Disability Rights California

California's protection & advocacy system

Specialty Mental Health Services through a County Mental Health Plan

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Specialty Mental Health Services through a County Mental Health Plan (MHP)

Some mental health services are available through fee-for-service Medi-Cal[1] providers or Medi-Cal managed care plans, while others are available only through county Mental Health Plans under the Specialty Mental Health Services Waiver.[2] This publication focuses on specialty mental health services available through County Mental Health Plans (MHPs).

For more information on mental health services available through Medi-Cal see Publication #5609.01 – Medi-Cal Managed Care Plans and Mental Health Services.

What are specialty mental health services?

Specialty mental health services can include Rehabilitative Mental Health Services, Psychiatric Inpatient Hospital Services, Targeted Case

[1]If you are on fee-for-service Medi-Cal you can go to any provider who takes Medi-Cal. It also means that you are not enrolled in a Medi-Cal managed care plan. - (Return to Main Document)

[2] Welfare & Institutions Code § 14189. - (Return to Main Document)

Management, Psychiatrist Services, Psychologist Services, EPSDT[3] Supplemental Specialty Mental Health Services, and Psychiatric Nursing Facility Services.[4] A more detailed list of specific covered services is available below. Specialty mental health services are provided by mental health specialists, such as psychiatrists, psychologists, licensed clinical social workers (LCSWs), licensed marriage and family therapists (MFTs), psychiatric technicians, or peer support providers. Your primary care physician or other physical health care provider can also provide general mental health services to you if you both agree. However, these are not considered to be specialty mental health services.

How are specialty mental health services provided?

Specialty mental health services are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs).[5] All of the MHPs are part of county mental health or behavioral health departments.[6] The MHP can provide services through its own employees or through contract providers.[7]

What are the specialty mental health services that I am entitled to?

You are entitled to a specialty mental health service if the service is both a covered service under the Medi-Cal program and is medically necessary for you. Covered services are provided only if they are also medically necessary.[8]

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[3] Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services. - (Return to Main Document)

[4] 9 C.C.R. § 1810.247(a-g).

[5] Cal. Welf. & Inst. Code §14680(b).

[6] Cal. Welf. & Inst. Code §14680(d).

[7] 9 C.C.R. §1810.436(a).

[8] 9 C.C.R. §1810.345(a).

Which specialty mental health services are covered?

Outpatient specialty mental health services are **covered** if they are on the following list.[9]

(a) Rehabilitiative Mental Health Services, including:
    1. Mental health services
    2. Medication support services
    3. Day treatment intensive
    4. Day rehabilitation
    5. Crisis intervention
    6. Crisis stabilization
    7. Adult residential treatment services
    8. Crisis residential treatment services
    9. Psychiatric health facility services
(b) Psychiatric inpatient hospital services
(c) Targeted case management
(d) Psychiatrist Services
(e) Psychologist services
(f) EPSDT supplemental specialty mental health services (for individuals under age 21); and
(g) Psychiatric Nursing Facility Services

Only outpatient services are discussed in this memo.

“Mental health services” includes individual or group therapies and interventions that can reduce mental disability and restore, improve or maintain functioning. These should help with learning, development, independent living and enhanced self-sufficiency and that are not provided as part of another mental health program (e.g. such as a day or residential program). Service activities may include assessment, plan development, therapy, rehabilitation and related services.[10]

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[9] 9 C.C.R. § 1810.247 “Specialty Mental Health Services.” - (Return to Main Document)

[10] 9 C.C.R. § 1810.227

"Rehabilitation" is broad and is a service that includes help in improving, maintaining or restoring function, daily living, social and leisure, grooming and personal hygiene skills, meal preparation, support resources and medication education.[11]

"Targeted Case Management" is a service that can help you access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services, including housing. This can be done through communication, coordination, referral, placement, plan development, and monitoring progress and services to ensure access.[12]

What does "medically necessary" mean?

A service is medically necessary if you need the service in order to address your particular mental health condition. Even if a service is medically necessary for you, it must also be a covered service under the Medi-Cal program in order for you to be entitled to it.

There are four parts to the medical necessity criteria:

1. You must have a **diagnosis** of at least one of the mental disorders listed in the regulations:[13]
   - Pervasive Developmental Disorders, except Autistic Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy and Early Childhood
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
   - Mood Disorders, except Mood Disorders due to a General Medical Condition

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[11] 9 C.C.R. § 1810.243

[12] 9 C.C.R. Sec 1810.249

[13] 9 C.C.R. § 1830.205(b)(1)(A-R)

- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses.

2. You must have an **impairment** as a result of the disorder that affects your ability to function individually or in the community.[14]
3. The **intervention** (the mental health service that you need) must be focused on addressing the impairment.[15]
4. The intervention must meet **specialty mental health service criteria**. This means that your condition would be responsive to mental health treatment, but would not be responsive to physical health care based treatment.[16]

If you are under age 21, but you do not meet the medical necessity requirements outlined in 9 C.C.R. § 1830.205(b)(2-3), you may still receive services if you have one of the diagnosis listed above and the condition you have would not be responsive to physical health care treatment.[17]

What if I have more than one diagnosis?

Having a diagnosis that is not included on the list will not preclude you from receiving services as long as you have at least one diagnosis that is

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[14] 9 C.C.R. § 1830.205(b)(2)(A-B).

[15] 9 C.C.R. § 1830.205(b)(3)(B)(1-2).

[16] 9 C.C.R. § 1830.205(b)(3)(C).

[17] 9 C.C.R. § 1830.210(a)(1-3).

included on the list. If you have more than one diagnosis but at least one of your diagnoses is on the list above, you will still receive specialty mental health services.[18]

How do I get specialty mental health services?

You must request the service from your county's MHP, i.e., the county mental health or behavioral health department. If you are not getting services now, you can call the MHP's access line and ask for an assessment. See the California Department of Mental Health Website for a list of MHP access line toll-free telephone numbers. The list is available at http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Services must be provided to you when you need them. This means that you cannot be placed on a waiting list for services. It also means that you cannot be told to call back later because all of the appointment slots have been filled. You should at least get an assessment of your need for services.

Do I approve my client plan and services?

Yes. Your "client plan" should include the specialty mental health services that you are eligible for and document that you agree. You can sign the plan or your provider can indicate that you agree and participate in your plan.[19]

What if I am unhappy with my services or if my MHP denies, reduces, or suspends services?

If you have had a negative experience with your MHP, you can file a grievance. If your services get changed or you are denied services you feel you are entitled to, you can file an appeal. The Department of Health Care Services recently issued a memorandum discussing grievance and appeal processes, which you can view at:

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[18] 9 C.C.R. § 1830.205(c).

[19] 9 C.C.R. 1810.205.2 and 440(c).

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf

Disability Rights California has also released a publication discussing grievance and appeal processes, Publication #7134.01 - County Mental Health Plan (MHP) Grievances, Appeals, and Fair Hearings

Time and Distance Standards for Mental Health Services[20]

Beginning on July 2018, there will be new rules about how counties provide services. Counties will be required to provide services within a certain distance from your residence and within certain time frames. The details are listed below.

Rural counties must provide care within 60 miles or 90 minutes from the beneficiary's residence. These counties include:

- Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne

Small counties must provide care within 45 miles or 75 minutes from the beneficiary's residence. These counties include:

- Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Sana Barbara, Sutter, Tulare, Yolo, and Yuba

Medium counties must provide care within 30 miles or 60 minutes from the beneficiary's residence. These counties include:

- Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura

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[20] Department of Health Care Services, MHSUDS Information Notice No.: 18-011, Feb. 13, 2018, *available at* http://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf, pg 6. - (Return to Main Document)

Large counties must provide care within 15 miles or 30 minutes from the beneficiary's residence. These counties include:

- Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara

Timely Access to Appointments[21]

All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, must provide timely access to services.

Specifically, the following services must be made available within the following timelines.

Urgent care appointments that do not require prior authorization must be provided within 48 hours; whereas urgent care appointments that do require prior authorization must be provided within 96 hours.

Non-urgent primary care appointments must be provided within 10 business days; non-urgent specialist (psychiatry) appointments must be provided within 15 business days; non-urgent mental health provider (non-psychiatry) appointments must be provided within 10 business days; and non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health conditions must be made within 15 business days.

Telephone wait times must be limited to no more than 10 minutes. Triage services must be made available 24/7 and call back time cannot exceed 30 minutes.

Timely Access – Limited Exceptions

There are, however, limited exceptions to the timeliness of appointments.

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[21] 28 C.C.R. section 1300.67.2.2(c)(5).

For example, for extended appointments[22], where the referring or treating provider has determined a longer wait time will not have a detrimental impact on the health of the beneficiary* and noted this exception in the record, the timeline for the next appointment may extend past the aboce timelines.

Additionally, individuals who have periodic visits may have longer time periods between visits and may be schedule those visits in advance.[23]

[22] 28 C.C.R. section 1300.67.2.2(c)(5)(G).

[23] 28 C.C.R. section 1300.67.2.2(c)(5)(H).