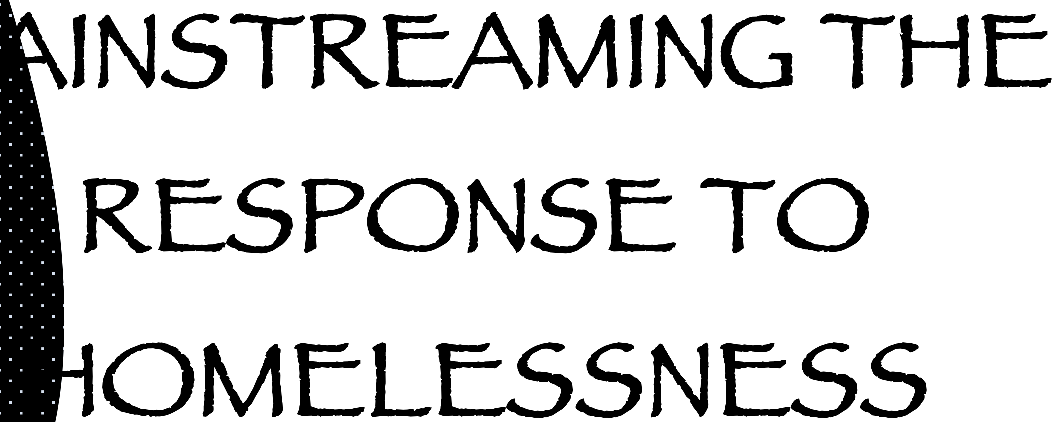

MAINSTREAMING THE RESPONSE TO HOMELESSNESS

Accessing Medi-Cal Funds for Treatment and Services to Homeless People

September 23, 2003

Association of Bay Area Governments

Metro Center Auditorium

Oakland, CA

Presented by

The Corporation for Supportive Housing

and HomeBase

Sponsored by

Dept. of Housing and Urban Development, Community Planning and Development Office, California State Office

Additional Resources Contributed by

The Charles and Helen Schwab Foundation

The California Endowment

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Mainstreaming the Response to Homelessness:
Accessing Medi-Cal Funds for Services to Homeless People
September 23, 2003
9:00-4:00
ABAG

Oakland, CA

AGENDA

9:00 a.m. Registration and Networking, Welcome and Introductions
Moderator: Darin Lounds, Program Officer, CSH

9:40 a.m. I. Overview of the Programs of Medi-Cal
The Medi-Cal framework, the different types of Medi-Cal, the flow of funds and client-eligibility.
- Mental Health
- Drug
- Health Care

II. Medi-Cal Role for Homeless Programs:
- Eligibility for Reimbursement
  - Individual's Eligibility – Medical Necessity
  - Medi-Cal Services Covered
  - Provider Participation
- Procedures for Billing/Reimbursement

III. Administrative Requirements
- Signing up to become a medical provider
- Knowing Whether Your County's Fee-for-Service /Managed Care Plan: It Matters!

Presenters:

Jack Tanenbaum, Small County Liaison/Deputy Director, California Mental Health Directors Association
Jim Cortese, Program Operations Division, Contract Management Branch, California Department of Alcohol and Drug Programs
Judith Phelps, Chief, Provider Services Section, Payment Systems Division, California Department of Health Services
Karen Gruneisen, Staff Attorney, HomeBase (Moderator)

12:30 p.m. Lunch

1:00 p.m. IV. The Value of Partnership

Hear about a successful partnership strategy between a county's Housing Authority and Mental Health Department to provide Medi-Cal services. Ask questions!

Panelists:

Kimberly Carroll, Senior Program Manager, Supportive Housing, Marin Housing Authority
Diane Slager, Mental Health Program Manager, Marin County Health and Human Services, Community Mental Health Services Division
Liz Orlin, Associate Director, CSH (Moderator)

1:50 p.m. Break

2:00 p.m. V. Medi-Cal Funding Options in Practice:

Including clinical billing issues and administrative impacts in the Targeted Case Management, Rehab and Federal Qualified Health Center (FQHC) options. Ask questions!

Panelists:

Richard Heasley, Executive Director; Conard House
Robert Ratner, Director; Lifelong Medical Care/ Supportive Housing Program
Steven Fields, Executive Director; Progress Foundation
Darin Lounds, Program Officer, CSH (Moderator)

3:30 p.m. VI. Wrap Up/ Next Steps

Additional Resources
Suggested Next Steps
Event Evaluation
Liz Orlin, Associate Director, CSH (Moderator)

Program Name	Medi-Cal
Administering Agency	California Department of Health Services P.O. Box 942732 Sacramento, CA 94234-7320
Funding Availability	Ongoing, based on services rendered and reimbursement rate
Program Overview	Medi-Cal is the State of California's implementation of the federal Medicaid program, providing free or reduced-cost medical services to low-income Californians. The state determines eligibility rules and broad guidelines, delegating specific implementation details to the counties. The Medi-Cal program varies significantly by county in terms of program structure (managed care vs. fee for service, for instance), and enrollment procedures, and eligibility interpretations are often different depending on the county.
Additional Resources	*Understanding Medi-Cal: The Basics*, Medi-Cal Policy Institute: http://www.medi-cal.org *The Guide to Medi-Cal Programs*, Medi-Cal Policy Institute: http://www.medi-cal.org Medi-Cal Website: http://medi-cal.ca.gov DHS Website: http://www.dhs.ca.gov

Medi-Cal Services are Delivered through Two Different Systems:

Managed Care and Fee-for-Service[1]

Managed Care- a method of delivering and financing health care that seeks to control health care costs by coordinating an individual's health care; managed care plans (sometimes called HMO's) typically receive a prepaid rate for each member enrolled in the plan and maintain some level or risk for providing all necessary services for enrolled members within that prepaid rate. A provider joins a managed care plan to deliver services under this system.

Fee-for-Service- the traditional method of paying for care, in which health care providers are reimbursed for a particular service (such as office visits, medical procedures, and prescriptions) at a rate established by the Medi-Cal program.

[1] Understanding Medi-Cal: The Basics, Medi-Cal Policy Institute, September 2001.

Medi-Cal Eligibility

Arguably the most complex aspect of the Medi-Cal program, client eligibility for benefits is determined on a categorical basis, with over 150 different eligibility codes used in determining an individual's status. Eligibility criteria are set by the state, though each county trains its intake staff according to its own interpretation of the state's criteria. Most eligibility codes fall into one of five categories:

Public-Assistance Linked

CalWORKs and SSI/SSDI Recipients
Some families who have low incomes but don't qualify for CalWORKs or SSI

Public-Assistance Correlated (Section 1931(b))

Families who aren't CalWORKs recipients, but would have been eligible under AFDC
Families who qualify for CalWORKs but only want Medi-Cal
Families whose earnings make them ineligible for cash assistance

Medically Needy/Medically Indigent

Medically Needy category covers those whose incomes are too high for cash assistance, but otherwise qualify for CalWORKs or SSI
Medically Indigent category covers low-income pregnant women, children under 21, and some adults in long-term care

Federal Poverty Level Programs

Pregnant women and children under age 6 at/below 133% FPL
Children ages 6-19 in families at/below 100% FPL

Other Eligibility Groups

Transitional Medi-Cal for families transitioning off CalWORKs or 1931(b)
Refugees
Low-income Medicare recipients
People in special treatment programs (i.e. tuberculosis, dialysis)
Undocumented immigrants (pregnancy, emergency care, and certain long-term only)

Application Procedure: Medi-Cal applications are accepted on an ongoing basis. Applications are traditionally processed in-person, either at the county welfare agency, or at a community-based organization with an out stationed county eligibility worker. County eligibility workers assist clients with completing forms, collect necessary paperwork, and cross-reference the applicant's information with state databases to verify eligibility. Applicants are notified of their status by mail within 45 days.

Children and pregnant women have the option of completing a mail-in enrollment form as an alternative to in-person enrollment. Certified Application Assistants (CAA) may help applicants with the paperwork, and receive a $50 payment for each successfully

enrolled child. The Healthy Families program established this mail-in enrollment procedure in 1998, and legislation passed in 2000 has mandated the development of a simplified mail-in enrollment form for all beneficiaries.

The State of California has also launched a new initiative called Health-e-App, which allows pregnant women and children to determine eligibility for benefits and apply for Medi-Cal online, with the help of a CAA. This reduces paperwork and the likelihood of application errors. More information can be found at http://healtheapp.org.

All applicants must recertify annually to maintain their benefits, and must report any changes (i.e. income, marital status) that may affect their eligibility.

Mental Health Medi-Cal

Since research demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance and that the needs of persons with mental illness are not always paid adequate attention to in an all inclusive health care managed care system, **specialty mental health services** have been carved out from the rest of Medi-Cal managed care. Thus a distinction was made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs which could be met by a general health care practitioner).

Specialty mental health services for Medi-Cal beneficiaries are provided by the county or through a contract with the county. Each California county operates its own mental health plan for Medi-Cal beneficiaries. (Placer County's plan includes Sierra County.)

General mental health care needs for Medi-Cal beneficiaries remain under the purview of DHS either through their physical health managed care plans or through the FFS/MC system.

The Specialty Mental Health Services Medi-Cal program provides medically necessary mental health services for eligible Medi-Cal beneficiaries. Services include Rehabilitation and Targeted Case Management. The Department of Mental Health (DMH) is the state agency responsible for administering this program through county Mental Health Plans (MHPs).

In this section:

Services Reimbursable
Provider Participation
State/County/Provider Structure of Relationships
Licensing and Certification
The Reimbursement Process: Data Collection and Billing

For more information on Mental Health Medi-Cal, go to www.dmh.cahwnet.gov and your county mental health page.

What Services Are Eligible For Reimbursement?

Specialty Mental Health Services are covered by Medi-Cal when they are provided to Medi-Cal beneficiaries by a certified provider, at its certified location by a Mental Health Plan (MHP) for the DMH, and when they have been determined to be medically necessary.

"**Medically Necessary**" means:

the client must have one of the included diagnoses for specialty mental health services in the DSM IV[i]; and

the client must have at least one of the following as result of the mental disorder:

- a significant impairment in an important area of life functioning; or
- a probability of significant deterioration in an important area of life functioning; and

all of the following:

- the focus of the proposed intervention is to address the impairment or potential impairment identified;
- the proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; and
- the condition would not be responsive to physical healthcare treatment.

Services must be provided by or under the direction licensed mental health providers.

[MHP does not pay for special mental health services provided to a client enrolled in a Medi-Cal managed care plan to the extent specialty mental health services are covered by that plan.]

Specialty Mental Health Services

MHPs are not required to provide or arrange for any specific specialty mental health service, but shall ensure that the specialty mental health services available are adequate to meet the needs of the clients.

(1) Rehabilitative services

Mental health services means:

individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency; and

that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.

Service activities may include but are not limited to (these are defined below):

- assessment
- plan development
- therapy
- rehabilitation
- collateral.

Medication support services means:

Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness, including:

- evaluation of the need for medication
- evaluation of clinical effectiveness and side effects
- obtaining informed consent
- medication education
- plan development related to the delivery of the service and/or assessment of the client.

Day treatment intensive services means:

a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting,

with services available at least three hours and less than 24 hours each day the program is open.

Service activities may include, but are not limited to (these are defined below):

- assessment
- plan development
- therapy
- rehabilitation

- collateral.

Day rehabilitation services means:

a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning;
which provides services to a distinct group of clients; and
is available at least three hours and less than 24-hours per day the program is open.
Service activities may include, but are not limited to (these are defined below):

- assessment
- plan development
- therapy
- rehabilitation
- collateral.

Crisis intervention means:

a service lasting less than 24 hours,
to or on behalf of a client for condition which requires more timely response than a regularly scheduled visit.
Service activities may include, but are not limited to (these are defined below):

- assessment
- therapy
- collateral.

Crisis stabilization means:

a service lasting less than 24 hours,
to or on behalf of a client for condition which requires more timely response than a regularly scheduled visit, and
provided in a 24-hour health facility or a hospital-based outpatient program or at other sites certified to provide this service.
Service activities may include, but are not limited to (these are defined below):

- assessment
- therapy
- collateral.

Adult residential treatment services means:

rehabilitative services

provided in a non-institutional, residential setting
which provide a therapeutic community including a range of activities and services for clients
who would be at risk of hospitalization or other institutional placement if they were not in the program
with service available 24 hours a day, 7 days a week.
Service activities may include, but are not limited to (these are defined below):

- assessment
- plan development
- therapy
- rehabilitation
- collateral.

Crisis residential treatment services mean:

therapeutic or rehabilitative services
provided in a non-institutional resident setting
which provides a structured program for clients as an alternative to hospitalization for

- clients experiencing an actuate psychiatric episode or crisis
- who do not present medical complications requiring nursing care with
- service supporting clients in their efforts to restore, maintain and apply interpersonal and independent living skills, and to access community support systems.

Service available 24 hours, 7 days a week.
Service activities may include, but are not limited to (these are defined below):

- assessment
- plan development
- therapy
- rehabilitation
- crisis intervention (which also is a "service" and defined above) and
- collateral.

Psychiatric health facility services means:

therapeutic and/or rehabilitative services
provided in a non-hospital psychiatric health facility on an inpatient basis

to clients who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings.

(2) Psychiatric inpatient hospital services (provided to a client while in a psychiatric inpatient hospital)

(3) Targeted case management means

Services that assist a beneficiary to access needed:

medical
educational
social
prevocational
vocational
rehabilitative; or
other community services.

The service activities may include, but are not limited to:

communication, coordination, and referral;
monitoring service delivery to ensure beneficiary access to service and the service delivery system;
monitoring of the beneficiary's progress; and
plan development.

Case management services ensure that the changing needs of the person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs.

(4) Psychiatrist services means:

services provided by licensed physicians, within their scope of practice
who have contracted with the Mental Health Plan to provide specialty mental health services; or
who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program.

(5) Psychologist services means:

Services provided by licensed psychologists, within their scope of practice ;
to diagnose or treat a mental illness or condition.

(6) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services means:

an initial, periodic, or additional health assessment of a person under 21 years of age; or

a health assessment, examination, or evaluation of a person under 21 years of age by a licensed health care professional acting within his or her scope of practice, to determine the existence of physical or mental illnesses or conditions; or

any other encounter with a licensed health care professional that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition for a person under 21 years of age;

provided to correct or ameliorate the diagnosis in the DSM IV which provide the basis for medical necessity

(7) Psychiatric nursing facility services means:

skilled nursing facility services that include special treatment services

for mentally disordered persons

provided by an entity that is licensed as a skilled nursing facility, and

is certified by the DEMH to provide special treatment program services.

Service Activities:

Assessment means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Collateral means a service activity to a significant support person in a client's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity. (**Significant support person** means persons, in the opinion or the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a minor, the legal representative of a client who is not a minor, a person living in the same household as the beneficiary, the client's spouse and relatives of the beneficiary.)

Plan development means a service activity which consists of development of client plans, approval of client plans and/or monitoring of a client's progress.

Rehabilitation means a service activity which includes assistance in improving, maintaining or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills and support resources; and/or medication education.

Therapy means a service activity which is a therapeutic intervention that focuses primarily on symptom reductions as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

A note about the Fee for Services Medi-Cal (FFS/MC) Program

The FFS/MC program provides reimbursement for a comprehensive range of health services and a limited range of mental health services. Services are reimbursed on a fee-for-service basis, or within managed care contracts. These mental health FFS/MC services are provided primarily by private hospitals and private practitioners such as physicians (psychiatrists, psychologists, hospitals, and nursing facilities).

What Providers are Eligible for Reimbursement?

Individual Provider means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries.

Individual provider includes:

licensed physicians,
licensed psychologists,
licensed clinical social workers,

licensed marriage, family and child counselors; and
registered nurses with a master's degree within their scope of practice.

Organizational Provider means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provide the services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and other staff.

Licensed mental health professional means:

licensed physicians,
licensed clinical psychologies,
licensed clinical social workers,
licensed marriage, family and child counselors,
registered nurses,
licensed vocational nurses; and
licensed psychiatric technicians.

Any provider may apply for certification, and if it meets the standards, may bill pre-authorized services for eligible beneficiaries.

State/County/Provider Structure of Relationships

Most Medi-Cal beneficiaries using mental health care obtain services through county-administered mental health plans. The California Department of Health Services (DHS) delegates administrative responsibility for most mental health services to the Department of Mental Health (DMH). Counties contract with the DMH.

The Department of Mental Health's administrative responsibilities include:

1. Designate a local Mental Health Plan
2. Approve county Implementation Plans
3. Renew or terminate contracts with Mental Health Plans
4. Determine the methodology for allocating state funds to the MHPs annually
5. Ongoing oversight to an MHP through site visits and monitoring of data reports and claims processing
6. Approve the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects

In each county, the Board of Supervisors may request designation of the county as a Mental Health Plan. When designated, the MHP's responsibilities include:

(1) Establish an Implementation Plan including
   a. procedures for MHP payment,
   b. a process for selecting providers,
   c. a Cultural Competence Plan,
   d. a quality Improvement and Utilization Management Programs plan,
   e. client confidentiality plan,
   f. outreach efforts,
   g. a plan to assure screening, referral and coordination with other necessary services including substance abuse, educational, health, housing and vocational rehabilitation services

(2) Enter into a Memorandum of Understanding with any Medi-Cal Managed Care Plan to coordinate the provision of health care and mental health care services

(3) Review and certify providers to participate as mental health service

(4) Set rates for reimbursement pursuant to regulations

(5) Determine requirements for providers to obtain pre-authorization before rendering services

(6) Submit reports to the DMH concerning client grievances, hospital contracts, hospital rates, balances of allocations and any reports required in the contract with the DMH

(7) Assure that clients have access to specialty mental health services

(8) Reimburse providers

(9) Submit claims for services to DMH

Provider responsibilities include:

a. Must be certified and licensed to participate as a specialty mental health services provider and must comply with all state regulations and terms of the Mental Health Plan, including a Cultural Competence Plan
b. Maintain a safe facility
c. Store and dispense medications in compliance with all applicable state and federal laws and regulations

d. Maintain client records in a manner that meets state and federal standards
e. Meet the terms of the MHP's Quality Management Program and Cultural Competency standards
f. Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process
g. Provide for appropriate supervision of staff
h. Have as head of service a licensed mental health professional or other appropriate individual
i. Possess appropriate liability insurance
j. Have accounting and fiscal practices that are sufficient to comply regulations
k. Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process

Licensing and Certification

The MHP certifies providers, licensed by the State. A provider must comply with all Mental Health Specialty and other applicable Medi-Cal regulations.

How Does the Reimbursement Process Work?

Data Collection

Providers are required to maintain client records in a manner consistent with state and federal law.

Billing

Providers submit billings to the MHP for medically necessary, pre-approved services (except in the case of need for emergency care), for reimbursement at rates set by the MHP, contract or law. The MHP certifies and submits claims to DMH for reimbursement.

[1] The diagnoses referred to are:

a. Pervasive Developmental Disorders, except Autistic Disorders
b. Disruptive Behavior and Attention Deficit Disorders
c. Feeding and Eating Disorders of Infancy and Early Childhood
d. Elimination Disorders
e. Other Disorders of Infancy, Childhood, or Adolescence
f. Schizophrenia and other Psychotic Disorders
g. Mood Disorders
h. Anxiety Disorders
i. Somatoform Disorders
j. Factitious Disorders
k. Dissociative Disorders
l. Paraphilias
m. Gender Identity Disorder

n. Eating Disorders
o. Impulse Control Disorders Not Elsewhere Classified
p. Adjustment Disorders
q. Personality Disorders, excluding Antisocial Personality Disorder

Medication-Induced Movement Disorders related to other included diagnoses.

Drug Medi-Cal

The Drug Medi-Cal (DMC) program provides medically necessary substance abuse treatment services for eligible Medi-Cal beneficiaries. Services include Narcotic Treatment Program Services, Outpatient Drug Free Treatment, Day Care Rehabilitative Treatment, Naltrexone Treatment, and Perinatal Residential Substance Abuse.

The Department of Alcohol and Drug Programs (ADP) is the state agency responsible for administering the Drug Medi-Cal Program. The Department of Health Services (DHS), which administers the State's Medi-Cal Program, has delegated this responsibility to ADP through an interagency agreement.

Currently substance abuse is excluded from managed care and is reimbursed on a fee-for-service basis. However, there is currently a Statewide planning effort underway to create an outcome-based managed System of Care for substance abuse services.

In this section:

Services Reimbursable
Provider Participation
State/County/Provider Structure of Relationships
Licensing and Certification to Become a Provider
The Reimbursement Process: Data Collection and Billing

For more information on Drug Medi-Cal, go to www.adp.cahwnet.gov.

What Services are Eligible for Reimbursement?

The following services are covered by Drug Medi-Cal when they are provided to Medi-Cal beneficiaries by a certified Drug Medi-Cal provider, at its certified location, and when they have been determined to be medically necessary. "Medically Necessary" means that the services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. Services must be provided by or under the direction of a physician, provided according to specified requirements, and are subject to utilization controls.

(1) **Narcotic treatment program services**, utilizing methadone and/or levoalphacetylmethadol (LAAM) as narcotic replacement drugs, including intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone and/or LAAM, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates.

(2) Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, subject to the following limitations:

Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse or a return to substance abuse. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month. Individual counseling shall be limited to intake crisis intervention, collateral services, and treatment and discharge planning.

(3) **Day care habilitative services** including intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention. Day care habilitative services shall be provided only to pregnant

and postpartum women and/or to EPSDT-eligible[2] beneficiaries. The service shall consist of regularly assigned, structured, and supervised treatment.

[2] Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is Medicaid's comprehensive and preventive child health program for individuals under 21.

(4) **Perinatal[3] residential substance abuse services** including intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, subject to the following limitations:

Perinatal residential substance abuse services shall be provided in a residential facility licensed by ADP

Perinatal residential substance abuse services shall be reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents

Room and board shall not be reimbursable through the Medi-Cal program

(5) **Naltrexone treatment services** including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance abuse, body specimen screens, individual and group counseling, collateral services, and crisis intervention services. Naltrexone treatment services shall only be provided to a beneficiary who:

Has a confirmed, documented history of opiate addiction;

Is at least 18 years of age;

Is opiate free; and

Is not pregnant.

[3] Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.

What Providers are Eligible for Reimbursement?

Services must be provided by qualified certified substance abuse treatment clinics or perinatal residential programs that agree to abide by the definitions, rules and requirements for alcohol and drug treatment stabilization and rehabilitation services established by the Department of Alcohol and Drug programs in conjunction with the Department of Health Services, and that sign a provider agreement to serve all persons for whom these services are medically necessary.

Services must be provided by or under the supervision of a qualified substance abuse treatment professional functioning within the scope of their practice. A qualified substance abuse treatment professional means any provider qualified under the Medi-Cal program that has specialized training as required by state law and Medi-Cal regulations.

Any provider may apply for certification, and if it meets the standards, may bill DMC services for eligible beneficiaries and also determine the number of beneficiaries it would like to serve.

State/County/Provider Structure Of Relationships

The Department of Alcohol and Drug Program's (ADP) administrative responsibilities include:

(1) Providing administrative and fiscal oversight, monitoring, and auditing for the provision of statewide Drug Medi-Cal substance services.

(2) Conducting post service, post payment utilization reviews for compliance with standards of care and other requirements.

(3) Reviewing and certifying providers to participate in the Drug Medi-Cal program.

(4) Reimbursing providers for substance abuse services to Medi-Cal beneficiaries.

(5) Demanding recovery of payment in instances in which a provider has received an overpayment.

(6) Contracting directly with providers in any County which refuses to execute a Medi-Cal Drug Treatment Program contract.

(7) Establishing statewide maximum allowances for reimbursement.

(8) Receiving and managing appeals.

In each County, the Board of Supervisors authorizes a county department to administer alcohol and substance abuse programs, including Drug Medi-Cal substance abuse services. ADP then enters into a Drug Medi-Cal Treatment Program contract with the designated department. If a County decides not to administer the Drug Medi-Cal program, then ADP must contract directly with certified providers in the County.

The County Department's responsibilities include:

a. Contracting with providers, as applicable (Counties are required to contract with all certified providers who wish to bill DMC).
b. Implement and maintain a system of fiscal disbursement and controls over the Drug Medi-Cal substance abuse services rendered by providers.
c. Monitor to ensure that billing for reimbursement is within the rates established for services.

Process claims for reimbursement.

Provider responsibilities include:

1) Must be certified to participate in the Drug Medi-Cal treatment service system and must comply with all DMC requirements, including identifying the DSM diagnostic code, establishing the medical necessity for treatment, following DMC admission criteria and procedures, developing and updating treatment plans, preparing progress notes, minimum provider and beneficiary contact, justifying the need to continue services, prohibition of charging of fees to Drug Medi-Cal beneficiaries (except where share of cost is applicable), and completing a discharge summary.
2) Maintaining individual patient records for each beneficiary and group counseling sign-in sheets according to the specified requirements.
3) Providing services.
4) Submitting reimbursement claims and maintaining required documentation supporting good cause claims where the good cause results from provider-related delays.
5) (5) Submitting to utilization review and control by ADP, including site visits by ADP staff and development an implementation of a written plan to correct any deficiencies found during site visit.

Licensing and Certification

The Department of Alcohol and Drug Programs (ADP) certifies providers to participate in the Drug Medi-Cal program. A provider must be certified to participate in the Drug Medi-Cal treatment service system and must comply with all Drug Medi-Cal requirements.

Providers generally contract with the county to provide services. If a County decides not to administer the Drug Medi-Cal program, then ADP must contract directly with certified providers in the County.

How Does The Reimbursement Process Work?

Data Collection

A Drug Medi-Cal provider must establish, maintain, and update as necessary, an individual patient record for each beneficiary admitted to treatment and receiving services. An individual patient record means

a file for each beneficiary which shall contain, but not be limited to, information specifying the beneficiary's identifier (i.e., name, number), date of birth, the sex, race and/or ethnic background, address and telephone number, next of kin or emergency contact, and all documentation relating to the beneficiary gathered during the treatment episode, including all intake and admission data, all treatment plans, progress notes, continuing services justifications, laboratory test orders and results, referrals, counseling notes, discharge summary and any other information relating to the treatment services rendered to the beneficiary.

The provider must keep this information for at least three years from the date of the last face-to-face contact.

Billing

Counties and direct contract providers submit Drug Medi-Cal (DMC) claims to ADP no later than 30 calendar days after the month of service, unless the County or provider has good cause. Claims can be submitted to ADP electronically through the AOD InfoNet. ADP reviews the claims and sends them to the Department of Health Services (DHS) for processing and payment.

Drug Medi-Cal maximum rates are developed by ADP and set annually by the Department of Health Services. Providers may bill for actual costs up to the maximum allowances established for the fiscal year.

Health Medi-Cal

California's general health Medi-Cal program provides medically necessary medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for qualified beneficiaries. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. Medi-Cal covers a broad range of health care services, including primary care, mental health, long-term care, and dental services.

The Department of Health Services (DHS) is the state agency responsible for administering the general health Medi-Cal Program.

In this section:

Services Reimbursable
Provider Participation
State/County/Provider Structure of Relationships
Licensing and Certification to Become a Provider
The Reimbursement Process: Data Collection and Billing

For more information on Medi-Cal, go to www.medi-cal.ca.gov and to http//pro.medi-cal.ca.gov.

What Services are Eligible for Reimbursement?

The following services, which is not an exhaustive list, are covered by Medi-Cal when they are provided to Medi-Cal beneficiaries by a certified Medi-Cal provider, at its certified location, and when they have been determined to be medically necessary.

A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

- Hospital inpatient and outpatient care
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Examinations and follow-up care for children under age 21 (under the Early and Periodic Screening, Diagnostic and Treatment program, called Child Health and Disability Prevent program in California
- Dental/vision care for adults
- Prescription drugs

A note about FQHCs:

FQHCs include Health Care for the Homeless programs and Community Health Centers, which receive cost-based reimbursement under special rules. Not only can FQHCs provider services to clients of homeless housing providers, e.g. to delivery on-site care and health education to clients with follow-up at nearby clinics for more complex needs, but

mental health services can be provided by psychiatrists and Licensed Clinical Social Workers employed by or under contract with the FQHC.

What Providers are Eligible for Reimbursement?

Services must be provided by qualified, certified health care providers that agree to abide by the definitions, rules and requirements of the Department of Health Services and that sign a provider agreement to serve all persons for whom these services are medically necessary.

Any provider may apply for certification, and if it meets the standards, may bill DHS for services for eligible beneficiaries and also determine the number of beneficiaries it would like to serve. A list of potential providers include:

Acupuncturists
Audiologists
Blood Banks
Child Health and Disability Prevention Providers
Chiropractors
Christian Science Facilities
Christian Science Practitioners
Clinical Laboratories or Laboratories
Comprehensive Perinatal Providers
Dental School Clinics
Dentists
Dispensing Opticians
Durable Medical Equipment and Medical Supply Providers
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Providers
EPSDT Supplemental Services Providers
Fabricating Optical Laboratory
Hearing Aid Dispensers
Home Health Agencies Hospices
Hospital Outpatient Departments
Hospitals
Intermediate Care Facilities
Intermediate Care Facilities for the Developmentally Disabled
Local Educational Agency Providers
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nursing Facilities
Occupational Therapists
Ocularists Optometrists

Orthotists
Organized Outpatient Clinics
Outpatient Heroin Detoxification Providers
Personal Care Service Providers
Pharmacies/Pharmacists
Physical Therapists
Physicians
Podiatrists
Portable X-ray Services
Prosthetists
Providers of Medical Transportation
Psychologists Rehabilitation
Centers Renal Dialysis Centers and Community
Hemodialysis Units
Respiratory Care Practitioners
Rural Health Clinics
Short-Doyle (mental health) Medi-Cal Providers
Skilled Nursing Facilities
Speech Therapists
Targeted Case Management Providers
Federally Qualified Health Centers (FQHC's) which serve populations in particular need of care, such as the homeless

State/County/Provider Structure Of Relationships

The Department of Health Service’s administrative responsibilities include:

DHS’s Medical Care Services is responsible for the overall coordination and direction of health care delivery systems supported by the DHS. MCS directly operates California's Medicaid program (Medi-Cal) and the program's eligibility, scope of benefits, reimbursement, and other related components. MCS is responsible for the Department's fiscal intermediary contract which pays claims for programs operated by Primary Care and Family Health and Prevention Services. MCS will:

- Promote equitable access to high-quality medical care for low-income and uninsured Californians
- Manage available funds in a fiscally prudent manner to maximize the State's purchasing power
- Further expand organized health care delivery through managed care systems emphasizing primary care and clinical preventive services
- Develop "client friendly" systems by creating uniform entry systems and eliminating unnecessary categorical barriers
- Seek and develop culturally appropriate health care systems

Provider responsibilities include:

1. Applying for enrollment as a Medi-Cal provider with DHS
2. Entering into and abiding by the terms of the Provider Agreement and other laws and regulations
3. Maintaining in good standing licenses, certifies or other approvals to provide health care services
4. Keeping client medical records confidential
5. Maintaining individual patient records for each beneficiary according to the specified requirements
6. Providing medically necessary services
7. Submitting reimbursement claims to DHS
8. Submitting to utilization review and control by DHS, including site visits by DHS staff and development an implementation of a written plan to correct any deficiencies found during site visit

Licensing and Certification

The Department of Health Services certifies providers to participate in the Medi-Cal program. A provider must be certified to participate in the Medi-Cal treatment service system and must comply with all Medi-Cal requirements.

How Does The Reimbursement Process Work?

Data Collection

Providers are required to maintain client records in a manner consistent with state and federal law.

Billing

Providers submit billings electronically to DHS for medically necessary services for reimbursement at rates set by DHS.

[See also next section, Administration.]

Enrollment of Providers in the Medi-Cal Program

Preconditions to enrollment:

1. Certified by the Department to participate as a
    a. licensed clinic,
    b. licensed health facility, or
    c. clinics exempt from licensure under Health and Safety Code section 1206.

2. Submit to the Department a completed application package on forms specified and which
    a. contain complete and accurate information,
    b. are signed in ink under penalty of perjury by someone with authority, and
    c. are notarized

Application package includes:

- Application forms for enrollment
- Disclosure Statements
- Provider Agreements
    - Medi-Cal Provider agreement or
    - Medi-Cal Physician Application/Agreement
- All required attachments.

Application Review Criteria and Notice of Department Action

- Application package signed, notarized, complete
- Applicant has a valid license, certificate or other approval to provide the health care services, goods, supplies or merchandise
- Meets all applicable standards for participation in the Medi-Cal program including provision of only medically necessary services
- Applicant has all state and local licenses, permits or authorizations necessary to operate a business and to provide the services being rendered or the equipment or supplies being provided
- All fines, and all debts due and owing (including overpayments) to any Federal, State or local government that relate to Medicare, Medicaid (including Medi-Cal) and all other Federal and

State health care programs have been paid or satisfactory arrangements have been made to fulfill obligations

- The applicant is not one of the following
  - One with an ownership or control interest in the applicant's business
  - One who is an agent or managing employee of an applicant

  who has been convicted, found liable for, or entered into a settlement in lieu of conviction for fraud and/or abuse in any government programs within 10 years of the date of the application package

  who is under investigation for fraud and/or abuse in any government program at the time of the application
- The applicant has satisfactorily corrected any discrepancies in the application package within the time specified
- The applicant has satisfactorily corrected any discrepancies identified in the background check, onsite inspection or unannounced visit within the time limit specified
- The applicant has satisfactorily demonstrated to the Department that s/he has an established place of business appropriate and adequate for the services, goods, supplies or merchandise claimed or intended to be claimed to the Medi-Cal program as relevant to his or her business and/or scope of practice

Medi-Cal Managed Care Delivery Models by County [4]

All counties have Fee-for-Service systems. The counties listed below have a Managed Care system in addition to Fee-for-Service.

County	Two-Plan Model	Geographic Managed Care (GMC)	County Organized Health System (COHS)	Prepaid Health Plan (PHP)	Primary Care Case Management (PCCM)	Fee-For-Service Managed Care (FFSMC)
Alameda	x					
Contra Costa	x					
Fresno	x					
Kern	x					
Los Angeles	x				x	
Marin				x		
Monterey			x			
Napa			x			
Orange			x			
Placer						x
Riverside	x					
Sacramento		x				
San Bernardino	x					
San Diego		x				
San Francisco	x					
San Joquin	x					
San Mateo			x			
Santa Barbara			x			

[4] Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families, Mathematica Policy Research, Inc. May 2003.

Santa Clara	x					
Santa Cruz			x			
Solano			x			
Sonoma				x		x
Stanislaus	x					
Tulare	x					
Yolo			x			

Descriptions of the Medi-Cal Managed Care Delivery Models[5]

Two Plan Model- Medi-Cal beneficiaries are enrolled in either a public entity (known as a Local Initiative) or a commercial plan on a mandatory basis; some counties have two commercial plans

Geographic Managed Care (GMC)- the state contracts with a number of commercial managed care plans to deliver care on a capitated basis; beneficiary enrollment in a plan is mandatory for the CalWorks population and others may join voluntarily

County Organized Health System (COHS)- enrollment in a single county-run plan is mandatory for Medi-Cal beneficiaries and occurs concurrent with enrollment in the Medi-Cal program; counties negotiate a contract with the California Medical Assitance Commission (CMAC) and are paid a on a capitated basis

Prepaid Health Plan (PHP)- Medi-Cal beneficiaries may voluntarily enroll in a managed care plan

Primary Care Case Management (PCCM)- primary care providers contract with the state to provide primary care and specialty services on a capitated basis; enrollment is voluntary for Medi-Cal beneficiaries; PCCM was created a transitional model to full-risk managed care

Fee-for-Service Managed Care (FFSMC)- Medi-Cal beneficiaries are assigned a primary care provider for case management who are paid on a Fee-for-Service basis and act as a gatekeeper for specialty services

Key Words:

Capitation- a method of payment in managed care in which a provider is prepaid a fixed amount per person enrolled in an individual plan, based on a defined set of benefits and is typically paid monthly regardless of the type of care delivered or the frequency with which a patient uses services

Managed Care- a method of delivering and financing health care that seeks to control health care costs by coordinating an individual's

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[5] Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families, Mathematica Policy Research, Inc. May 2003; Understanding Medi-Cal: The Basics, Medi-Cal Policy Institute, September 2001.

health care; managed care plans (sometimes called HMO's) typically receive a prepaid rate for each member enrolled in the plan and maintain some level or risk for providing all necessary services for enrolled members within that prepaid rate.

The CSH Medicaid Project

The Corporation for Supportive Housing has initiated an ongoing project to study how Medicaid funds can be used to fund services provided in supportive housing. The project is part of CSH's ongoing effort to maintain and expand supportive housing by identifying new ways to fund its development, operations, and services. CSH's White Paper, *An Introduction to the CSH Medicaid Project* is attached, and the following are currently available for downloading at www.csh.org (select Resources, then Funding Resources, then Medicaid Resources):

The Basics of the Federal/State Medicaid Program

An introduction covering who is eligible for Medicaid, what services are covered, and who can receive Medicaid reimbursement for providing these services. This paper also considers the implications Medicaid managed care programs may have on eligibility and reimbursement; opportunities and challenges for supportive housing providers; and potential changes to the Medicaid program.

Medicaid in Supportive Housing: Lessons for Policy-Makers

Despite the proven value of using Medicaid financing to fund services in supportive housing, complexity has made it difficult for many states and providers to tap into this promising resource. This paper provides an overview of current strategies for using Medicaid to finance supportive housing, and concludes with a list of recommendations for further action by local, state and federal policy-makers to facilitate the use of Medicaid financing for supportive housing.

Supportive Housing Providers' Experiences and Perspectives on Medicaid

An overview of strategies and issues identified by providers who have used Medicaid to pay for services in supportive housing, including: (1) aligning services with the requirements of Medicaid funding; (2) documentation and record-keeping; (3) staffing needs, including credentials, skills, and training; (4) infrastructure requirements, including management information systems and

administrative support for billing; and (5) ensuring adequate funding for services that are not reimbursed by Medicaid.

Current Opportunities for Medicaid Financing

This paper examines seven strategies that are currently used or being explored for using Medicaid to pay for services in supportive housing: the Rehabilitation Option; the Targeted Case Management (TCM) Option; using these options to fund Assertive Community Treatment (ACT) programs and other client-centered services; partnerships with Federally Qualified Health Centers (FQHC); Home and Community Based Services 1915(c) waivers; other federal waivers; and the Assisted Living and Personal Care Option. It describes the federal framework and rules for each along with examples from several states.

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