

Appendix A: Behavioral Health Benefits in Cal MediConnect
Coverage Responsibility Matrix

Updated January 2020

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be “carved out”). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1 and Coverage Matrix 2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California’s 1915(b) waiver and State Plan Amendments for targeted case management and rehabilitative mental health services.

Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder treatment services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria specified in the 1115 waiver special terms and conditions and county Intergovernmental Agreement.

Coverage Matrix 1: Mental Health Benefits

Inpatient Services			
	Type of Service	Benefit Coverage	Primary Financial Responsibility under the Demonstration
Psychiatric inpatient care in a general acute hospital	Facility Charge	Medicare <i>Subject to coverage limitations *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Inpatient care in free-standing psychiatric hospitals (16 beds or fewer)	Facility Charge	Medicare <i>Subject to coverage limitations and depends on facility and license type *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Psychiatric health facilities (PHFs) (16 beds or fewer)	Facility Charge (<i>Most are not Medicare certified</i>)	Medi-Cal	County Mental Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
Emergency Department	Facility Charges	Medicare	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Long-Term Care			
Skilled Nursing Facility	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
SNF-STP (fewer than 50% beds)	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following an acute inpatient hospital stay of at least three days. For long-term care placement, Medi-Cal fee-for-service pays for these costs.

Institutions for Mental Disease			
Long-term care		Benefit Coverage	Primary Financial Responsibility under the Demonstration
SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)[§]	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Not covered by Medicare or Medi-Cal+	County Mental Health Plan
	Facility Charge ages 65 and older	Medi-Cal	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Mental health rehabilitation centers (MHRCs) (IMD)	Facility Charges	Not covered by Medicare or Medi-Cal	County Mental Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Psychiatric health facilities (PHFs) with more than 16 beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	County	County Mental Health Plan
	Facility Charge ages 65 and older (<i>most are not Medicare certified</i>)	Medi-Cal*	County Mental Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Free-standing psychiatric hospital with 16 or more beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion *</i>	Medicare*	Health Plan
	Facility Charge ages 65 and older	Medicare	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan

* Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his or her Medicare psychiatric hospital coverage, then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters [02-06](#) and [10-02](#).

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following an acute inpatient hospital stay of at least three days. For long-term care placement, Medi-Cal fee-for-service pays for these costs.

[§] Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act.

Outpatient Mental Health Services			
		Primary Financial Responsibility	
Type of Service	Benefit Coverage	Patient meets criteria for MHP specialty mental health services & is being treated by the county MHP [^]	Patient does NOT meet criteria for MHP specialty mental health services
Pharmacy	Medicare	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	Medicare	Health Plan	Health Plan
Outpatient services within the scope of primary care	Medicare	Health Plan	Health Plan
Psychological testing/ assessment	Medicare	Health Plan	Health Plan
Mental health services [§] (Individual and group therapy, assessment, collateral)	Medicare	Health Plan	Health Plan
Mental health services [§] (Rehabilitation and care plan development)	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication management/Medication support services [§] (Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)	Medicare	Health Plan	Health Plan
Medication support services [§] (instruction in the use, risks and benefits of and alternatives for medication; and plan development)	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day rehabilitation	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis intervention	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis stabilization	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Adult Residential treatment services	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis residential treatment services	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Targeted Case Management	Medi-Cal	County Mental Health Plan	Not a covered benefit for beneficiaries not meeting medical necessity criteria

[^]1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

[§] Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

- [DMH INFORMATION NOTICE NO: 10-11](#) May 6, 2010; [DMH INFORMATION NOTICE NO: 10-23](#) Nov. 18, 2010; [DMH INFORMATION NOTICE NO: 11-06](#) April 29, 2011

Coverage Matrix 2: Substance Use Disorder Benefit -1115(a) Waiver Opt-In Counties

	Type of Service	Benefit Coverage	Primary Financial Responsibility under the Demonstration
Inpatient	Inpatient Detoxification ¹	Medicare	Health Plan
Inpatient/Outpatient	Professional Services ²	Medicare	Health Plan
Outpatient	Structured Assessment Brief Intervention and Referral to Treatment (SBIRT) ³	Medicare	Health Plan
	Drugs Used to Treat Opioid Dependence ⁴	Medicare	Health Plan
	Partial Hospitalization Program	Medicare	Health Plan
	Outpatient Services	Drug Medi-Cal	DMC-ODS Pilot Program
	Intensive Outpatient Treatment Services	Drug Medi-Cal	DMC-ODS Pilot Program
	Narcotic (Opioid) Treatment Services ⁵	Drug Medi-Cal	Health Plan (as of January 1, 2020)
	Additional Medication Assisted Treatment ⁶	Drug Medi-Cal	DMC-ODS Pilot Program
	Withdrawal Management ⁷	Drug Medi-Cal	DMC-ODS Pilot Program
	Residential Treatment Services ⁸	Drug Medi-Cal	DMC-ODS Pilot Program

¹ Any medication provided as part of inpatient treatment would be bundled into the inpatient payment and not paid separately. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1604.pdf>

² Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90; <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> and <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf>

³ One alcohol misuse screening covered per year. Up to four counseling sessions may be covered if positive screening results. Must be delivered in a primary care setting. SBIRT may be provided via telehealth. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

⁴ Medicare Part D does not cover methadone when used for treatment of opioid dependence. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1604.pdf>

⁵ Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020 <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121719.pdf>

⁶ Counties contracting to participate in DMC-ODS may choose to offer additional MAT beyond the required NTP services. These additional services shall be described in the county intergovernmental agreement. Additional MAT includes the ordering, prescribing, administering, and monitoring of all medications for SUDs. These are medically necessary services that are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

⁷ DMC-ODS counties are required to provide at least one level of withdrawal management services. DMC-ODS counties may offer additional levels.

⁸ Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.