatient	Outpatient	Pharmacy	Emergency
1	Provide a current copy of your plan's "No Prior Authorization (NPA) List" or "Prior Authorization List", whichever guidance is made available to providers.	Please attach your response to question 1. No other response is needed for this question.			
2	Does your plan require prior authorization for any inpatient services? (Yes/No) If yes, what is the review criteria or guidelines used in making a determination?				
3	Does your plan have a limit of days a member can receive inpatient care before needing the treatment to be reauthorized? <i>See Example 1 on guidance tab</i>				
4	Does your plan have a process for reviewing retrospective authorization requests? (Yes/No) If yes, what is the review criteria, guidelines and timeframe used in making a determination? <i>See Example 1 on guidance tab</i>				
5	Does your plan have a process for reviewing concurrent authorization requests? (Yes/No) If yes, what is the review criteria, guidelines and timeframe used in making a determination? <i>See Example 2 on guidance tab</i>				
6	What is your plan's process, strategy, evidentiary standard or other factors used to determine prior authorization requirements for services? (e.g. panels of experts, evidentiary standard based on clinically appropriate standards) <i>See Example 4 on guidance tab</i>				

MCP Name:

\*include Subcontractors

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

Prior Authorization and Referral Process		Inpatient	Outpatient	Pharmacy	Emergency
7	<p>When determining medically appropriate treatment standards, does your plan apply the same evidentiary standard to both medical/surgical and mental health/substance use disorder benefits? (Yes/No)</p> <p>If yes, are the treatment standards based off of recommendations made by panels of experts with appropriate training and expertise? (Yes/No)</p> <p>If yes, please provide policies and procedures related to the process, factors and standards used to make this determination.</p> <p><i>See Example 4 on guidance tab</i></p>				
8	<p>For services that require authorization after a limit is reached, what is the benefit type and maximum number of visits for needing an authorization?</p> <p>What is your process and underlying factors for the prior authorization policy for these services?</p> <p><i>See Example 8 on guidance tab</i></p>				
9	<p>Can multiple treatments be included under the same prior authorization? (Yes/No)</p> <p>If yes, what treatments can be included together?</p> <p><i>See Example 9 on guidance tab</i></p>				
10	<p>Does your plan require prior authorization in order for a member to obtain substance use disorder services such as SBIRT, tobacco cessation, etc.? (Yes/No)</p> <p>If yes, what is the review criteria or guidelines used in making a determination?</p> <p><i>See Example 10 on guidance tab</i></p>				
11	<p>Does your plan require approval of referrals made from PCP's to specialty services? (Yes/No)</p> <p>If yes, what is the review criteria or guidelines used in making a determination and are they more restrictive than the minimum required by DHCS?</p>				

MCP Name:

\*include Subcontractors

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

Prior Authorization and Referral Process		Inpatient	Outpatient	Pharmacy	Emergency
12	<p>Does your plan require prior authorization in order for a member to obtain mild to moderate mental health services? (Yes/No)</p> <p>If yes, what is the review criteria or guidelines used in making a determination?</p> <p><i>See Example 12 on guidance tab</i></p>				
Pharmacy and Drug Formulary		Inpatient	Outpatient	Pharmacy	Emergency
13	<p>What is the process, strategy, evidentiary standard or other factors you use for formulary review on prior authorization of pharmacy services (e.g. panels of experts, evidentiary standard based on clinically appropriate standards)</p> <p><i>See Example 4 on guidance tab</i></p>				
14	<p>Do you require a member to first try one form of treatment before progressing to other treatments (e.g. fail first, step therapy)? (Yes/No)</p> <p>If yes, what treatments/services/prescriptions?</p>				
15	<p>Do you reimburse out of network pharmacy providers?</p>				
16	<p>Do you require labs, drug testing, or any other patient compliance monitoring as a part of prior authorization requirements? (Yes/No)</p> <p>If yes, only list requirements to receive the treatment, do not include testing that is recommended or preferred.</p>				
17	<p>Do you have different utilization management criteria based on diagnosis for any particular medication(s)?</p> <p><i>See Example 13 on guidance tab</i></p>				
Provider Network, Credentialing and Contracting		Inpatient	Outpatient	Pharmacy	Emergency
18	<p>Do you require additional credentialing standards beyond DHCS required standards for physicians? (Yes/No)</p> <p>If yes, what additional standards do you require for physicians?</p> <p><i>See Example 5 on guidance tab</i></p>				
19	<p>Do you require additional credentialing standards beyond DHCS required standards for licensed non-physician providers? (Yes/No)</p> <p>If yes, what additional standards do you require for non-physician providers?</p> <p><i>See Example 5 on guidance tab</i></p>				

MCP Name:

\*include Subcontractors

**MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT  
Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey**

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

Provider Network, Credentialing and Contracting		Inpatient	Outpatient	Pharmacy	Emergency
20	Do you restrict the types of provider specialties that can provide certain mental health and/or substance use disorder benefits? (Yes/No) If yes, what provider types can provide mental health and/or substance use disorder services/treatments? <i>See Example 5 on guidance tab</i>				
21	What DHCS required services/treatments are covered by your plan for a member who needs treatment while outside of California? <i>See Example 7 on guidance tab</i>				
22	Do you restrict the geographic location in which services can be received? <i>See Example 11 on guidance tab</i>				
23	Do you restrict the type(s) of facilities in which enrollees can receive services? This question only pertains to facilities that are considered more restrictive than listed in the DHCS Provider Manual.				
24	Do you have multiple network tiers?				
Case Management and Care Coordination		Inpatient	Outpatient	Pharmacy	Emergency
25	What case management services are available and/or required?				
26	Are there any limits on case management services? (Yes/No) If yes, what are they?				
27	How do you address court-ordered services that are not covered by Mental Health/Substance Use Disorder?				
28	What services require a written treatment plan before a member can receive services and what frequency are they required to be updated?				
Treatment Restrictions and/or Exclusions		Inpatient	Outpatient	Pharmacy	Emergency
29	Does your plan limit treatment or service options based on failure to complete prior treatment or due to patient non-compliance? (Yes/No) If yes, what is the criteria for each benefit?				
30	Does your plan require a member to first try one form of treatment before progressing to other treatments? (Yes/No) If yes, what treatments or services?				

MCP Name:

\*include Subcontractors

**MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**  
**Non-Quantitative Treatment Limitations and Quantitative Treatment Limitations Survey**

Summarize the MCP's applicable QTLs and NQTLs, including any variations by benefit into the correct classification.

Financial Requirements		Inpatient	Outpatient	Pharmacy	Emergency
31	What is your plan's policy on payment for services that require prior authorization if the prior authorization is not obtained but treatment is provided? <i>See Example 3 on guidance tab</i>				
32	Are there any group size rules for billing purposes?				
33	What services can be billed for half day of service?				
34	What constitutes as a half day of service versus a full day for billing purposes?				
35	Is your plan required to cover costs for member's first day of admission?				



## Mental Health Parity and Addiction Equity Act Overview

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued the Federal Register, which requires state Medicaid agencies to comply with the MHPAEA requirements and included regulations for program compliance with the parity rule.

As a result, the Department of Health Care Services (DHCS) is conducting a mandatory assessment of Medicaid benefits across all managed care delivery systems to ensure the State's compliance with the Federal Parity rule. In an effort to **assess** existing practices in key areas, DHCS is surveying the Managed Care Organizations, Mental Health Plans<sup>1</sup>, DMC-ODS County Plans, and counties providing other SUD services.

The rule requires DHCS to examine medical/surgical and mental health and substance use disorder (MHSUD) benefits in four benefit classifications: 1) inpatient; 2) outpatient; 3) emergency; and, 4) pharmacy/formulary. The assessment includes a review of treatment limitations (quantitative and non-quantitative) and financial requirements, which are defined as follows:

- Quantitative treatment limitations (QTLs) include the number of visits/days covered, frequency of treatment, or other limits on duration and scope of treatment.
- Non-quantitative treatment limitations (NQTLs) include utilization management procedures such as prior authorization, concurrent review, medical necessity, and step therapy protocols<sup>2</sup>.
- Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket limits.

The enclosed survey covers NQTLs, QTLs, and financial requirements in the following categories:

- Authorization
- Case Management and Care Coordination
- Client Plans
- Progressive Therapy/Step Therapy
- Provider Network, Credentialing and Contracting
- Medication Prescribing, Authorization, and Monitoring
- Financial Requirements
- Disclosure Requirements

The purpose of the survey is to assess existing practices, not determine compliance.

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<sup>1</sup> For purposes of this survey, "County" refers to Mental Health Plans, DMC-ODS Plans, and other county SUD services.

<sup>2</sup> Step therapy protocols (also called progressive therapies) indicate a progression of services (e.g., group therapy preceding individual therapy and Full Service Partnership levels of care).

## **Survey Instructions:**

1. Please complete the survey below as accurately as possible.
2. For short answer questions, please provide a brief response and include citations for County policies and procedures, or other documentation, that will assist with DHCS' review.
3. Please consider practices for services to both adult and children/youth beneficiaries when responding to the survey questions.
4. The survey questions apply to mental health and substance use disorder services.
5. Please complete and return the survey to DHCS no later than Friday, February 3, 2017.
6. If you have questions or require assistance in completing the survey, please contact Brian Keefer at [Brian.Keefer@dhcs.ca.gov](mailto:Brian.Keefer@dhcs.ca.gov)
7. Please submit requested documentation to [Brian.Keefer@dhcs.ca.gov](mailto:Brian.Keefer@dhcs.ca.gov) no later than Friday, February 17, 2017.

### **Authorization Procedures**

#### **Guidance:**

- Prior Authorization refers to authorization and approval of services prior to service delivery, which may include review of medical necessity criteria before services begin.
- Concurrent Authorization refers to daily stay review for inpatient and residential services or per treatment (or set of treatments) review for outpatient services.
- Retrospective Authorization refers to post-service delivery review and authorization of services, usually via request for payment/claims processing.
- Pre-Notification refers to notification of services prior to or concurrently with service delivery for a beneficiary.

#### **Please provide the following documentation:**

- A list of all services requiring prior authorization
- Policies and Procedures (P&Ps): Authorization of Inpatient Services
- Hospital Utilization Review Committee (URC) Policies and Procedures (P&Ps): Authorization of Inpatient Services
- Policies and Procedures (P&Ps): Authorization of Outpatient Services
- Policies and Procedures (P&Ps): Authorization of Residential Services
- Policies and Procedures (P&Ps): Authorization Criteria and/or Evidentiary Standards
- Authorization Review and Chart Audit Tools
- Provider Manual
- Network Provider Boilerplate Contract (for individual and organizational providers)

Parity Review Assessment		YES	NO	NOT SURE
	Does the COUNTY require prior authorization for any <b>inpatient services</b> (including both acute and administrative days)?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY limit prior-authorization to a specific number days for <b>inpatient services</b> (including both acute and administrative days)?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY conduct concurrent authorization review for any <b>inpatient services</b> (including both acute and administrative days)?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY conduct retrospective authorization review for <b>inpatient services</b> (including both acute and administrative days)?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Are the COUNTY's P&Ps on authorization of inpatient services more restrictive than the minimum state or federal requirements?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	What is the COUNTY's process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <b>inpatient services</b> ?	COUNTY Response:		
	What are the hospital's Utilization Review Committee (URC) procedures for authorization of <b>inpatient services</b> (both admissions and continued stay services)?	COUNTY Response:		
	What is the role of psychiatrists and/or physicians in authorization of <b>inpatient services</b> ?	COUNTY Response:		
	Does the COUNTY require prior authorization for <b>psychiatric health facility services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY limit prior-authorization to a specific number days for <b>psychiatric health facility services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY conduct concurrent authorization review for any <b>psychiatric health facility services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Does the COUNTY conduct retrospective authorization review for <b>psychiatric health facility services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	Are the COUNTY's P&Ps more restrictive than the minimum state or federal requirements?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
	What is the COUNTY's process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <b>psychiatric health facility services</b> ?	COUNTY Response:		
	What is the role of psychiatrists and/or physicians in authorization of <b>psychiatric health facility services</b> ?	COUNTY Response:		
	Does the COUNTY require prior authorization for <b>residential services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>

Does the COUNTY limit prior-authorization to a specific number days for <b>residential services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY conduct concurrent authorization review for any <b>residential services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY conduct retrospective authorization review for <b>residential services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Are the COUNTY's P&Ps more restrictive than the minimum state or federal requirements?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input checked="" type="checkbox"/>
What is the COUNTY's process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <b>residential services</b> ?	COUNTY Response:		
What is the role of psychiatrists and/or physicians in authorization of <b>residential services</b> ?	COUNTY Response:		
Does the COUNTY require prior authorization for any <b>outpatient services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY require approval of referrals for any <b>outpatient services</b> (e.g., ICC, IHBS, TBS, Psychiatry, IOT)?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY require a level of care assessment, approved by the COUNTY, for any <b>outpatient services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY limit prior-authorization to a specific number days/visits (i.e., 10 clinic visits before a new authorization is required) for <b>outpatient services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY conduct concurrent authorization review for any <b>outpatient services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY conduct retrospective authorization review (e.g., via claims payment processing, etc.) for any <b>outpatient services</b> ?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Are the COUNTY's P&Ps more restrictive than the minimum state or federal requirements?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
What is the COUNTY's process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <b>outpatient services</b> ?	COUNTY Response:		
What is the role of psychiatrists and/or physicians in authorization of any <b>outpatient services</b> ?	COUNTY Response:		
Does the COUNTY require prior authorization for <b>crisis stabilization services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
Does the COUNTY conduct concurrent authorization review for any <b>crisis stabilization services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>
Does the COUNTY conduct retrospective authorization review (e.g., via claims payment processing, etc.) for any <b>crisis stabilization services</b> ?	MH <input type="checkbox"/>	MH <input type="checkbox"/>	MH <input type="checkbox"/>

	What is the COUNTY's process, strategy, evidentiary standards, and/or other factors (e.g., panels of experts, evidentiary standard based on clinically appropriate standards, etc.) used to determine authorization for <b>crisis stabilization services</b> ?	COUNTY Response:		
	What is the role of psychiatrists and/or physicians in authorization of <b>crisis stabilization services</b> ?	COUNTY Response:		
	Does the COUNTY require providers to pre-notify the COUNTY when providing services to a new beneficiary?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	Does the COUNTY require providers to pre-notify the COUNTY when providing a new service to an existing beneficiary?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
7	What is the COUNTY's policy on payment for services that require prior authorization if the prior authorization is not obtained by the provider, but treatment is provided?	COUNTY Response:		
<b>Case Management and Care Coordination</b>				
<b><u>Please provide the following documentation:</u></b>				
<ul style="list-style-type: none"> <li>• Policies and Procedures (P&amp;Ps): Case Management</li> <li>• Policies and Procedures (P&amp;Ps): Care Coordination</li> <li>• Provider Manual</li> <li>• Practice Guidelines</li> </ul>				
Parity Review Assessment		YES	NO	NOT SURE
	Are there any limitations imposed on case management services?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, please specify:	COUNTY Response:		
	Are there any limitations imposed on care coordination services?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, please specify:	COUNTY Response:		
<b>Client Plans</b>				
<b><u>Please provide the following documentation:</u></b>				
<ul style="list-style-type: none"> <li>• Policies and Procedures (P&amp;Ps): Client Plans</li> <li>• Provider Manual</li> </ul>				
10	What is the COUNTY's standard timeframe for completion of the client plan?	COUNTY Response:		
11	What is the COUNTY's standard timeframe for updating the client plan?	COUNTY Response:		
12	What is the COUNTY's procedure for periodically reviewing the client plan?	COUNTY Response:		

### Progressive Therapy/ Step Therapy

**Guidance:**

- Progressive therapies could include, for example, 8 group sessions before individual treatment is authorized.

**Please provide the following documentation:**

- Policies and Procedures (P&Ps): Selecting Interventions
- Policies and Procedures (P&Ps): Progressive Therapies
- Practice Guidelines
- Provider Manual

Parity Review Assessment		YES	NO	NOT SURE
	Does the COUNTY limit treatment options based on failure to complete prior treatments and/or due to client non-compliance?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, what criteria are used to make such determinations?	COUNTY Response:		
	Does the COUNTY require a beneficiary to first try one form of treatment before progressing to other treatments?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, what treatments or services?	COUNTY Response:		
	Is the determination at all based on the cost of the treatment?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>

### Provider Network, Credentialing and Contracting

**Please provide the following documentation:**

- Policies and Procedures (P&Ps): Credentialing
- Provider Manual

Parity Review Assessment		YES	NO	NOT SURE
15	What are the COUNTY's current procedures for credentialing licensed providers (e.g., Psychiatrists, Psychologists, LCSW, LMFT, LPCC, RN)?	COUNTY Response:		
16	What are the COUNTY's current procedures for credentialing non-licensed providers?	COUNTY Response:		
17	Does the COUNTY have multiple network tiers (e.g., preferred providers)?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	Does the COUNTY restrict the types of provider specialties that can provide certain mental health and/or substance use disorder services?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, what provider types and services are restricted?	COUNTY Response:		
	Does the COUNTY require beneficiaries to access services in a specific geographic location/area?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>

	If yes, under what circumstances are such restrictions imposed?	COUNTY Response:		
	What are the COUNTY's limitations regarding access to out-of-network providers?	COUNTY Response:		
<b>Medication Prescribing, Authorization and Monitoring</b>				
<b>Guidance:</b>				
<ul style="list-style-type: none"> <li>Pharmacy is not a covered benefit under the 1915(b) Waiver.</li> <li>For SMHS, consider prescribing practices rather than authorization procedures.</li> <li>For DMC and SUD services, consider prescribing and authorization procedures, if applicable.</li> <li>For SUD services, include Medication Assisted Treatment</li> </ul>				
<b>Please provide the following documentation:</b>				
<ul style="list-style-type: none"> <li>Policies and Procedures (P&amp;Ps): Medication Monitoring</li> <li>Policies and Procedures (P&amp;Ps): Prescribing Practices</li> <li>Policies and Procedures (P&amp;Ps): Medication Assisted Treatment</li> <li>Practice Guidelines: Medication</li> </ul>				
Parity Review Assessment		YES	NO	NOT SURE
	Does the COUNTY require labs, drug testing, or any other patient compliance monitoring for the purposes of prescribing certain types of medications?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	If yes, list applicable medications.	COUNTY Response:		
21	What criteria are used for prescribing medications?	COUNTY Response:		
22	What are the COUNTY's procedures for medication monitoring?	COUNTY Response:		
<b>Regarding Financial Requirements</b>				
<b>Please provide the following documentation:</b>				
<ul style="list-style-type: none"> <li>Policies and Procedures (P&amp;Ps): Provider Claims Processing</li> <li>Policies and Procedures (P&amp;Ps): Group Size Limitations</li> <li>Policies and Procedures (P&amp;Ps): Cost Sharing</li> <li>Policies and Procedures (P&amp;Ps): Rate Development</li> </ul>				
Parity Review Assessment		YES	NO	NOT SURE
23	What are the COUNTY's methods for determining usual, customary, and reasonable charges?	COUNTY Response:		
24	What are the COUNTY's methods for determining reimbursement rates for providers?	COUNTY Response:		
25	Does the COUNTY have any group size rules for billing purposes?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
	Does the COUNTY impose any cost-sharing requirements?	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>

If yes, under what circumstances?		COUNTY Response:		
<b>Disclosure Requirements</b>				
<b><u>Please provide the following documentation:</u></b>				
<ul style="list-style-type: none"> <li>• Policies and Procedures (P&amp;Ps): Medical Necessity Determinations</li> <li>• Policies and Procedures (P&amp;Ps): Information Dissemination</li> </ul>				
<b>Parity Review Assessment</b>		<b>YES</b>	<b>NO</b>	<b>NOT SURE</b>
Does the COUNTY make the criteria for medical necessity determinations available to any current or potential beneficiaries upon request?		MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>
Does the COUNTY make the criteria for medical necessity determinations available to contracting providers upon request?		MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>	MH <input type="checkbox"/> SUD <input type="checkbox"/>

<b>Respondent Information</b>	
Please provide the following information. DHCS may contact you with regarding responses.	
Name	
Title	
Email	
Phone	
Role in County	



Attachment F  
Alternative Benefit Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
San Francisco Regional Office  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

---

Toby Douglas, Director  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

**MAR 28 2014**

Dear Mr. Douglas:

Enclosed for your records is an approved copy of California's Alternative Benefit Plan (ABP) State Plan Amendment (SPA) CA-13-035. This ABP, which was submitted on December 30, 2013, meets all federal statutory and regulatory requirements for establishing an ABP.

All requirements pertaining to ABPs must be met, including -- but not limited to -- benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and managed care service delivery systems (i.e., SPAs and managed care contracts). Future amendments to California's approved Medicaid program that are made by SPAs, waivers or managed care contracts may require corresponding amendments to the ABP if the change to the benefit in the approved State plan will be mirrored in the ABP.

This ABP SPA is approved effective January 1, 2014. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 3.1-L:
  - ABP 1, page 1
  - ABP 2a, page 1
  - ABP 3, pages 1-2
  - ABP 4, page 1
  - ABP 5, pages 1-42
  - ABP 7, pages 1-2
  - ABP 8, pages 1-4
  - ABP 9, pages 1
  - ABP 10, page 1
  - ABP 11, page 1

Page 2 – Toby Douglas, Director

If you have any questions, please contact Tom Schenck at (415)744-3589 or [tom.schenck@cms.hhs.gov](mailto:tom.schenck@cms.hhs.gov).

Sincerely,

Originally signed by Gloria Nagle

Gloria Nagle, Ph.D., MPA  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Laurie Weaver, California Department of Health Care Services  
Wendy Ly, California Department of Health Care Services

**Medicaid Alternative Benefit Plan: Summary Page (CMS 179)**

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**State/Territory****name:****California****Transmittal Number:**

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

13-0035

**Proposed Effective Date**

01/01/2014

*(mm/dd/yyyy)***Federal Statute/Regulation Citation**

Section 1902(a)(10)(A)(i)(VIII); SEction 1902(k)(1); Section 1937

**Federal Budget Impact**

	<b>Federal Fiscal Year</b>	<b>Amount</b>
<b>First Year</b>	2014	\$ 557306000.00
<b>Second Year</b>	2015	\$ 743074000.00

**Subject of Amendment**

ACA Alternative Benefit Plan

**Governor's Office Review**

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

**No reply received within 45 days of submittal**

- Other, as specified**

Describe:

The Governor's Office does not wish to review the State Plan Amendment

**Signature of State Agency Official****Submitted By:****Kathryn Waje****Last Revision****Date:****Mar 25, 2014****Submit Date:****Dec 30, 2013**



# Alternative Benefit Plan

OMB Control Number: 0938-1148  
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Alternative Benefit Plan Populations ABPI

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

### Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130724



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

**Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A) (i)(VIII) of the Act** ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

In accordance with CMS instruction and technical assistance, California has fully aligned its benefits in the ABP to reflect the State Plan, using the Blue Cross/Blue Shield FEHBP to define the EHBs. To the extent services are considered Long Term Services and Supports (LTSS), these services are only available under the ABP to individuals who meet the medically frail criteria. The criterion governing the availability of these State Plan services aligns with or is at least as stringent as the medically frail criteria. As such, those ABP recipients who qualify for State Plan LTSS services based on medical necessity will be considered medically frail and will not be subject to a separate determination beyond the applicable, service-specific needs assessment.

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917



# Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L-

OMB Expiration date: 10/31/2014

## Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

### Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
  - The state/territory offers benefits based on the approved state plan.
  - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - The state/territory offers the benefits provided in the approved state plan.
    - Benefits include all those provided in the approved state plan plus additional benefits.
    - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - The state/territory offers only a partial list of benefits provided in the approved state plan.
    - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

### Selection of Base Benchmark Plan



# Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.  No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP 5. The state assures the accuracy of all information in ABP 5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807





# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Benefits Description	ABP5
The state/territory proposes a "Benchmark-Equivalent" benefit package. <input type="checkbox"/> No	
<b>Benefits Included in Alternative Benefit Plan</b>	
Enter the specific name of the base benchmark plan selected:	
The Standard Blue Cross/Blue Shield Preferred Provider Option-Federal Employees Health Benefit Program (FEHBP)	
Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."	
Secretary-Approved	



# Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided:

Hospital Outpatient & Outpatient Clinic Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The following outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month: acupuncture, audiology, occupational therapy, podiatry, and speech therapy; may exceed limit for medical necessity with Treatment Authorization Request (TAR). Includes Indian Health Services.

Benefit Provided:

Outpatient Hospital: Outpatient Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

Frequency limits of once per lifetime on some surgeries.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes anesthesiologist services.

Benefit Provided:

Other Licensed Practitioners: Podiatry

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 per month

Duration Limit:

None

Scope Limit:

Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics, FQHCs and RHCs.



# Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Remove

Benefit Provided:

Other Licensed Practitioners: Chiropractic

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 per month

Duration Limit:

None

Scope Limit:

Pregnant women and EPSDT covered. Other beneficiaries are only covered in FQHCs and RHCs.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Scope of licensure.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Outpatient Hospital: Treatment Therapies

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



# Alternative Benefit Plan

Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/infusion therapy, medication management.		
Benefit Provided: Physician Services: Allergy Care	Source: State Plan 1905(a)	Remove
Authorization: Authorization required in excess of limitation	Provider Qualifications: Medicaid State Plan	
Amount Limit: 8 injections within 120 days	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Emergency treatment does not require TAR.		
Benefit Provided: Outpatient Hospital: Dialysis/Hemodialysis	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly.		
Benefit Provided: Non-Emergency Ambulance Transportation	Source: State Plan 1905(a)	



# Alternative Benefit Plan

Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: None	Duration Limit: None	
Scope Limit: As related to program covered services.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Other Medical Care: Air transportation only covered when ground transportation is not feasible; transportation covered from non-contract hospital to nearest contract hospital when patient is stable.		
Benefit Provided: Hospice	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: Six months, but may be longer with TAR	
Scope Limit: Any Medi-Cal eligible recipient certified by a physician as having a life expectancy of six months or less. Includes routine home care, continuous home care, respite care and general inpatient care.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Children may receive concurrent palliative care.		
Add		



# Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided:

Outpatient Hospital: Emergency

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including emergency dental services, as certified by the attending physician or other appropriate provider.

Benefit Provided:

Medical Transportation: Ambulance Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Nearest hospital capable of meeting patient's need.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Air transportation only covered when ground transportation is not feasible.

Add



# Alternative Benefit Plan

## ■ Essential Health Benefit 3: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital/Surgical Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Frequency limits of once per lifetime on some surgeries.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Room and Board. Professional services performed by physicians, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME and medical supplies; and Indian Health Services. These facilities are not Institutions for Mental Disease (IMD) and the IMD payment exclusion applies.

Benefit Provided:

Inpatient Hospital: Bariatric Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Patient must be at or above specified BMI levels and meet certain conditions to qualify.

Benefit Provided:

Other Lic. Practitioner: Anesthesiologist Services

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



# Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Inpatient Hospital: Organ & Tissue Transplantation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Transplant surgery, pre-transplant evaluation, post-operative care and laboratory services for bone marrow, heart, liver, kidney, heart-lung, simultaneous kidney-pancreas, single lung, double lung, pancreas, small bowel and combined liver-small bowel surgeries.

Benefit Provided:

Inpatient Hospital: Reconstructive Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Cosmetic surgery is not a covered benefit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgery is limited to that performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function and/or to create a normal appearance, to the extent possible. Includes breast reconstruction after mastectomy.

Add





# Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care Collapse All

Benefit Provided:

Physician Service: Prenatal Care

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Date of conception through delivery.

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Diagnostic services include sonography, genetic testing and cordocentesis; genetic screening of father for cystic fibrosis if he is a Medi-Cal beneficiary.

Benefit Provided:

Inpatient Hospital: Delivery and Postpartum Care

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Delivery through 60 days after delivery.

Scope Limit:

Medical services related to delivery and postpartum care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital stay 48 to 96 hours post delivery.

Benefit Provided:

Physician Services: Breastfeeding Education

Source:

State Plan Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Other

Duration Limit:

Birth through discharge visit

Scope Limit:

Mother of newborn.



# Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

May be provided by physician, a registered nurse or a registered dietician working under physician.

Remove

Benefit Provided:

Nurse Midwife Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Date of conception through 60 days after delivery.

Scope Limit:

Under supervision of physician

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



# Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided:

Rehabilitation: Outpatient Mental Health

Source:

State Plan Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Professional/Outpatient Mental Health Services. Includes individual and group psychotherapy, psychological testing and medication management.

Benefit Provided:

Rehabilitation: Outpatient Specialty Mental Health

Source:

State Plan Other

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other/Outpatient Specialty Mental Health Services. Includes day treatment services; crisis intervention and stabilization; adult crisis residential; mental health services; medication management and targeted case management.

Benefit Provided:

Rehabilitation: Inpatient Mental Health

Source:

State Plan Other

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



# Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient Specialty Mental Health Services. Acute psychiatric inpatient hospital services, psychiatric health facility services and psychiatric inpatient professional services. The IMD payment exclusion applies to acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient professional services only when those services are provided in a facility that is considered an IMD based on 42 CFR Sections 435.1009 and 435.1010.

Benefit Provided:

Rehabilitation: Substance Use Disorder Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient Substance Use Disorder Services. Services include Outpatient Drug Free; Intensive Outpatient Treatment; Naltrexone Treatment; Narcotic Treatment Program. Post periodic review. Prior authorization is required for Narcotic Treatment Program counseling more than 200 minutes per month.

Benefit Provided:

Physician Service: Heroin/Opioid Detoxification

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

21 consecutive days per treatment

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient heroin/opioid detoxification. Services include Narcotic Treatment Program. When medically necessary, additional 21-day treatments are covered after 28 days have passed since beneficiary completed a preceding course of treatment. Includes medically necessary services to diagnose and treat diseases that are concurrent with, but not part of, outpatient heroin or other opioid detoxification services.



# Alternative Benefit Plan

<b>Benefit Provided:</b> Inpatient Hosp.:Voluntary Inpatient Detoxification	<b>Source:</b> State Plan 1905(a)	<b>Remove</b>
<b>Authorization:</b> Prior Authorization	<b>Provider Qualifications:</b> Medicaid State Plan	
<b>Amount Limit:</b> None	<b>Duration Limit:</b> None	
<b>Scope Limit:</b> None		
<b>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</b> Room and Board. Professional services performed by physicians to aid detoxification, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME, and medical supplies. These facilities are not IMDs and the IMD payment exclusion applies.		
<b>Add</b>		



# Alternative Benefit Plan

## ■ Essential Health Benefit 6: Prescription drugs

### Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The State of California's ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.



# Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Physical Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Authorizations is valid for up to 120 days and must include a treatment plan. Prior authorization is not granted for more than 30 treatments at any one time.

Benefit Provided:

Home Health: Durable Medical Equipment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Replacement limits vary by type of equipment.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health: Hearing Aids

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

\$1,510 cap per person, per year; some exceptions

Duration Limit:

None

Scope Limit:

\$1,510 annual cap may be exceeded for medical necessity.



# Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Replacement hearing aids for those that are lost, stolen or damaged are not subject to the \$1,510 cap.

Remove

Benefit Provided:

PT and Related Services: Speech Therapy/Audiology

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 per month

Duration Limit:

None

Scope Limit:

Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:

PT and Related Services: Occupational Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 per month

Duration Limit:

None

Scope Limit:

Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:

Other Licensed Practitioner: Acupuncture

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan





# Alternative Benefit Plan

Amount Limit: 2 per month	Duration Limit: None	Remove
Scope Limit: Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.		
Benefit Provided: Rehabilitative Services: Cardiac Rehabilitation	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		
Benefit Provided: Rehabilitative Services: Pulmonary Rehabilitation	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Pulmonary rehabilitation for acute airway obstruction or sputum induction for diagnostic purposes is limited to 6 in 30 days; aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis is limited to 1 in 30 days.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: May exceed limit for medical necessity.		



# Alternative Benefit Plan

Benefit Provided:		Source:	
Home Health:Medical Supplies,Equipment, Appliances		State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	None		
Scope Limit:			
Cochlear implant for one ear only; frequency limits on replacement parts.			
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
Includes surgically implanted hearing devices, prior authorization required. Certain medical supplies require TAR.			
Benefit Provided:		Source:	
Orthotics/Prostheses		State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:		
Authorization required in excess of limitation	Medicaid State Plan		
Amount Limit:	Duration Limit:		
Frequency limits on replacements	None		
Scope Limit:			
TAR required when cumulative costs of orthotics exceed \$250 and prosthetics exceed \$500.			
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
Benefit Provided:		Source:	
Home Health Services		State Plan 1905(a)	
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	None		
Scope Limit:			
Written plan of care reviewed by physician every 60 days, provided by home health agency that meets conditions for participation for Medicare.			



# Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Authorization requirements vary based upon type of service. Services include nursing services which may be provided by a registered nurse when no home health agency exists in area; home health aid services; medical supplies and equipment; and therapies.

Remove

Benefit Provided:

Skilled Nursing Facility and Other

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

90 days

Scope Limit:

Benefit provided only as a short stay.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biologicals, supplies, appliances, and equipment. Patient must need daily care.

Benefit Provided:

FQHC Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Rehabilitative/Habilitative Services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Only the rehabilitative and/or habilitative portion of the FQHC benefit is offered through this EHB.

Add



# Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services		Collapse All <input type="checkbox"/>
Benefit Provided:	Source:	
<input type="text" value="Outpatient Laboratory and X-Ray Services"/>	<input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="See below"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month by the Laboratory Services Reservation System (LSRS). Up to four of the following radiological ultrasound procedure codes for each beneficiary per year based on medical necessity: ultrasound, chest ultrasound, abdominal, and retroperitoneal. More than four requires documentation of medical necessity or by report. Prior authorization required for portable X-ray unless performed in SNF or ICF. Various advanced imaging procedures are covered, based on medical necessity. Many of the procedures require a TAR and are subject to frequency limitations."/>		
<input type="button" value="Add"/>		



# Alternative Benefit Plan

Essential Health Benefit 9: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Family Planning Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

See below

Scope Limit:

Individuals of childbearing age; must be 21 to receive sterilization

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes family planning visits and counseling, invasive contraceptive procedures/devices, tubal ligations, vasectomies, contraceptive drugs or devices, and laboratory procedures, radiology and drugs associated with family planning procedures. TAR required for inpatient sterilization. Frequency limits on certain contraceptives and other services. Informed consent required for sterilizations.

Benefit Provided:

Physician Services: Smoking Cessation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

By or under supervision of physician

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes diagnosis, treatment, smoking cessation products when used in conjunction with behavior modification support, referral to 1-800 helpline and one face-to-face counseling session per quit attempt for specific populations.

Add



# Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Up to age 21, or to finish treatment that began before beneficiary turned 21. Some outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR. Children enrolled in the ABP receive screenings according to the current Bright Futures periodicity schedule, which is at least as robust as the screenings received by children enrolled in the traditional State Plan. California is making changes to its policies so that all children enrolled in Medi-Cal will soon receive screenings in accordance with the current Bright Futures periodicity schedule.

Add



# Alternative Benefit Plan

Other Covered Benefits from Base Benchmark

Collapse All



# Alternative Benefit Plan

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Cognitive Rehabilitation Therapy (CRT)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 substitution: Rehabilitation, Cognitive Rehabilitation Therapy. Federally Qualified Health Center (FQHC) services are being used from the existing State Plan for substitution purposes. Cognitive Rehabilitation Therapy would be considered 'Rehabilitation and Habilitative Services and Devices' EHB7 category. CRT aims to rehabilitate lost or altered cognitive skills, enabling individuals to reach functional and independent daily living. FQHCs provide numerous rehabilitative services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Hospital Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Outpatient Hospital and Clinic Services -- The following hospital outpatient and clinic services are limited to a maximum of two services in any one calendar month or any combination of two services per month: acupuncture, audiology, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with Treatment Authorization Request (TAR). Includes Indian Health Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Ambulatory Surgical Center Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Outpatient Hospital Services, Outpatient Surgery -- Outpatient surgery includes anesthesiologist services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Podiatry"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Other Licensed Practitioners, Podiatry. Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Chiropractic"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Other Licensed Practitioners, Chiropractic -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from"/>		





# Alternative Benefit Plan

<p>the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.</p>		<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Allergy Care"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p><input type="text" value="EHB 1 duplication: Physician Services, Allergy Care -- Emergency treatment for allergy care does not require TAR."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Treatment Therapies"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p><input type="text" value="EHB 1 duplication: Outpatient Hospital Services, Treatment Therapies -- Chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/infusion therapy, medication management."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Emergency Services/Accidents"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p><input type="text" value="EHB 2 duplication: Outpatient Hospital Services, Emergency -- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including emergency dental services, as certified by the attending physician or other appropriate provider."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Ambulance"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p><input type="text" value="EHB 2 duplication: Medical Transportation, Ambulance Service -- Emergency Medical Transportation. Air transportation only covered when ground transportation is not feasible; emergency transportation does not require TAR."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Surgical Procedures"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p><input type="text" value="EHB 3 duplication: Inpatient Hospital Services, Surgical Services -- Room and Board. Professional services performed by physicians, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME and medical supplies; and Indian Health Services."/></p>		



# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Gastric Restrictive Procedures"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 3 duplication -- Inpatient Hospital Services, Bariatric Surgery: Patient must be at or above specified BMI levels and meet certain conditions to qualify for bariatric surgery."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Anesthesia"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 3 duplication -- Anesthesiologist Services: medically necessary services by an anesthesiologist."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Organ/Tissue Transplants"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 3 duplication: Inpatient Hospital Services, Organ &amp; Tissue Transplantation -- Transplant surgery, pre-transplant evaluation, post-operative care and laboratory services for bone marrow, heart, liver, kidney, heart-lung, simultaneous kidney-pancreas, single lung, double lung, pancreas, small bowel and combined liver-small bowel surgeries."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Reconstructive Surgery"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 3 duplication: Inpatient Hospital Services, Reconstructive Surgery -- Reconstructive surgery is limited to that performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function and/or to create a normal appearance, to the extent possible. Includes breast reconstruction after mastectomy."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Hospice Care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Hospice Care -- Hospice includes routine home care, continuous home care, respite care and general inpatient care. Children may receive concurrent palliative care."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Prenatal Care"/>	Source: Base Benchmark	



# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="EHB 4 duplication: Physician Services, Prenatal Care -- Diagnostic services include sonography, genetic testing and cordocentesis; genetic screening of father for cystic fibrosis if he is a Medi-Cal beneficiary."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Delivery and Postpartum Care"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 4: Inpatient Hospital Services, Delivery and Postpartum Care -- Medical services related to delivery and postpartum care. Hospital stay 48 to 96 hours post delivery."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Breastfeeding Education"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 4 duplication: Physician Services, Breastfeeding Education -- Breastfeeding education may be provided by physician, a registered nurse or a registered dietician working under physician."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Maternity Care by a Nurse Midwife"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 4 duplication: Services Furnished by a Nurse-Midwife -- services provided by nurse midwife from conception through 60 days after delivery."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Outpatient Hospital Services: Mental Health"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 5 duplication: Rehabilitation, Outpatient Mental Health -- Includes individual and group psychotherapy, psychological testing and medication management."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Outpatient Hospital Services: Mental Health"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 5 duplication: Rehabilitation, Outpatient Specialty Mental Health -- Includes day treatment services; crisis intervention and stabilization; adult crisis residential; mental health services; medication support; and targeted case management."/>		



# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient Hospital Services: Mental Health"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 5 duplication: Rehabilitation, Inpatient Specialty Mental Health Services -- Acute psychiatric inpatient hospital services, psychiatric health facility services and psychiatric inpatient professional services. The IMD payment exclusion applies to acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient professional services only when those services are provided in a facility that is considered an IMD based on 42 CFR Sections 435.1009 and 435.1010."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Hospital Services: SUD"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 5 duplication -- Rehabilitation: Outpatient Substance Use Disorder Services. Services include Outpatient Drug Free; Intensive Outpatient Treatment; Naltrexone Treatment; Narcotic Treatment Program. Post periodic review. Prior authorization is required for Narcotic Treatment Program counseling more than 200 minutes per month."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Physician Services: Heroin/opioid detoxification"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 5 duplication -- Rehabilitation: Outpatient heroin/opioid detoxification. Services include Narcotic Treatment Program. When medically necessary, additional 21-day treatments are covered after 28 days have passed since beneficiary completed a preceding course of treatment. Includes medically necessary services to diagnose and treat diseases that are concurrent with, but not part of, outpatient heroin or other opioid detoxification services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient Hospital Services: Detoxification"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 5 duplication: Inpatient hospital, Voluntary Inpatient Detoxification -- Room and Board. Professional services performed by physicians to aid detoxification, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME, and medical supplies. These facilities are not Institutions for Mental Disease (IMD) and the IMD payment exclusion applies."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Prescription Drug Benefits"/>	Source: Base Benchmark	



# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 6 duplication: Prescribed Drugs -- TAR required for more than six prescriptions per month.

Remove

Base Benchmark Benefit that was Substituted:

Physical Therapy

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical therapy -- Authorizations for physical therapy is valid for up to 120 days and must include a treatment plan. Prior authorization is not granted for more than 30 treatments at any one time.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services, Durable Medical Equipment -- durable medical equipment prescribed by physician.

Base Benchmark Benefit that was Substituted:

Hearing Aids

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services, Hearing Aids -- \$1,510 annual cap for hearing aid benefits may be exceeded for medical necessity.

Base Benchmark Benefit that was Substituted:

Speech Therapy/Audiology

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical Therapy and Related Services, Speech Therapy/Audiology -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted:

Occupational Therapy

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical Therapy and Related Services, Occupational Therapy -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry



# Alternative Benefit Plan

<input type="text" value="and speech therapy; may exceed limit for medical necessity with a TAR."/>		<input type="button" value="Remove"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Alternative Treatments: Acupuncture"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Other Licensed Practitioners, Acupuncture -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Cardiac Rehabilitation"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Rehabilitative Services, Cardiac Rehabilitation"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Pulmonary Rehabilitation"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Rehabilitative Services: Pulmonary Rehabilitation"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Medical Supplies, Equipment, Devices"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Home Health Services, Medical Supplies and DME; and Prosthetic Devices -- Certain medical supplies require TAR. Cochlear implant for one ear only; frequency limits on replacement parts. Includes surgically implanted hearing devices, prior authorization required. Certain medical supplies require TAR."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Orthopedic and Prosthetic Devices"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Prescribed Prosthetic Devices -- TAR required when cumulative costs of orthotics exceed \$250 and prosthetics exceed \$500."/>		



# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Home Health Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 7 duplication: Home Health Services -- Authorization requirements for home health services vary based upon type of service. Services include nursing services which may be provided by a registered nurse when no home health agency exists in area; home health aid services; medical supplies and equipment; and therapies."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Lab, X-Ray, and Other Diagnostic Tests"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 8 duplication: Other Laboratory and X-Ray Services -- Laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month by the Laboratory Services Reservation System (LSRS). Up to four of the following radiological ultrasound procedure codes for each beneficiary per year based on medical necessity: ultrasound, chest ultrasound, abdominal, and retroperitoneal. More than four requires documentation of medical necessity or by report. Prior authorization required for portable X-ray unless performed in SNF or ICF. Various advanced imaging procedures are covered, based on medical necessity. Many of the procedures require a TAR and are subject to frequency limitations."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Family Planning"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 9 duplication: Family Planning Services -- Includes family planning visits and counseling, invasive contraceptive procedures/devices, tubal ligations, vasectomies, contraceptive drugs or devices, and laboratory procedures, radiology and drugs associated with family planning procedures. TAR required for inpatient sterilization. Frequency limits on certain contraceptives and other services. Informed consent required for sterilizations."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Treatment Therapies: Dialysis/Hemodialysis"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="EHB 1 duplication: Outpatient Hospital, Dialysis/Hemodialysis -- Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Educational Classes &amp; Programs: Smoking Cessation"/>	Source: Base Benchmark	



# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="EHB 9 duplication: Physician Services, Smoking Cessation -- Includes diagnosis, treatment, smoking cessation products when used in conjunction with behavior modification support, referral to 1-800 helpline and one face-to-face counseling session per quit attempt for specific populations."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Skilled Nursing Care Facility"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 7 duplication: Skilled Nursing Facility and Other -- Nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biologicals, supplies, appliances and equipment. Patient must need daily care."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Medical Services Provided by Physician"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB1 duplication: Physician Services -- physician services within license."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Ambulance Transport Service"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="EHB 1 duplication: Medical Transportation, Non-Emergency Ambulance Service -- Air transportation only covered when ground transportation is not feasible; transportation covered from non-contract hospital to nearest contract hospital when patient is stable."/>		
		<input type="button" value="Add"/>





# Alternative Benefit Plan

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Adult Dental"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="Adult dental services will be available May 2014; a separate SPA is forthcoming. However, this benefit is currently available to EPSDT and pregnant beneficiaries."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Newborn Hearing Screening"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="Not applicable to New Adult Group."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Nursery Care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="Not applicable to New Adult Group."/>		
		<input type="button" value="Add"/>



# Alternative Benefit Plan

Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Federally Qualified Health Centers (FQHC) services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

None

Scope Limit:

None

Other:

Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, and psychologists. Rehabilitative and/or habilitative services are not included as part of the Other 1937 Benefits.

Other 1937 Benefit Provided:

Rural Health Clinic (RHC) services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

None

Scope Limit:

None

Other:

Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, and psychologists.

Other 1937 Benefit Provided:

Indian Health Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications:

Other

Authorization:

Other

Amount Limit:

Varies

Duration Limit:

None

Scope Limit:

None



# Alternative Benefit Plan

Other: Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, psychologists, and optometrists.		Remove
Other 1937 Benefit Provided: Alternative Birth Centers	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: Conception through discharge.	
Scope Limit: None		
Other: Licensed or Otherwise State-Approved Free Standing Birthing Centers.		
Other 1937 Benefit Provided: Non-Emergency Medical Transportation Services	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: Lowest cost type to cover patient's need	Duration Limit: None	
Scope Limit: Covered in ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care for a Medi-Cal benefit.		
Other:		
Other 1937 Benefit Provided: Adult Vision	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 1 routine eye exam in 24 months	Duration Limit: None	



# Alternative Benefit Plan

Scope Limit:	
<input type="text" value="Orthoptics, pleoptics and glasses are not covered."/>	<input type="button" value="Remove"/>
Other:	
<input type="text" value="Glasses and contact lenses are covered for EPSDT and pregnant women."/>	
Other 1937 Benefit Provided:	Source:
<input type="text" value="Local Education Agency Services"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>
	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:
<input type="text" value="Authorization required in excess of limitation"/>	<input type="text" value="Medicaid State Plan"/>
Amount Limit:	Duration Limit:
<input type="text" value="24 services within 12 months"/>	<input type="text" value="None"/>
Scope Limit:	
<input type="text" value="Medi-Cal eligible public school children up to age 22 or end of school year beneficiary turns 22."/>	
Other:	
<input type="text" value="May exceed 24 services within 12 months with TAR or authorization provided by Individualized Education Plan, Individualized Family Service Plan, California Children Services, Short-Doyle, or prepaid health plan. Services include health and mental health evaluation and education, individualized education plan, individualized family service plan, physician services, physical therapy, occupational therapy, speech therapy, audiology services, psychology and counseling, nursing services, school health aid services, medical transportation/mileage and targeted care management services."/>	
Other 1937 Benefit Provided:	Source:
<input type="text" value="TCM: Children at Risk of Medical Compromise"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>
	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>
Amount Limit:	Duration Limit:
<input type="text" value="None"/>	<input type="text" value="None"/>
Scope Limit:	
<input type="text" value="Children up to age 21."/>	
Other:	
<input type="text" value="1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes children who need assistance to access medical, social and education services when comprehensive case management is not provided elsewhere. Only available in specific areas Prior authorization is not required."/>	
Other 1937 Benefit Provided:	Source:
<input type="text" value="TCM: Medically Fragile with Multiple Diagnoses"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>



# Alternative Benefit Plan

<p>Authorization: <input type="text" value="Other"/></p> <p>Amount Limit: <input type="text" value="None"/></p> <p>Scope Limit: <input type="text" value="Beneficiaries up to age 21."/></p> <p>Other: <input type="text" value="1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Prior authorization is not required. Only available in specific counties."/></p>	<p>Provider Qualifications: <input type="text" value="Medicaid State Plan"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	<p><input type="button" value="Remove"/></p>
<p>Other 1937 Benefit Provided: <input type="text" value="Case Management: Children with IEP/IFSP"/></p> <p>Authorization: <input type="text" value="Other"/></p> <p>Amount Limit: <input type="text" value="None"/></p> <p>Scope Limit: <input type="text" value="Children up to age 21 with an Individualized Education Plan or Individualized Family Service Plan."/></p> <p>Other: <input type="text" value="1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Prior authorization is not required."/></p>	<p>Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/></p> <p>Provider Qualifications: <input type="text" value="Medicaid State Plan"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	<p><input type="button" value="Remove"/></p>
<p>Other 1937 Benefit Provided: <input type="text" value="TCM: Individuals at Risk of Institutionalization"/></p> <p>Authorization: <input type="text" value="Other"/></p> <p>Amount Limit: <input type="text" value="None"/></p> <p>Scope Limit: <input type="text" value="Individuals 18 or older in frail health who meet specific criteria."/></p> <p>Other: <input type="text" value="1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Only available in specific counties. Prior authorization is not"/></p>	<p>Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/></p> <p>Provider Qualifications: <input type="text" value="Other"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	



# Alternative Benefit Plan

<input type="text" value="required."/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="TCM: Persons in Jeopardy of Negative Outcomes"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="People in jeopardy of negative health or psycho-social outcomes due to disparity factors."/>		
Other: <input type="text" value="1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes people who need assistance to access medical, social and education services when comprehensive case management is not provided elsewhere. Only available in specific counties. Prior authorization is not required."/>		
Other 1937 Benefit Provided: <input type="text" value="TCM: Individuals with a Communicable Disease"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Until risk of exposure has passed; limited to eligible individuals."/>		
Other: <input type="text" value="1915(g) State Plan. Services to assist eligible individual access medical, social and educational services. Includes people who need assistance to access medical, social and education services when comprehensive case management is not provided elsewhere. Only available in specific counties. Prior authorization is not required."/>		
Other 1937 Benefit Provided: <input type="text" value="Case Management: Lead Poisoned"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	



# Alternative Benefit Plan

Scope Limit:

Children up to age 21 with laboratory test results showing elevated lead blood levels.

Remove

Other:

1915(g) State Plan. Services to assist eligible individual access medical, social and educational services. Prior authorization is not required.

Other 1937 Benefit Provided:

TCM: Individuals with Developmental Disability

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Individuals diagnosed with a developmental disability.

Other:

1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Prior authorization is not required.

Other 1937 Benefit Provided:

Skilled Nursing Facility

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical necessity as described in "other."

Other:

The individual is unable to perform some activity of daily living independently and patient must need daily care. Services include nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biological, supplies, appliances and equipment. An initial authorization may be granted for periods up to one year from date of admission and shall be required prior to the transfer of a beneficiary between skilled nursing facilities. The attending physician must re-certify at least every 60 days.

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package



# Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="283 hours per month"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input other.\""="" type="text" value="Medical necessity as described in \"/>		
Other: <input type="text" value="Beneficiary has chronic, disabling disease expected to last at least 12 months and requires assistance in performing some activities of daily living, is unable to obtain, retain or return to work, and is at risk of institutional placement. Authorized by county based upon assessment in accordance with plan of treatment prepared by physician. Services may include activities such as assistance with administration of medication, basic personal hygiene, eating, grooming, etc. Beneficiary must not be an inpatient or resident of a hospital, NF, ICF-DD, or ICF-MD."/>		
Other 1937 Benefit Provided: <input type="text" value="Self-Directed Personal Assistance Services"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="283 hours per month"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input other.\""="" type="text" value="Medical necessity as described in \"/>		
Other: <input type="text" value="1915(j) State Plan. Beneficiary has chronic, disabling disease expected to last at least 12 months and requires assistance in performing some activities of daily living, is unable to obtain, retain or return to work, and is at risk of institutional placement. Authorized by county based upon assessment in accordance with plan of treatment prepared by physician. Services include personal care and related services, to be self-directed by the beneficiary. Beneficiary may not be an inpatient or resident of a hospital, NF, ICF-DD, or ICF-MD."/>		
Other 1937 Benefit Provided: <input type="text" value="Community First Choice Option"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input other.\""="" type="text" value="Medical necessity as described in \"/>		





# Alternative Benefit Plan

Other:

1915(k) State Plan. Effective on July 1, 2013, an individual is eligible for CFCO services when, (1) he or she is in an eligibility group under the State Plan that includes nursing facility services or has an income that is at or below 150 percent of the Federal Poverty Level, and in addition, (2) it is determined that in the absence of home and community-based attendant services and supports, he or she would otherwise require a Medicaid-covered level of care furnished in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, an institution providing psychiatric services (for individuals under age 21), or an institution for mental diseases (for individuals age 65 and over). The individual is unable to perform some activity of daily living independently and without access to this service would be at risk of placement in out-of-home care. Services include assistance with Activities of Daily Living; and acquisition, maintenance and enhancement of skills necessary for the individual to accomplish activities of daily living and health related tasks. The California Department of Social Services will complete authorization by annual review or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative. EPSDT beneficiaries may receive additional services for medical necessity.

Remove

Other 1937 Benefit Provided:

Home and Community Based Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical necessity as described in "other."

Other:

1915(i) State Plan. Must have developmental disability and need habilitation services. Individual must have a condition that results in major impairment of cognitive and/or social functioning and is likely to retain new skills through habilitation. Services include habilitation – community living arrangement services, supported living services, day services, behavioral intervention services, respite care, supported employment, prevocational services, homemaker services, home health aide services, community based adult services; personal emergency response systems; and vehicle modification and adaptation services. A developmental disability is a condition that originated before the age of 18, expected to continue indefinitely and constitute a substantial disability for the individual. It includes mental retardation, cerebral palsy, autism and any other disabling conditions similar to mental retardation, but not handicapping conditions solely physical in nature.

Add



# Alternative Benefit Plan

Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130814



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Benefits Assurances

ABP7

### EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age.  Yes

- The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).
- The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- Through an Alternative Benefit Plan.
- Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

### Prescription Drug Coverage Assurances

- The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.
- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

### Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.



# Alternative Benefit Plan

- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

## PRA Disclosure Statement

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V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
  - Managed Care Organizations (MCO).
  - Prepaid Inpatient Health Plans (PIHP).
  - Prepaid Ambulatory Health Plans (PAHP).
  - Primary Care Case Management (PCCM).
- Fee-for-service.
- Other service delivery system.

## Managed Care Options

### Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

### Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

CA has actively engaged in numerous activities to ensure successful expansion of Medicaid coverage to newly eligible adults. CA is expecting that approximately 600,000 eligible beneficiaries will be covered on January 1, 2014 with a projected take up between 30,000-45,000 a month over the course of the first year. CA has 35 health plan contract amendments and has worked closely with the Region 9 team to ensure all 35 contracts are executed prior to January 1, 2014. To ensure network adequacy, CA assessed health plan capacity based on the provider ratios, such as PCPs (1:2000) and Physicians (1:1200) as well as measures of time and distance to Hospitals and PCPs (10 miles or 30 minutes). Additionally, CA took into account the Primary Care Physicians who are accepting new patients.

The majority of the newly eligible adults will be enrolled in Medi-Cal managed care through the administrative eligibility transition of the current Low Income Health Program (LIHP) population. LIHP is a county-based, optional health care services program under the California "Bridge to Reform" §1115 Medicaid Demonstration. To meet expansion goals, DHCS in collaboration with stakeholders implemented a LIHP Transition Plan to ensure a seamless transition of LIHP enrollees to the Medi-Cal Program. CA monitors network capacity and access issues on a quarterly basis. Additionally, CA monitors access to care through an Ombudsman's office for Managed Care enrollees and a compliance call center through its Licensing department. CA will determine trends or daily activities to work with health plans to address issues or concerns of access to care. As a result of extensive preparation, CA remains in good standing to implement effective January 1, 2014.

### MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes



# Alternative Benefit Plan

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

The State submitted a section 1115 Demonstration proposal as a bridge toward full health care reform implementation in 2014. This proposal allows CA to phase in coverage in individual counties for adults aged 19-64 with incomes at or below 133 percent of the federal poverty level (FPL), who are eligible under the new Affordable Care Act State option and adults between 133 percent - 200 percent of the FPL who are not otherwise eligible for Medicaid; expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers; implement a series of infrastructure improvements through a new funding sub-pool, that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care; create coordinated systems of care for Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans.

## Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

## PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program.

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

1915 (b) Medi-Cal Specialty Mental Health Services (SMHS) Consolidation. Section 1915 (b) waivers relevant to Specialty Mental Health Services (SMHS) have been in effect in California since 1995. An eighth renewal of the SMHS waiver has been granted for a two year period effective July 1, 2013-June 30, 2015. For the purposes of the SMHS waiver program, persons with special health care needs are adults who have a serious mental disorder and children with a serious emotional disturbance. These beneficiaries are identified through the assessment process by the county Mental Health Plan (MHP) as meeting the SMHS medical necessity criteria. The design of managed care for California's Medi-Cal mental health program was phased in over several years. The State's enabling legislation for this waiver is set forth at Welfare and Institutions (W&I) Code, Sections 14680-14685.1 and 14700-14726.



# Alternative Benefit Plan

All Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to the services provided through the waiver if they meet the medical necessity criteria. During the eighth waiver renewal SMHS will be provided to the newly eligible adult beneficiaries by the county MHPs. CMS approved a waiver amendment request to include this population on December 26, 2013.

The PIHPs are not at risk for FFP for the cost of services. The SMHS Consolidation waiver program is administered locally by each county's MHP and each county's MHP provides, or arranges for, specialty mental health services for Medi-Cal beneficiaries. MHPs are not paid on a capitated basis; instead, MHPs are paid on a fee-for-service basis.

Beneficiaries are automatically enrolled in the single MHP in their county. The State continues to contractually require MHPs to ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis.

Beneficiaries are provided with a choice of providers within the MHP and an opportunity to change providers whenever feasible. Although the regulation allows MHPs to limit the beneficiary's choice to two (2) providers, the beneficiary may request an additional change if not satisfied; the opportunity for choice may be limited by feasibility. In most cases, feasibility is linked to the number of providers in the MHP's network.

Access continues to be assured and monitored through state regulations, and the MHP contract, the State's review and approval of any amendments to the MHPs implementation plans for the program on-going contract management by the State; and formal triennial reviews of the MHPs conducted by State staff, and annual External Quality Reviews conducted by the contracted External Quality Review Organization.

## Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

## Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- Traditional state-managed fee-for-service
- Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

A significant proportion of total Medi-Cal expenditures are generated through the FFS health care delivery system. FFS providers render services and then submit claims for payment that are adjudicated, processed and paid (or denied) by the Medi-Cal program's fiscal intermediary. Generally, Medi-Cal outpatient FFS rates are set at no more than 80% of the California Specific Medicare Rate. The CA-MMIS system reimburses at no more than the maximum allowable rate that is on file in the system. Further, as a result of the Managed Care expansion in California, all 58 counties now participate in a Managed Care system, which prior to the expansion served approximately 74% of the total Medi-Cal population or about 6.0M Medi-Cal beneficiaries in 30 counties.

Specified services are carved out of the Managed Care Plans and only reimbursed via FFS, such as county based Specialty Mental Health Services (1915 (b) waiver) and Substance Use Disorder Services, which are reimbursed on a cost-based fee-for-service basis, based on certified public expenditures.

## Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):



# Alternative Benefit Plan

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130718





# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Employer Sponsored Insurance and Payment of Premiums ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

The state/territory otherwise provides for payment of premiums.

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals. The requirements for Requirements for Health Insurance Premium Payment (HIPP) Program / Cost Avoidance: Full scope or fee-for-service Medi-Cal; a high cost medical condition that requires on-going treatment from a medical provider; current health insurance coverage (or access to health coverage through an employer at the time of application) – policy must cover the health condition.

### Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The state assures that ESI coverage is established in sections 3.2 and 4.22(c) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A."

### PRA Disclosure Statement

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# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## General Assurances

ABP10

### Economy and Efficiency of Plans

- The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

### Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

### PRA Disclosure Statement

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V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Payment Methodology

ABP11

### Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

### PRA Disclosure Statement

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V.20130807

### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services**

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered Services include all Medically Necessary services, as defined in 42 USC Section 1396d(r), and W & I Code Section 14132(v). Covered Services shall include case management as well as Targeted Case Management services as defined in Attachment 11, Provision 3 of this Contract.

Contractor is required to provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation and Non-Medical Transportation, to and from medical appointments for Medically Necessary Covered Services that Contractor is responsible for providing pursuant to this Contract.

Contractor shall also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to Provision 8 below, regarding Mental Health Services. Contractor shall determine the Medical Necessity of EPSDT services using the criteria established in 42 USC Section 1396d(r), and W & I Code Section 14132(v).