Medi-Cal Explained FACT SHEET

# Medi-Cal Explained: New Medi-Cal Services at a Glance (2020–2023)

Author: Rachel Aberbach Metz, MPP

Since 2020, California has added several new benefits and services for Medi-Cal enrollees. Some of them are part of California Advancing and Innovating Medi-Cal (CalAIM), and others are new Non-Specialty Mental Health Services (NSMHS).[1] There are also benefits that establish a new billable provider type.

This fact sheet provides a high-level summary of several of these new services (Table 1):

1. New services introduced as part of the CalAIM initiative:
   a. Enhanced Care Management (ECM)
   b. Community Supports
2. New services added to the NSMHS benefit:
   a. Dyadic Care Services
   b. Family therapy
   c. Psychiatric collaborative care management (CoCM)
3. New services offered through new types of billable providers:
   a. Community health worker (CHW) services
   b. Doula services
   c. Peer Support Specialist Services

For each service, this fact sheet includes the following information:

- A brief description of the service
- Eligibility criteria for the service[2]
- Reimbursement information, including the following:
  - Payers (e.g., Medi-Cal managed care plan, Medi-Cal Fee-for-Service, County Specialty Mental Health plan, Drug Medi-Cal, and/or Drug Medi-Cal Organized Delivery System)
  - Eligible providers of the service
  - Special considerations for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that receive reimbursement under the prospective payment system
- Key sources to explore for more information

The sources are primarily California Department of Health Care Services (DHCS) policy guides, manuals, All Plan Letters, and Behavioral Health Information Notices. DHCS uses All Plan Letters to convey information about or interpretation of changes in policy or procedure to managed care plans (MCPs); these documents are good resources for the services covered under Medi-Cal managed

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care. DHCS uses Behavioral Health Information Notices to provide guidance about and interpretation of changes in policy or procedure to behavioral health plans.

This fact sheet also provides basic information about billing for these new services. Service providers interested in receiving Medi-Cal reimbursement for the service must meet the following requirements:

- Have a contract with the payer of the services, which may include one or more of the following:
  - DHCS for fee-for-service Medi-Cal enrollees
  - Managed care plans. In many service areas this means having contracts with all MCPs operating in the service area, as well as any delegated entities, which may include a separate organization administering their NSMHS.
  - County Specialty Mental Health plan
  - Drug Medi-Cal or Drug Medi-Cal Organized Delivery System
- Enroll as Medi-Cal providers if there is a state-level enrollment pathway to do so
- Obtain a National Provider Identifier (NPI) or contract with a billing entity that has one.[3]

Each service described below includes a section on "where to find more information," with sources that offer a deeper understanding of requirements and reimbursement mechanisms.

**Table 1. Summary of New Services**

| Service | Payer(s) | Billable by RHCs/FQHCs | Effective Date of Service |
|---|---|---|---|
| **Those Introduced as Part of the CalAIM Initiative** | | | |
| Enhanced Care Management (ECM) | ▪ MCP(s) | Yes — outside PPS rate | Started January 1, 2022, with new populations phased in through January 2024 |
| Community Supports | ▪ MCP(s) | Yes — outside PPS rate | Started January 1, 2022; however, each service is optional and may not be provided by every health plan. |
| **Those Added to the NSMHS Benefit** | | | |
| Dyadic Care Services | ▪ MCP(s)/NSMHS plan(s)<br>▪ DHCS for Medi-Cal FFS | Yes — at the PPS rate plus an *additional* FFS payment | Revisions effective January 1, 2023 |
| Family therapy | ▪ MCP(s)/NSMHS plan(s)<br>▪ DHCS for Medi-Cal FFS | Yes — at the PPS rate | January 1, 2020 |
| Psychiatric collaborative care management (CoCM) | ▪ MCP(s)/NSMHS plan(s)<br>▪ DHCS for Medi-Cal FFS | Yes — at the PPS rate | January 1, 2021 |
| **Those Offered Through New Types of Billable Providers** | | | |
| Community health worker (CHW) services | ▪ MCP(s)<br>▪ DHCS for Medi-Cal FFS | No | January 1, 2022 |
| Doula services | ▪ MCP(s)<br>▪ DHCS for Medi-Cal FFS | No | January 1, 2023 |
| Peer Support Specialist Services | ▪ MHP/DMC/DMC-ODS | Yes — outside PPS rate | January 1, 2022 |

Source: Author analysis of relevant DHCS documents.

Notes: *CalAIM* is California Advancing and Innovating Medi-Cal. *DHCS* is California Department of Health Care Services. *DMC* is Drug Medi-Cal. *DMC-ODS* is Drug Medi-Cal Organized Delivery System. *FFS* is fee-for-service. *FQHC* is Federally Qualified Health Center. *MCP* is managed care plan. *MHP* is County Mental Health Plan. *NSMHS* is Non-Specialty Mental Health Services. *PPS* is prospective payment system. *RHC* is rural health clinic.

# Enhanced Care Management (ECM)

## What is the service?

Intensive coordination of health and health-related services. ECM is "high touch," including in-person visits, and "whole person," meaning it spans all medical, behavioral, social, oral, and long-term services and supports needs. Services are intended to meet enrollees where they are: on the street, in a shelter, in their doctor's office, or at home.

There are seven core services:

1. Outreach and engagement
2. Comprehensive assessment and care management plan development
3. Enhanced coordination of care
4. Health promotion
5. Transitional care service
6. Member and family supports
7. Coordination of and referral to community and social support services

## Who is eligible to receive the service?

To receive services, people must be enrolled in a MCP. MCPs determine and authorize eligibility for each member. In some cases, health plans may allow for presumptive authorizations. There are *nine populations of focus* phased in between January 1, 2022, and January 1, 2024.[4]

1. People experiencing homelessness
2. People at risk for avoidable hospital or emergency department utilization
3. People with serious mental health and/or substance use disorder needs
4. People transitioning from incarceration
5. Adults living in the community and at risk for long-term-care institutionalization
6. Adult nursing facility residents transitioning to the community
7. Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond the CCS condition
8. Children and youth involved in Child Welfare
9. Pregnant and postpartum people ("birth equity population of focus")

## Who is eligible to provide the service?

A wide range of agencies can be ECM providers, including but not limited to counties, hospitals, FQHCs, clinics, and community-based organizations. Provider agencies with a state-level Medi-Cal enrollment pathway must enroll as Medi-Cal providers. State-level enrollment pathways are available through either the DHCS Provider Enrollment Division or another state department with a recognized enrollment pathway.[5] Provider agencies without a state-level pathway must be vetted by the MCP to participate. Provider organizations must have the ability to submit claims or invoices with required data elements, and have a National Provider Identifier (NPI), among other requirements.[6]

## Who pays for the service?

MCP(s) only. Only managed care plan members are eligible for the service.

## Can Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs) bill for the service?

Yes, RHCs/FQHCs may receive ECM reimbursement payments in addition to PPS payments, and those reimbursements are not subject to the annual reconciliation process.

## Where can I find more information about the service?

- Visit "CalAIM Enhanced Care Management and Community Supports," DHCS, for more information and key documents. Recommended resource documents include the following:
  - *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS. The guide provides a comprehensive overview of ECM as well as operational guidance.
  - *CalAIM Enhanced Care Management and Community Supports Frequently Asked Questions (FAQ)* (PDF), DHCS.

- *CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS): Contract Template Provisions* (PDF), DHCS. The contract template provides the MCPs' responsibilities for administration of ECM.
- *Enhanced Care Management and Community Supports (formerly "In Lieu of Services") Provider Standard Terms and Conditions* (PDF), DHCS. The Standard Terms and Conditions provides details on definitions, provider requirements, delivery, and payment.

# Community Supports

## What are the services?

*Fourteen optional* services that can be provided, but are not required to be provided, by MCPs:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Medical respite/recuperative care
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically supportive food/meals/medically tailored meals
13. Sobering centers
14. Asthma remediation

Community Support Services are optional, and the services offered vary by MCP. *CalAIM Community Supports - Managed Care Plan Elections* (PDF) from DHCS provides the status as of June 2023; however, MCPs may add additional Community Supports every six months.

## Who is eligible to receive the services?

To receive services, people must be enrolled in a MCP. Community Supports are optional services for the health plan and for the member. Eligibility guidelines vary as outlined in the *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF) and by individual MCP policy. MCPs determine and authorize eligibility for each member. Authorization periods vary by MCP and by service.

## Who is eligible to provide the services?

A wide range of agencies can be Community Supports providers, including but not limited to counties, hospitals, FQHCs, clinics, and community-based organizations. Provider agencies with a state-level Medi-Cal enrollment pathway must enroll as Medi-Cal providers. State-level enrollment pathways are available through either the DHCS Provider Enrollment Division or another state department with a recognized enrollment pathway.[7] Provider agencies without a state-level pathway must be vetted by the MCP to participate. Provider organizations must have the ability to submit claims or invoices with required data elements, and have a National Provider Identifier (NPI), among other requirements.[8]

## Who pays for the service?

MCP(s) only. Only managed care members are eligible for the services.

## Can RHCs/FQHCs bill for the services?

Yes, RHCs/FQHCs may receive Community Supports reimbursement payments in addition to PPS payments, and those reimbursements are not subject to the annual reconciliation process.

## Where can I find more information about the services?

- Visit "CalAIM Enhanced Care Management and Community Supports," DHCS, for more information and key documents. Recommended resource documents include the following:

- *Medical Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS. The guide provides a comprehensive overview of Community Supports as well as operational guidance.
- *CalAIM Enhanced Care Management and Community Supports Frequently Asked Questions (FAQ)* (PDF), DHCS.
- *CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS): Contract Template Provisions* (PDF), DHCS. The contract template provides the MCPs' responsibilities for administration of Community Supports.
- *Enhanced Care Management and Community Supports (formerly "In Lieu of Services") Provider Standard Terms and Conditions* (PDF), DHCS. The Standard Terms and Conditions provides details on definitions, provider requirements, delivery, and payment.

## Dyadic Care Services

### What are the services?

A family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified. A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care is provided within pediatric primary care settings whenever possible. Services are intended to foster access to preventive care for children, increased rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health.

Covered services are behavioral health services for children and/or their parent(s) or caregiver(s) and include those targeted toward the children (Medi-Cal enrollees under 21):

1. Dyadic behavioral health well-child visits
2. Dyadic comprehensive community support services
3. Dyadic psychoeducational services
4. Dyadic family training and counseling for child development dyadic therapy

As well as those targeted toward the caregiver:

1. Brief emotional/behavioral assessment
2. Adverse childhood experiences screening
3. Alcohol and drug Screening, Brief Intervention, and Referral to Treatment (SBIRT) services
4. Depression screening
5. Health behavior assessments and interventions
6. Psychiatric diagnostic evaluation
7. Tobacco cessation counseling

### Who is eligible to receive the services?

Children (Medi-Cal enrollees under 21) and/or their parent(s) or caregivers(s). The parent(s) or caregiver(s) do not need to be enrolled in Medi-Cal so long as the care is for the direct benefit of the child. Authorizations are not required for dyadic care services (or for any NSMHS) unless specified age restrictions or frequency limits are exceeded.

### Who is eligible to provide the services?

Licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, licensed psychologists, psychiatric physician assistants, psychiatric nurse practitioners, and psychiatrists. Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, and psychology assistants may render services under a supervising clinician (professional clinical counselors, associate clinical social workers, and psychology assistants are not eligible FQHC providers).

### Who pays for the service?

- The MCP for managed care members (either in-house or through a behavioral health plan contracted by the MCP)
- DHCS for Medi-Cal FFS enrollees

### Can RHCs/FQHCs bill for the services?

Yes. RHCs and FQHCs are eligible to receive their PPS rate if the dyadic care is delivered as a face-to-face encounter (either in-person or via telehealth) by a billable provider. Dyadic services may be reimbursed an additional amount at the FFS rate established for services if the service provided does

not meet the definition of an RHC/FQHC visit or exceeds frequency limitations. These FFS payments are outside of the annual reconciliation process.

### Where can I find more information about the services?

- Dana Durham (chief, Managed Care Quality and Monitoring Division, DHCS) to all Medi-Cal managed care health plans, All Plan Letter 22-029 (Revised) (PDF), March 20, 2023. This is the All Plan Letter for dyadic services and the family therapy benefit.
- *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (PDF), DHCS.[9] This is the Medi-Cal provider manual for Non-Specialty Mental Health Services: Psychiatric and Psychological Services; information about Dyadic Care Services can be found on page 13.

## Family Therapy

### What is the service?

The primary focus of family therapy sessions, a type of psychotherapy, is family dynamics as they relate to the patient's mental status and behavior(s). Sessions are typically 50 minutes and must be at least 27 minutes to be billable.

### Who is eligible to receive the service?

Medi-Cal enrollees age 20 or younger are eligible to receive family therapy if needed to correct or ameliorate a child's mental health condition. Family therapy must be composed of at least two family members, but both need not be present. Specifically, the child or youth Medi-Cal enrollee who meets the criteria for family therapy does not need to be present (i.e., caregivers can receive couples therapy in support of interparental dynamics that are affecting the child). Authorizations are not required for family therapy (or for any NSMHS) unless specified age or frequency limits are exceeded.

### Who is eligible to provide the service?

Licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, licensed psychologists, psychiatric physician assistants, psychiatric nurse practitioners, and psychiatrists. Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, and psychology assistants may render services under a supervising clinician (professional clinical counselors, associate clinical social workers, and psychology assistants are not eligible FQHC providers).

### Who pays for the service?

- The MCP for managed care members (either in-house or through a behavioral health plan contracted by the MCP)
- DHCS for Medi-Cal FFS enrollees

### Can RHCs/FQHCs bill for the service?

Yes. RHCs and FQHCs are eligible to receive their PPS rate if the service is delivered as a face-to-face encounter (either in-person or via telehealth) by a billable provider.

### Where can I find more information about the service?

- Dana Durham (chief, Managed Care Quality and Monitoring Division, DHCS) to all Medi-Cal managed care health plans, All Plan Letter 22-029 (Revised) (PDF), March 20, 2023. This is the All Plan Letter for dyadic services and the family therapy benefit.
- *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (PDF), DHCS.[10] This is the Medi-Cal provider manual for Non-Specialty Mental Health Services: Psychiatric and Psychological Services; information about family therapy can be found on page 26.

# Psychiatric Collaborative Care Management

## What is the service?

Collaborative care is a type of integrated care to treat common mental health conditions, such as depression and anxiety, that require systematic follow-up due to their persistent nature. Collaborative care integrates two key team members into the primary care team, a behavioral health care manager and a psychiatric/addiction medicine consultant, to treat people with mental health and/or substance use disorders.

## Who is eligible to receive the service?

Medi-Cal enrollees with a mental health or substance use disorder being served in primary care. Authorizations are not required for collaborative care management (CoCM) unless specified age or frequency limits are exceeded.

## Who is eligible to provide the service?

A behavioral health care manager, in consultation with a psychiatric consultant and under the direction of the treating physician or other qualified health professional. Billing is based on the time of the behavioral health care manager activities (in consultation with others on the team).

## Who pays for the service?

- The MCP for managed care members (either in-house or through a behavioral health plan contracted by the MCP)
- DHCS for Medi-Cal FFS enrollees

## Can RHCs/FQHCs bill for the service?

Yes. RHCs and FQHCs are eligible to receive their PPS rate if the service is delivered as a face-to-face encounter (either in-person or via telehealth) by a billable provider. FQHCs and RHCs can also bill FFS; however, these FFS payments are subject to the annual reconciliation process.

## Where can I find more information about the service?

- *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (PDF), DHCS.[11] This is the Medi-Cal provider manual for Non-Specialty Mental Health Services: Psychiatric and Psychological Services; information about psychiatric CoCM can be found on page 24.
- *Evaluation and Management (E&M)* (PDF), DHCS. This is the Evaluation and Management manual, part of the Medi-Cal provider manual for Non-Specialty Mental Health Services: Psychiatric and Psychological Services. Information about psychiatric CoCM can be found on page 43.

# Community Health Worker (CHW) Services

## What are the services?

CHW services are preventive health services delivered by a CHW.[12] Services include health education, health navigation, screening and assessment, individual support, or advocacy to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. Not all services provided by a CHW are part of the CHW services benefit (e.g., if a CHW is providing ECM services, those services are billable under ECM, not the CHW benefit).

## Who is eligible to receive the services?

To receive CHW services, a Medi-Cal enrollee must have a written recommendation from a physician, physician assistant, nurse practitioner, clinical nurse specialist, podiatrist, nurse-midwife, licensed midwife, registered nurse, public health nurse, psychologist, licensed marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, dentist, licensed educational

psychologist, licensed vocational nurse, or pharmacist. The recommending provider must ensure that the enrollee meets eligibility criteria prior to recommending CHW services. (See Appendix A for eligibility criteria.) CHW services are preventive health services, and MCPs cannot require prior authorization for the first 12 units of service.

Services are considered medically necessary if the enrollee meets one or more of the following conditions:

1. Has one or more chronic health (including behavioral health) conditions or exposure to violence and trauma
2. Is at risk for a chronic health condition or environmental health exposure
3. Faces barriers meeting their health or health-related social needs
4. Would benefit from preventive services

Providers *cannot* bill for CHW services if the enrollee is receiving ECM during the same time period.

### Who is eligible to provide the services?

CHWs may include providers known by a variety of job titles, such as *promotores*, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

CHWs must meet all of the following qualifications:

1. Have lived experience[13]
2. Demonstrate minimum qualifications through one of the following pathways:
   a. CHW certification
   b. Violence Prevention Professional Certification
   c. Work experience (2,000 hours as a CHW within the past 3 years)
3. Complete a minimum of six hours of additional training annually

In addition, CHWs must have a "supervising provider." A supervising provider is the organization employing or otherwise overseeing the CHW. The supervising provider ensures that CHWs meet qualifications, provides oversight and submits claims for services provided by CHWs. Supervising providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS's Provider Enrollment Division. Supervising providers without a state-level pathway must be vetted by the MCP to participate.

### Who pays for the service?

- MCPs for managed care members
- DHCS for Medi-Cal FFS enrollees

### Can RHCs/FQHCs bill for the services?

No, RHCs/FQHCs cannot be reimbursed for the CHW benefit.[14]

### Where can I find more information about the services?

- Visit "Medi-Cal Coverage of Community Health Worker (CHW) Services Is Effective July 1, 2022," DHCS.
- Dana Durham (chief, Managed Care Quality and Monitoring Division, DHCS) to all Medi-Cal managed care health plans, All Plan Letter 22-016 (Revised) (PDF), September 9, 2022. This is the All Plan Letter for the CHW services benefit.
- *Community Health Worker (CHW) Preventive Services* (PDF), DHCS. This is the Medi-Cal Provider Manual: Part 2 - Community Health Worker (CHW) Preventive Services.

## Doula Services

### What are the services?

Doula services are preventive health services. They include health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doula services may be provided only during pregnancy, labor and delivery, miscarriage, and abortion, and within one year of the end of an enrollee's pregnancy.

### Who is eligible to receive the services?

A Medi-Cal enrollee who is pregnant, or was pregnant in the past year, and either would benefit from doula services or requests doula services. To receive doula services, Medi-Cal enrollees must have a written recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice. Doula services are preventive services, and a written recommendation serves as authorization for the following:

1. One initial visit
2. Up to eight additional visits, which may be provided in any combination of prenatal and postpartum visits
3. Support during labor and delivery (including labor and delivery resulting in a stillbirth)
4. Up to two extended, three-hour postpartum visits after the end of a pregnancy

Medi-Cal enrollees interested in doula services can reach out to their MCP to ask how to access these services.

### Who is eligible to provide the services?

Doulas must meet all of the following qualifications:

1. Be at least 18 years old
2. Possess an adult/infant cardiopulmonary resuscitation (CPR) certification
3. Complete basic Health Insurance Portability and Accountability Act (HIPAA) training
4. Demonstrate minimum qualifications through a training pathway or a work experience pathway

### Who pays for the service?

- MCPs for managed care members
- DHCS for Medi-Cal FFS enrollees

### Can RHCs/FQHCs bill for the services?

No.

### Where can I find more information about the services?

- Visit "Doula Services as a Medi-Cal Benefit," DHCS.
- Dana Durham (chief, Managed Care Quality and Monitoring Division, DHCS) to all Medi-Cal managed care health plans, All Plan Letter 22-031 (PDF), December 27, 2022. This is the All Plan Letter for doula services.
- *Doula Services* (PDF), DHCS. This is the Medi-Cal Provider Manual: Part 2 - Doula Services.

## Peer Support Specialist Services

### What are the services?

Peer Support Specialist Services are recovery-oriented, culturally appropriate, trauma-aware services that promote engagement, socialization, self-sufficiency, self-advocacy, and natural supports. These services can be delivered and claimed as a stand-alone service or in conjunction with other services offered through the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, including inpatient and residential services.

### Who is eligible to receive the services?

Medi-Cal enrollees meeting the criteria for SMHS, DMC, or DMC-ODS, as well as the parents, family members, and caregivers who support them. Services can include contact with family members or other people supporting the enrollee, if the purpose of that participation is to focus on the treatment needs of the enrollee by supporting the achievement of the enrollee's goal(s). There may be times when, based on clinical judgment, the enrollee is not present during the delivery of the service but remains the focus of it.

### Who is eligible to provide the services?

Peer support specialists must meet all of the following qualifications:

1. Be at least 18 years old
2. Possess a high school diploma or equivalent degree

3. Self-identify as having experience with the process of recovery from a mental illness or substance use disorder, either as a consumer of recovery services or as the parent, caregiver, or family member of such a consumer
4. Be willing to share their experience
5. Have a strong dedication to recovery
6. Agree to adhere to the code of ethics
7. Complete the training requirements for a peer support specialist
8. Pass the certification examination approved by DHCS for a peer support specialist

Peer support specialists certified through the program administered by the California Mental Health Services Authority (CalMHSA) will be recognized as Medi-Cal peer support specialists by all counties that elect to participate in the Medi-Cal Peer Support Services benefit under agreement with the DHCS.

## Who pays for the service?

Counties that opt in are able to implement Peer Support Services within the Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and/or County Mental Health Plan (MHP) delivery system.

## Can RHCs/FQHCs bill for the services?

Yes. Reimbursement is fee-for-service through contracts with county MHP, DMC, and/or DMC-ODS, which is outside of the PPS rate and not part of the reconciliation process.

## Where can I find more information about the services?

- Visit "Medi-Cal Peer Support Services," DHCS and "Medi-Cal Peer Support Specialist Certification," California Mental Health Services Authority.
- *Behavioral Health Information Notice No: 21-041* (PDF), DHCS. This Behavioral Health Information Notice was sent to multiple California nongovernmental organizations to provide standards for implementing the Medi-Cal Peer Support Specialist Certification Program.
- *Behavioral Health Information Notice No: 22-026* (PDF), DHCS. This Behavioral Health Information Notice was sent to multiple California nongovernmental organizations to provide guidance regarding the submission of an opt-in letter and claiming requirements for Peer Support Services in the DMC, DMC-ODS, and SMHS programs.

## Endnotes

1. *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (PDF), California Department of Health Care Services (DHCS), updated November 2022.
2. Specific restrictions on eligible populations or authorization policies may be in place; it is critical to check with the local MCP(s), Specialty Mental Health Services (SMHS) provider, and/or Non-Specialty Mental Health Services (NSMHS) administrator(s) for local regulations.
3. *National Provider Identifier (NPI) Application: A Step-by-Step Guide for Providers Participating in the ECM and Community Supports Programs* (PDF), DHCS, accessed June 22, 2023.
4. *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, updated July 2023. See page 7 for a timeline. Adults with Intellectual or Developmental Disabilities (I/DD) was initially a population of focus; however, DHCS has now clarified that I/DD alone is not a population of focus and must be co-occurring with another population of focus.
5. Sarah Brooks (deputy director, Health Care Delivery Systems, DHCS) to all Medi-Cal managed care health plans, All Plan Letter 19-004 (PDF), June 12, 2019.
6. *CalAIM Data Guidance: Billing and Invoicing Between ECM/Community Supports Providers and MCPs* (PDF), DHCS, updated April 2023.
7. Brooks, All Plan Letter 19-004.
8. *CalAIM Data Guidance*, DHCS.
9. "Medi-Cal Provider Manuals: Part 2 – Psychological Services (PSY)," DHCS, accessed June 22, 2023.
10. "Medi-Cal Provider Manuals: PSY," DHCS.
11. "Medi-Cal Provider Manuals: PSY," DHCS.
12. CHWs may include providers known by a variety of job titles, such as *promotores*, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.
13. CHWs must have lived experience that aligns with and provides connection between the CHW and the community or population being served. This may include, but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.
14. Although RHCs/FQHCs cannot bill for the CHW benefit, RHCs/FQHCs can be reimbursed for two other services that can be provided by community health workers: (1) Services offered under the Comprehensive Perinatal Services Program (CPSP) can be provided by a CHW and an RHC/FQHC and reimbursed at their PPS rate, and (2) RHC/FQHCs can include CHWs as part of their ECM staffing and receive ECM reimbursement outside of their PPS rate.

## About the Author

Rachel Aberbach Metz, MPP, is an independent consultant with 25 years of experience working on issues related to health care, health insurance, Medicaid, homelessness, housing, youth development, after-school programs, early childhood, and fiscal leveraging. Over the last five years, Rachel has focused on health and housing with an emphasis on reducing homelessness, including increasing shelter and housing services with a focus on sustaining programs and planning and implementation of CalAIM services.

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# Appendix A. Medical Necessity Criteria for Community Health Worker Services

The recommending provider shall determine whether an enrollee meets the medical necessity criteria for community health worker services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure or elevated blood glucose levels, which indicate risk but do not yet warrant diagnosis of a chronic condition)
- Positive adverse childhood experiences (ACEs) screening
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity
- One or more visits to a hospital emergency department within the previous six month, or being at risk of institutionalization
- One or more stays at a detox facility within the previous year
- Two or more missed medical appointments within the previous six months
- Enrollee request for support in health system navigation or resource coordination services
- Need for recommended preventive services

CHW services are also available to enrollees who meet any of the following circumstances as determined by a licensed practitioner if the services are intended for violence prevention:

- Violently injured as a result of community violence.
- At significant risk of experiencing violent injury as a result of community violence.
- Chronic exposure to community violence.