SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

727

FROM: Department of Mental Health **SUBMITTAL DATE:**

SUBJECT: Approve the Memorandum of Understanding between Inland Empire Health Plan (IEHP) and the Riverside County Department of Mental Health.

RECOMMENDED MOTION: Move that the Board of Supervisors:

1. Approve the Memorandum of Understanding (MOU) between Inland Empire Health Plan and the Riverside County Department of Mental Health for Medi-Cal and Medicare Dual Choice beneficiaries for FY 2011/2012;
2. Authorize the Chairman of the Riverside County Board of Supervisors to sign the MOU; and
3. Authorize the Director of Riverside County Mental Health (RCDMH) to sign ministerial amendments and renewals for this MOU with IEHP for Medi-Cal and Medicare Dual Choice mental health services through June 30, 2016.

BACKGROUND: On September 2, 2008, Agenda Item 3.108, the Riverside County Board of Supervisors approved the third amendment to the MOU between Inland Empire Health (IEHP) and the RCDMH to provide a coordination of mental and physical health services. In FY 2011/2012, the RCDMH started working with IEHP to develop an updated, all inclusive MOU that appropriately reflects both parties' agreement and understanding of the services to be rendered under this agreement to both Medi-Cal and Medicare Dual Choice beneficiaries. **(Continued on Page 2)**

JW:KL:SL

Jerry Wengerd, Director
Department of Mental Health

FINANCIAL DATA	Current F.Y. Total Cost:	$ 0	In Current Year Budget:	YES
	Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	NO
	Annual Net County Cost:	$ 0	For Fiscal Year:	11/12

SOURCE OF FUNDS:

Positions To Be Deleted Per A-30	☐
Requires 4/5 Vote	☐

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: ELENA M. BOEVA 1-30-12 DATE

Departmental Concurrence

Dep't Recomm.: ☐ Consent ☒ Policy

Per Exec. Ofc.: ☐ Consent ☒ Policy

Prev. Agn. Ref.: 09/02.08 agenda item 3.108 | **District:** All | **Agenda Number:** 3.19

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

SUBJECT: Approve the Memorandum of Understanding between Inland Empire Health Plan (IEHP) and the Riverside County Department of Mental Health.

BACKGROUND (continued):
The California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.370, requires Medi-Cal Mental Health Plans to enter into MOU agreements with Medi-Cal Managed Care Plans (physical health care) to ensure appropriate care for Medi-Cal and Medicare Dual Choice beneficiaries. These regulations stipulate that Medi-Cal and Medicare mental health services shall be provided to Medi-Cal and Medicare beneficiaries through the Mental Health Plan, which is administered by the RCDMH.

The updated, all inclusive IEHP MOU establishes the referral protocol of the Riverside County Medi-Cal population and Medi-cal/Medicare eligible population enrolled in the IEHP Medi-cal and Medicare Dual Choice program. The IEHP MOU also defines the protocol for coordinating the care mutually shared between IEHP and RCDMH clients. The protocol states that IEHP will refer to RCDMH IEHP members whose psychological condition would not be responsive to physical health care services. RCDMH will, in return, accept Medi-Cal referrals from IEHP for determination of medical necessity, and provide mental health specialty evaluation services. In addition, RCDMH Medi-Cal beneficiaries enrolled in IEHP will receive services with or without a referral by IEHP. Therefore, the RCDMH is requesting that the Riverside County Board of Supervisors approve the MOU between IEHP and the RCDMH to provide mental services to Medi-Cal and Medicare Dual Choice beneficiaries.

PERIOD OF PERFORMANCE:
This MOU shall be effective upon execution by both parties, and shall continue in effect until June 30, 2012. The term may be extended for up to four (4) additional one (1) year periods, in succession, at the mutual consent of the parties, without requiring further action of the governing entities of either party. The MOU may be terminated at any time pursuant to the provision herein. In the event that the term of the MOU is extended for the four (4) additional one (1) year periods, the MOU shall terminate on June 30, 2016. The MOU further stipulates that in no event shall this MOU be extended past June 30, 2016 without a new MOU, or an amendment to this MOU which specifically extends the term of the MOU.

FINANCIAL IMPACT:
The MOU between IEHP and RCDMH has a zero dollar amount ($0) as specified in the agreement. However, IEHP will reimburse RCDMH at 100% of the Medicare allowable for all billable services. No County funds are required.

Joint Powers Agency Inland Empire Health Plan

RESOLUTION NO.11-310

APPROVAL OF THE MEMORANDUM OF UNDERSTANDING WITH THE RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH FOR MENTAL HEALTH SERVICES TO MEDI-CAL MEMBERS AND MEDICARE DUALCHOICE MEMBERS

WHEREAS, the Chief Executive Officer, or his designee, has determined that it is necessary, desirable and prudent to retain the services of the Riverside County Department of Mental Health for the provision of Mental Health Services to Medi-Cal Members and Medicare DualChoice Members; and,

WHEREAS, the Inland Empire Health Plan is required by the Department of Managed Health Care to coordinate public health services with the County of Riverside; and,

WHEREAS, it is deemed necessary, desirable and prudent by the Chief Executive Officer, or his designee, to approve the Memorandum of Understanding with the Riverside County Department of Mental Health for the provision of Mental Health Services for Medi-Cal Members and Medicare DualChoice Members, and a copy of the document has been provided to each Board member, and the original shall be maintained by the Secretary to the Governing Board; now, therefore,

BE IT RESOLVED, DETERMINED AND ORDERED by the Governing Board of Inland Empire Health Plan, at its regular meeting assembled on December 12, 2011, that the Memorandum of Understanding with the Riverside County Department of Mental Health, for the provision of Mental Health Services for Medi-Cal Members and Medicare DualChoice Members, is approved.

BE IT FURTHER RESOLVED, DETERMINED AND ORDERED that this Memorandum of Understanding replaces the existing Riverside County Memorandum of Understanding for the provision of Mental Health Services approved on Resolution 08-139.

1 BE IT FURTHER RESOLVED, DETERMINED AND ORDERED that the Chief
2 Executive Officer, or his designee, is authorized to execute any necessary documents to
3 effectuate this Memorandum of Understanding, without requiring any further Board approval.
4
5
6 State of California)
County of San Bernardino)
7
I, Vickie Hargrove, Secretary of the Inland Empire Health Plan, do hereby certify
8 that the foregoing resolution was duly and regularly adopted by the Governing Board of the
Inland Empire Health Plan.
9

Ayes:	Anderson, Buster, Ovitt, Williams, Zorn
Noes:	0
Abstain:	0
Absent:	Mitzelfelt, Tavaglione
Vacant:	0
Date:	December 12, 2011

Vickie Hargrove, Secretary

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MEMORANDUM OF UNDERSTANDING

BETWEEN

INLAND EMPIRE HEALTH PLAN

AND

COUNTY OF RIVERSIDE - DEPARTMENT OF MENTAL HEALTH

(MENTAL HEALTH SERVICES FOR MEDI-CAL AND MEDICARE DUALCHOICE MEMBERS)

MEMORANDUM OF UNDERSTANDING

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Attachment A	Activities Description Grid
Attachment B	Referral Algorithm
Exhibit I	MMCD Policy Letter 00-01 REV
Exhibit II	Behavioral Health Coordination of Care Web Forms
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Exhibit IV	Title 22, CCR, Section 51184, 51242, 51304, 51304, & 51532
Exhibit V	RCMHP Consumer Notices/Grievances and Appeals

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into on the date of its execution, by and between Inland Empire Health Plan (hereinafter referred to as "IEHP"), a Joint Powers Agency (hereinafter referred to as "JPA"), and Riverside County, through its Department of Mental Health, Mental Health Plan (hereinafter referred to as "RCMHP"). Any current agreements, as to this subject matter, are hereby terminated upon the execution of all parties of this MOU.

INTRODUCTION

The Riverside County Department of Mental Health, Mental Health Plan (RCMHP) and the Inland Empire Health Plan (IEHP) have complementary objectives to protect and promote the mental health of the general population. IEHP will be providing and arranging health care services for the community's Medi-Cal population and Medi-Cal/Medicare-eligible population enrolled in the IEHP Medicare DualChoice (HMO SNP) program and, thus is also concerned with the community's health, especially as it relates to the most vulnerable populations. With a common interest in the community's health, RCMHP and IEHP seek to become working partners in preventing disease, prolonging life, and promoting mental and physical health through organized efforts. This MOU delineates areas of understanding and agreement between RCMHP and IEHP.

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

1. **RCMHP RESPONSIBILITIES** – The following specialty mental health services are the responsibility of RCMHP: all of Short Doyle (SD) Medi-Cal (MC) specialty mental health services (inpatient and outpatient); Fee For Service (FFS)/MC outpatient specialty mental health services that meet state defined medical necessity criteria provided by psychiatrists and psychologists and other disciplines as per the mental health plan; FFS/MC inpatient specialty mental health services.

   1.01. RCMHP will have the responsibilities of coordination and provision of specified services for IEHP. RCMHP agrees to:

      1.01.01. Assign its Program Chief to serve as the primary liaison between RCMHP and IEHP. At the discretion of RCMHP, the liaison may represent RCMHP in the local dispute resolution process. In addition, appoint liaison personnel as needed to coordinate activities with IEHP for each service listed in Attachment A.

      1.01.02. Upon identification of a client who appears income-eligible for the Medi-Cal Program, provide referral to the Department of Public Social Services regarding application for Medi-Cal coverage. If an individual receiving services through RCMHP is an IEHP Member, RCMHP will refer them to their plan primary care provider as needed and appropriate.

      1.01.03. Provide technical assistance and consultation to IEHP staff concerning RCMHP services and requirements.

2. **IEHP RESPONSIBILITIES** – IEHP network physicians will provide outpatient mental health services within the Primary Care Physician's (PCP) scope of practice. Plan PCPs will

refer Members who need specialty mental health services to the appropriate FFS/MC mental health provider. IEHP and its network medical groups will case manage the physical health of the Member and coordinate service with the mental health referral provider. IEHP will ensure the provision of all psychotherapeutic drugs for Members. Reimbursement to pharmacies for those psychotherapeutic drugs listed in Exhibit I, Enclosure 2 (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997, will be made available by the Department of Health Care Services (DHCS) through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with IEHP or by an out-of-state pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

2.01. With respect to coordination of services provided by RCMHP, IEHP agrees to:

2.01.01. Notify staff and providers of their responsibility to refer Members, as appropriate and in compliance with Federal and State law, for services identified in Attachment A.

2.01.02. Inform Members of the availability of county mental health services and referrals through RCMHP.

2.01.03. The Clinical Director of Behavioral Health will serve as the primary liaison between IEHP and RCMHP. At the discretion of IEHP, the liaison may represent IEHP in the local dispute resolution process. In addition, IEHP will appoint liaison personnel as needed to coordinate activities with RCMHP for each service listed in Attachment A.

2.01.04. RCMHP will supply IEHP with pertinent information, forms, and educational materials as they are developed and become available. New materials will be jointly reviewed during quarterly joint operational meetings. IEHP will disseminate materials to network providers according to timelines mutually established by RCMHP and IEHP.

2.01.05. Coordinate with RCMHP in conducting outreach efforts, especially to under-served populations.

3. **JOINT OPERATING MEETINGS** – Meetings including the Director of Mental Health and/or the Program Chief, the Mental Health Services Supervisor, the IEHP Medical Director and/or the Director of Health Administration and the Clinical Director of Behavioral Health will be held on at least a quarterly basis to review all aspects of this MOU. At one of those meetings each year items to be re-negotiated or negotiated in relation to the MOU will be introduced.

4. **REIMBURSEMENTS**

4.01. IEHP will reimburse RCMHP at 100% of the Medicare allowable for all billable services.

4.02. RCMHP agrees to submit claims for reimbursement in accordance with IEHP's claim submission procedures.

4.03. The RCMHP shall provide medical records to support claim submission and payment request consistent with current federal and/or state laws and regulations governing

confidentiality of medical records, and public health statutes related to confidentiality. Where permitted by law, the RCMHP shall provide IEHP Members presenting for service with a request to release medical records to their known IEHP plan primary care physician to support IEHP's case management responsibilities. If an IEHP Member refuses the release of medical information, RCMHP shall submit documentation of such refusal with the claim for reimbursement.

4.04. On an annual basis, IEHP shall develop the Policy and Procedure Manual, which sets forth IEHP's administrative requirements, and make this available on the IEHP website for RCMHP's reference. This manual includes a description of claim submission procedures and IEHP's provider claims appeal system including the process for mediating claim disputes.

4.05. IEHP shall assure the timely reimbursement of the RCMHP including payment of claim within 45 days of receipt by IEHP of all necessary documentation as defined in IEHP's written claim submission procedures. IEHP shall notify RCMHP of any claim that is incomplete or contested within 45 days of receipt of IEHP of the claim.

4.06. In the event of termination of this Agreement, RCMHP shall submit claims for reimbursement of services provided in accordance with this Agreement prior to the effective date of termination.

4.07. RCMHP shall submit claims to IEHP for reimbursement within one year of the date of service (dos). For any claim received after 6 months but less than 9 months, the amount of reimbursement is reduced by 25%. For any claim received after 9 months but less than 12 months, the amount of reimbursement is reduced by 50%.

5. **TERM** - It is mutually agreed and understood that the obligation of IEHP is limited by and contingent upon the availability of the Department of Health Care Services (DHCS) funding for the Medi-Cal Managed Care Plan. IEHP shall notify RCMHP in writing within thirty (30) days of learning of any discontinuation of funding.

5.01. This MOU shall be effective upon execution by both parties, and shall continue in effect until June 30, 2012. The term may be extended for up to four (4) additional one (1) year periods, in succession, at the mutual consent of the parties, without requiring further action of the governing entities of either party. The MOU may be terminated at any time pursuant to the provision herein. In the event that the term of the MOU is extended for the four (4) additional one (1) year periods, the MOU shall terminate on June 30, 2016. In no event shall this MOU be extended past June 30, 2016 without a new MOU, or an amendment to this MOU, which specifically extends the term of the MOU.

6. **TERMINATION** - This MOU may be terminated by either party without cause, by giving at least sixty (60) days written notice, and may be terminated for cause by either party by giving ten (10) working days written notice of intention to terminate.

6.01. This MOU may be terminated due to the dissolution of IEHP by mutual action of the Riverside County and San Bernardino County Board of Supervisors. If IEHP has incurred no obligations, either County Board of Supervisors may terminate the JPA and IEHP by giving not less than sixty (60) days written notice thereof to the other County Board of Supervisors. Also, either County Board of Supervisors may

terminate the JPA by written mutual consent, by giving twelve (12) months written notice thereof to the other County Board of Supervisors given that the JPA cannot be terminated until all forms of indebtedness incurred by IEHP have been paid. or adequate provision for such payment has been made.

6.01.01. Upon dissolution of IEHP by Riverside County and San Bernardino County Board of Supervisors, this MOU is rendered null and void. The debts, liabilities, and/or obligations of IEHP are those of IEHP alone. Neither Riverside County nor San Bernardino County assumes any of the debts, liabilities and/or obligations of IEHP. The IEHP Governing Board also may terminate this MOU and must approve any termination of this MOU required by IEHP.

6.02. In the event of the issuance or receipt of a written notice to terminate, IEHP will notify DHCS within 30 days of the issuance or receipt of the notice.

7. **RESOLUTION OF DISPUTES** - Disputes between IEHP and RCMHP that cannot be resolved at the second level review as defined in Attachment A, shall be forwarded to the State Department of Health Care Services consistent with the procedure defined in CCR. TITLE 9, Section 1850.505, "Resolutions of Disputes Between MHPs and Medi-Cal Managed Care Plans."

7.01. Consistent with the terms specified in Attachment A, beneficiaries will continue to receive medically necessary services, including specialty mental health services and prescription drugs, while dispute is being resolved.

7.02. The provisions of Paragraph 6 ("TERMINATION") of the MOU shall not be affected by the provisions of the dispute resolution process defined in this section and in Section 22 of Attachment A.

8. **HOLD HARMLESS** - RCMHP will indemnify and hold IEHP harmless from loss, costs, or expenses caused by the negligent or wrongful acts or omissions of Riverside County officers, agents, and employees occurring in the performance of this MOU. IEHP will indemnify and hold harmless RCMHP from loss, costs, or expenses caused by the negligent or wrongful acts or omissions of IEHP officers, agents, and employees occurring in the performance of this MOU.

8.01. RCMHP agrees to hold harmless IEHP Members and the California Department of Health Care Services for financial liability by IEHP for services provided by RCMHP to IEHP Members under the terms of this MOU.

9. **ACCESS TO BOOKS AND RECORDS** - RCMHP and IEHP agree to maintain sufficient records, files and documentation necessary in case of audit by the Department of Managed Health Care (DMHC), DHCS or other regulatory agencies and such records will be available to IEHP in accordance with the Public Records Act unless specified differently within this MOU.

9.01. RCMHP agrees to maintain these records, files and documentation for a period of not less than five (5) years from the close of the fiscal year in which this MOU was in effect.

10. **CONFIDENTIALITY** - RCMHP and IEHP shall observe all federal, state and county requirements, and applicable law concerning the confidentiality of records. RCMHP and IEHP, as required by applicable law, shall strictly maintain confidentiality of medical records of patients.

11. **CONFLICT OF INTEREST** - The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which will conflict in any manner or degree with the performance of services required under this MOU.

12. **NONDISCRIMINATION** - Services and benefits shall be provided by RCMHP and IEHP to individuals without reference otherwise to their religion, color, sex, national origin, age, physical or mental handicaps or condition. RCMHP shall not discriminate in recruiting, hiring, promotion, demotion or termination practices on the basis of race, religious creed, color, national origin, ancestry, physical handicap, medical condition, marital status or sex in the performance of this MOU, and, to the extent they shall be found to be applicable hereto, shall comply with the provisions of the California Fair Employment Practices Act (commencing with Section 1410 of the Labor Code), and Federal Civil Rights Act of 1962 (P.L. 88-352).

13. **ENTIRE AGREEMENT** - This MOU constitutes the entire MOU between the parties hereto with respect to the subject matter hereof and all prior or contemporaneous MOUs of any kind or nature relating to the same shall be deemed to be merged herein. Any modifications to the terms of this MOU must be in writing and signed by the parties herein.

14. **NOTICES** - Unless expressly provided otherwise, all Notices herein provided to be given, or which may be given, by any party to the other, will be deemed to have been fully given when written and personally delivered or deposited in the United States mail, certified and postage prepaid and addressed as follows:

To IEHP:	**To RCMHP**:
Inland Empire Health Plan	Riverside County Department of Mental Health
303 East Vanderbilt Way	P.O. Box 7549
San Bernardino, CA 92408	Riverside, CA 92513-7549
(909) 890-2000	(909) 358-4501
Attn: Bradley P. Gilbert, MD	Attn: Jerry A. Wengerd
Chief Executive Officer	Director

15. **ASSIGNMENT** - This MOU and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by RCMHP or IEHP, and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the written consent of the other party, as approved by the IEHP Governing Board. Any assignment or delegation of this MOU by RCMHP to a third party shall be void unless prior written approval is obtained from IEHP and approved by the DHCS and DMHC.

16. **INVALIDITY OF SECTIONS OF MOU** - The unenforceability or invalidity of any Section or provision of this MOU shall not affect the enforceability and validity of the balance of this MOU.

17. **GOVERNING LAW** - IEHP, RCMHP and this MOU are subject to the laws of the State of California and the United States of America, including but not limited to: the California

Knox-Keene Act and the regulations promulgated thereunder by the DMHC, the Health Maintenance Organization Act of 1973 and the regulations promulgated thereunder by the United States Department of Health and Human Services, and the Waxman-Duffy Prepaid Health Plan Act and the regulations promulgated by DHCS.

17.01. The provisions of the Government Claims Act (Government Code Section 900, et seq.) must be followed for any disputes under this MOU and shall become applicable after the procedure in Paragraph 7 ("RESOLUTION OF DISPUTES") has been completed.

17.02. All actions and proceedings arising in connection with this MOU shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the counties of San Bernardino or Riverside, State of California.

17.03. IEHP is subject to the requirements of Chapter 2.2, Division 2, and Subchapter 5.5, Chapter 3, of Title 10 of the California Code of Regulations and any provision required to be in the MOU by either of these requirements shall bind the IEHP whether or not provided in the MOU.

18. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP and RCMHP are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August 21, 1996, and the laws and regulations promulgated subsequent hereto. IEHP and RCMHP agree to cooperate in accordance with the terms and intent of this MOU for implementation of relevant laws(s) and/or regulation(s) promulgated under this Law.

19. POLICY AND PROCEDURE MANUAL – On an annual basis, IEHP shall develop the Policy and Procedure Manual, which sets forth IEHP's administrative requirements, and make this available on the IEHP website for RCMHP's reference.

IN WITNESS WHEREOF, the parties hereto have executed this MOU in Riverside, California.

RIVERSIDE COUNTY

By: ______________________

John F. Tavaglione, Chairman

Riverside County Board of Supervisors

Date: ______________________

By: ______________________

Kecia Harper-Ihem, Clerk of the Board

Date: ______________________

INLAND EMPIRE HEALTH PLAN

By: ______________________

Bradley P. Gilbert, MD

Chief Executive Officer

Date: 12/8/11

By: ______________________

Chair, IEHP Governing Board

Date: 12-12-11

Attest: ______________________

Secretary, IEHP Governing Board

Date: 12-12-11

Approved as to Form and Consent:

By: ______________________

Jinny R. Yang

Staff Counsel for the Inland Empire Health Plan

Date: 12/12/11

ACTIVITIES DESCRIPTION GRID
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	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
1. Care Manager Liaison	RCMHP will provide workspace, equipment and technical assistance to support IEHP care manager liaison in the execution of his/her responsibilities. RCMHP will assign a management level staff member to serve as the primary onsite supervisor responsible for: a. Evaluating and approving candidates presented by IEHP to serve as the onsite liaison at RCMHP. b. Overseeing and providing support for the day-to-day activities of the IEHP care manager liaison; c. Collaborating with IEHP designated supervisor relative to evaluation of the care manager liaison's performance; d. Providing orientation training to IEHP care manager liaison as it relates to RCMHP; and e. Representing RCMHP's interest in the interpretation of RCMHP and IEHP policies, procedures and referral processes as they apply to IEHP Members who may also meet RCMHP eligibility criteria.	IEHP will present liaison candidates to RCMHP for approval. In collaboration with RCMHP, IEHP will assign a care manager liaison for onsite location at RCMHP to: a. Serve to represent IEHP's interest in the interpretation of RCMHP and IEHP policies, procedures and referral processes as they apply to IEHP Members who may also meet RCMHP's eligibility criteria; b. Provide coordination of care for IEHP Members eligible for RCMHP and other related community resources; c. Serve as a resource person and trainer to Members, RCMHP and IEHP staff, other community agencies and health care providers; d. Arrange case conferences in response to service and benefit questions arising out of either agency; e. Assist with the collection analysis of data and preparing case management reports; f. Assist with tracking continuity of care for identified IEHP/RCMHP Members; and g. Participate in both RCMHP and IEHP staff meetings, and in external meetings with other health service providers as assigned. IEHP will assign its Clinical Director of Behavioral Health to serve as IEHP's primary supervisor for all performance of the care manager liaison.
2. IEHP Secure Website for Coordination of Care	Through the IEHP Secure Website, RCMHP shall have secure access to Electronic Health Histories and may use Coordination of Care Web Forms (Exhibit II) to coordinate care and share pertinent prescription, lab and clinical data with other authorized providers with client consent	IEHP will maintain a secure website as a means for Providers to coordinate care. IEHP will provide RCMHP clinic sites, clinicians and administrative support staff with secure access and training on accessing Electronic Health Histories through the IEHP Secure Website, and offer the use of Coordination of Care Web Forms (Exhibit II) to share pertinent prescription, lab and clinical data with other authorized providers.
3. Services Provided	The scope of services provided by RCMHP under the terms of this agreement shall equal the services identified as Mental Health (MHP) responsibilities in MMCD Policy Letter No. 00-01 REV (Attached as Exhibit I). RCMHP will authorize outpatient and inpatient specialty mental health services to Medi-Cal beneficiaries enrolled in	IEHP will provide Medi-Cal beneficiaries outpatient mental health services within the scope of primary care, as provided by IEHP's contract with the State Department of Health Care Services (DHCS) and further defined in MMCD Policy Letter No. 00-01 REV (Attached as Exhibit I). Access to physical health care services and outpatient primary care

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
	IEHP pursuant to this agreement and to State and Federal regulations. Services will be provided with or without referral by IEHP. RCMHP will be responsible to provide emergency mental health services 24-hours a day, 7-days a week and non-emergency specialty mental health services during regular business hours, meeting the criteria outlined in State regulations (California Code of Regulations, Title 9, Chapter II, Article 2, Section 1820.205, 1830.205, 1830.210), as applicable. A Member may receive specialty mental health services for an included diagnosis when an excluded diagnosis is also present, as defined by State law and regulations. EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to, the attainment of the specialty mental health treatment goals.	mental health services will be made available 24-hours a day, 7-days a week. IEHP and RCMHP recognize that a Primary Care Physician's (PCP) ability to treat mental disorders may vary according to each provider's training and scope of practice. When possible, within the scope of primary care, and in the interest of providing comprehensive health care services, IEHP physicians will address the following conditions as they arise in the course of treatment of physical illness: 1. Psychological factors affecting a physical condition/illness; 2. Psychological symptoms precipitated by physical conditions/illnesses; and 3. Psychological conditions precipitated by non-physical conditions. As appropriate, IEHP and the provider will work with RCMHP to assure Members receive appropriate referrals for excluded diagnoses.
4. Diagnostic Evaluation and Triage	RCMHP will provide evaluation, triage and when authorized, specialty mental health services to IEHP Members whose psychological conditions would not be responsive to mental health or physical health care by the PCP. RCMHP's Access Unit (CARES) will evaluate a Member's symptoms, level of impairment and focus of intervention to determine if a Member meets medical necessity criteria for specialty mental health services. When medical necessity criteria are met, RCMHP authorizes services and provides Member with a choice of providers. When medical necessity criteria are not met, CARES staff will refer Member back to the referring PCP, notify IEHP case management, and/or refer to community service as appropriate.	IEHP and/or one of its delegated entities will arrange and pay for appropriate medical assessments of Members to identify co-morbid physical and mental health conditions. The PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the Member for specialty physical health care for such treatment.

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
	Individual mental health providers may arrange for records transfer by direct communication with the referring physician or may request records through IEHP case management.	
5. Referrals (Referral algorithm attached as Attachment B)	RCMHP will accept Medi-Cal referrals from IEHP staff, providers and IEHP Members (self-referral) for determination of medical necessity and provide appropriate mental health specialty evaluation services. When all medical necessity criteria are met, RCMHP Access Unit (CARES) will arrange for the provisions of specialty mental health services by a RCMHP provider. With Member consent, RCMHP will notify a Member's PCP, when requests for mental health services are received for the Member through self-referral or through any other outside agency (including schools, court of law, correctional facilities, etc.) With a Member's written consent or as otherwise permitted by State and Federal law, the identification of a patient/IEHP Member as well as clinical and other pertinent information will be shared between RCMHP and IEHP providers to ensure coordination of care. RCMHP may utilize the Coordination of Care Web Forms (Exhibit II) for this purpose. When RCMHP medical necessity criteria are not met, RCMHP will refer Members back to the Member's referring physician or will refer the Member to a community service. When requested by the Member, provider, IEHP or PCP, evaluation results, diagnosis, need for services, and recommendations to treat the Member's symptoms will be forwarded to the PCP (as signed release of information or other laws allow). When a mental health provider determines a Member's mental illness would be responsive to physical health care he/she may make a direct referral by contacting the primary care physician identified on the Member's health Plan card. He/she may use the IEHP Mental Health Coordination of Care Web Forms (Exhibit II) to arrange for a referral through IEHP case management.	Following a PCP's diagnostic evaluation, IEHP, and/or the PCP will refer to RCMHP a Member whose psychological condition would not be responsive to physical health care or primary care mental health services or when unable to determine if the condition is an included diagnosis and would not be responsive to primary care. When RCMHP informs the IEHP provider that a Member does not meet RCMHP medical necessity criteria the IEHP provider will work with RCMHP Access Unit staff to develop a referral to community resources when services are outside the PCP's scope of practice. If a Member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the Member to an appropriate Medi-Cal FFS mental health provider, if known to the Plan, or to a resource in the community that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, or other appropriate local provider or provider organization. IEHP will provide RCMHP clinic sites, clinicians and administrative support staff with secure access and training on the IEHP Secure Website, and offer the use of Coordination of Care Web Forms (Exhibit II) to share pertinent clinical data with other authorized providers.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
6. Service Authorizations	RCMHP will authorize evaluation and/or treatment services by mental health specialists, who are employed by, credentialed by and/or contracted with RCMHP, for services that meet medical necessity criteria. This will be done through the RCMHP Access Unit (CARES). RCMHP will not authorize services for which IEHP is responsible. IEHP case management staff will be available to assist network IPAs and RCMHP in coordinating care, including service authorizations.	IEHP and/or one of its delegated entities will authorize medical assessment and/or treatment services by providers who are credentialed by IEHP and contracted with an IEHP IPA. IEHP and/or one of its delegated IPAs will authorize all inpatient and outpatient medical assessment, consultation, and/or treatment services required for IEHP Members, and coordinate with RCMHP for those Members receiving care from RCMHP. IEHP will not authorize services for which RCMHP is responsible. IEHP case management staff will be available to assist network IPAs and RCMHP in coordinating care and obtaining appropriate service authorizations.
7. EPSDT Supplemental Services	RCMHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child (under the age of 21) is eligible for EPSDT supplemental services. If these criteria are met, RCMHP is responsible for arranging EPSDT supplemental services provided by specialty mental health professionals. RCMHP is responsible for paying for EPSDT supplemental services which are part of the Member's specialty mental health treatment. For a description of EPSDT Supplemental Services, see Exhibit III, "MMCD Letter No. 96-074" and Exhibit IV, "Title 22, CCR Sections 51184, 51242, 51304, 51340, 51340.1, and 51532."	When RCMHP determines that EPSDT supplemental services criteria are not met. IEHP may refer the child to the PCP for treatment of conditions within the PCP's scope of practice. Referrals to RCMHP will be made for treatment of conditions outside the PCP's scope of practice. IEHP case management assists RCMHP and Members by providing links to known community providers of supplemental services (e.g., support groups).
8. Psychotropic Medications and Formulary	RCMHP will provide a monthly updated list of specialty mental health physicians who will be prescribing medications to IEHP Members. The list is forwarded to IEHP's Director of Health Administration or Clinical Director of Behavioral Health. RCMHP may utilize the Coordination of Care Web Forms (Exhibit II) to notify IEHP PCPs of the medications prescribed for Members. RCMHP will also have access to the prescription history, labs and other clinical information available through the IEHP Secure Website. RCMHP providers will prescribe, as medically appropriate,	Prior authorization for prescribed formulary medication is provided as part of the online adjudication process used by IEHP pharmacies. Prior authorization exceptions will be reconciled by the individual pharmacy working with the IEHP pharmacy department and the RCMHP provider. When an IEHP provider is managing a Member's mental health condition, said providers will monitor the effects and side effects of psychotropic medications. Notice of actions, denials or deferrals shall be forwarded to the Supervisor of the RCMHP Access Unit.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	psychotropic medications for IEHP Members under treatment, and monitor the effects and side effects of such medications. IEHP Members may use any Medi-Cal pharmacy to access carved-out psychotropic medications. IEHP network pharmacies get an automatic online message to bill Medi-Cal Fee-For-Service (FFS) when claims are entered for these medications. IEHP Members are instructed to use contracted pharmacies to access all prescribed medications. (The list of carved-out psychotropic medications is attached as Exhibit I, Enclosure 2.)	IEHP provides Members with a Provider Directory, which lists contracted pharmacies. This Directory is updated bi-annually. Members are also encouraged to call the IEHP Member Services Department for the most recent changes to IEHP's contracted pharmacy network. IEHP will pay for psychotropic medications prescribed by RCMHP and IEHP providers and not included in the carved-out Psychotropic Formulary. IEHP providers will prescribe medically necessary medications for the treatment of physical conditions and mental health conditions treated through primary care and IEHP will pay for these medications. IEHP will provide RCMHP clinic sites, clinicians and administrative support staff with secure access and training on accessing prescription history through the IEHP Secure Website, and offer the use of Coordination of Care Web Forms (Exhibit II) for coordination of prescription medications with the Member's PCP.
9. Laboratory Services, Radiological and Radioisotope Services	RCMHP providers may use an RCMHP contracted laboratory or may contract individually with a licensed laboratory. IEHP will provide access to laboratory services in accordance with mutually accepted protocols and medical necessity standards. Protocols will reflect IEHP's responsibility for payment of laboratory services that are necessary for the diagnosis and treatment of the IEHP Member's mental health/substance abuse conditions, and for laboratory services that are needed to monitor the health of Members for side effects resulting from medications prescribed to treat a mental health diagnosis. RCMHP providers will be informed of the process for submitting claims. This information will be disseminated to RCMHP providers primarily through provision of a Provider Manual and through provider meetings conducted by	IEHP will pay for medically necessary laboratory, radiological, and radioisotope services required for the diagnosis, treatment, or evaluation of a Member's mental health/substance abuse condition, in accordance with Title 22, CCR, Section 51311. Laboratory services covered by IEHP include services needed to diagnose and treat mental health/substance abuse conditions; and to monitor the health of Members for side effects resulting from medications prescribed to treat a mental health diagnosis. The IEHP case management/mental health specialist will work directly with RCMHP providers, the PCP and RCMHP Central Access Unit to coordinate these services. IEHP will provide RCMHP clinic sites, clinicians and administrative support staff with secure access and training on accessing lab results through the IEHP Secure Website, and offer the use of Coordination of Care Web Forms (Exhibit II) for coordination of lab findings with

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
	RCMHP staff. Secondarily, targeted outreach will be extended to interested providers in the form of written communication and/or office visits to present a review of the authorization and claims process. RCMHP is not responsible for the costs of medically necessary radiologic and/or radioisotope services, treatment, or evaluation of a Member's mental health condition.	the Member's PCP.
10. Emergency Room Services – In and Out of Area	RCMHP is responsible for in and out of area facility charges resulting from the emergency services and care of a Plan Member whose condition meets MHP medical necessity criteria when such service and care do result in the admission of the Member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay. RCMHP is responsible for in and out of area facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the Member for psychiatric inpatient hospital services at that facility or any other facility. RCMHP shall cover and pay for all in and out of area professional services provided by a mental health specialist in an emergency room to a Plan Member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met. Out of area emergency mental health services shall be provided by RCMHP in accordance with Title 9, CCR, Sections 1830.220.	IEHP and/or its delegate shall cover and pay for in and out of area facility charges resulting from the emergency services and care of a Plan Member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the Member for psychiatric inpatient hospital services or when such services result in an admission of the Member for psychiatric inpatient hospital services at a different facility. IEHP and/or its delegate shall cover and pay for all in and out of area professional services except the professional services of a mental health specialist, when required for the emergency services and care of a Member whose condition meets MHP medical necessity criteria. Payment responsibility for charges resulting from the emergency services and care of a Plan Member with an excluded diagnosis or for a Plan Member whose condition does not meet MHP medical necessity criteria will be assigned as follows: IEHP and/or its delegate shall cover and pay for in and out of area facility charges and the medical professional services required for the emergency services and care of a Plan Member with an excluded diagnosis or a Plan Member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the Member for psychiatric inpatient hospital services.
* Note	Payment for the professional services of mental health specialist required for the emergency service and care of a Plan Member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.	Payment for the professional services of a mental health specialist required for the emergency service and care of a Plan Member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.
11. Psychiatric Nursing Facility Services	RCMHP will authorize and provide all medically necessary specialty mental health services for IEHP Members required	IEHP will be responsible for all medically necessary non-specialty professional and medical services not included under the IMD daily

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	in psychiatric Nursing Facility settings, which are also institutions for mental disease (IMD).	rate in psychiatric Nursing Facility setting. IEHP responsibility for long term care is limited to the month of admission plus the following month, provided disenrollment to Medi-Cal FFS is approved by DHCS (see Exhibit I, page 16, MMCD Policy Letter No. 00-01 REV).
12. Medical Transportation (Note: Medical Transportation Services are defined in Title 22, CCR, Section 51151.)	RCMHP must arrange and pay for medical transportation when the MHP's purpose for the medical transportation service is to transport a Plan Member receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to RCMHP.	IEHP will be responsible for the emergency and non-emergency ambulance, litter van, and wheelchair van medical transportation services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Section 51323, which are necessary to provide IEHP Members with access to Medi-Cal covered services including mental health services. IEHP will be responsible for emergency medical transportation services to the nearest facility capable of meeting the needs of the patient. IEHP will be responsible for medically necessary transfers between inpatient hospital services and psychiatric inpatient hospital services to address Plan Member mental health condition. IEHP will not be responsible for medical transportation services when the transportation is required to transfer a Member from one psychiatric inpatient hospital to another psychiatric inpatient hospital, or to another type of 24-hour care facility, when such transfers are not medically indicated (i.e., undertaken with the purpose of reducing RCMHP's cost of providing service).
13. Home Health Agency Services	If RCMHP determines an IEHP Member requires medically necessary specialty mental health services as part of home health care, RCMHP will authorize and arrange for these services. Authorized home mental health services shall be arranged by the RCMHP Access Unit in coordination with IEHP case management.	A homebound Plan Member is one who is essentially confined to home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for period for relatively short durations (Title 22, CCR, Section 51146). IEHP or its delegate will cover and pay for home health agency services as described in Title 22, CCR, Section 51337 prescribed by an IEHP Plan provider when medically necessary to meet the needs of homebound Plan Members. IEHP is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program or when specialty mental health services as

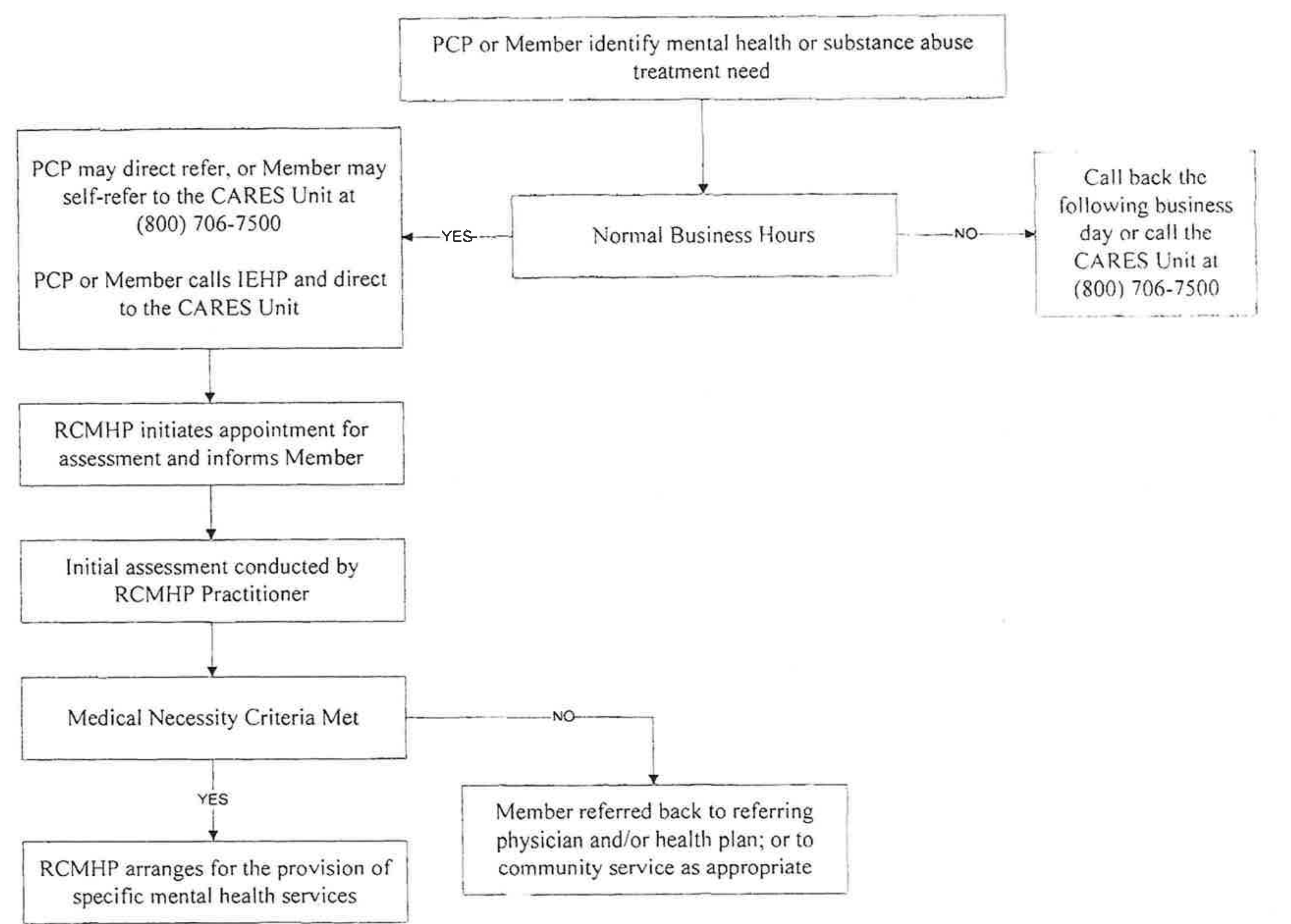
	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
		provided under Section 1810.247 are prescribed by a psychiatrist and provided at the home of the beneficiary. Home health agency services prescribed by IEHP providers to treat the mental health conditions of IEHP Members are the responsibility of IEHP.
14. Services for Developmentally Disabled Members	RCMHP will refer Members with developmental disabilities to Regional Centers for services such as respite care, out-of-home placement, supportive living services, etc. if such services are needed. When appropriate, RCMHP will inform IEHP, its delegated entity, and the PCP of such referrals.	IEHP PCPs will refer Members with developmental disabilities to Regional Centers for non-medical services such as respite care, out-of-home placement, supportive living services, etc. if such services are needed.
15. Covered Physical Health Care Services and Specialty Mental Health Services (Inpatient)	RCMHP is responsible for all hospital-based ancillary services, including all prescriptions included in the daily rate for these facilities. Note: Physical health care for the purpose of this section is defined in MMCD Policy Letter No. 00-01 REV, page 7 & 8, attached as Exhibit I.	IEHP will provide all medically necessary professional services to meet the physical health care needs of IEHP Members admitted to a general acute care hospital psychiatric ward or to a freestanding licensed psychiatric inpatient hospital. The initial health history and physical assessment will be performed and dictated within 24 hours of admission to the psychiatric unit. Plan responsibilities are further described in MMCD Policy Letter No. 00-01 REV, pages 7, 8 23, and 24 (Exhibit I).
16. Financial Considerations	RCMHP will not be reimbursed by IEHP for specialty mental health services rendered to IEHP Members.	Services and prescription medications that are the responsibility of IEHP (as specified in this Agreement) will be paid by IEHP, except for those medications carved-out by DHCS. See Exhibit I, Enclosure 2 for a list of carved-out medications.
17. Specialty Mental Health Service Providers	RCMHP will directly employ or contract with credentialed specialty mental health professionals who have sufficient capacity and willingness to serve IEHP Members who meet medical necessity criteria and are referred by the RCMHP Access Unit. Specialty Mental Health Service Providers are further defined in MMCD Policy Letter No. 00-01 REV, page 18, attached as Exhibit I.	IEHP will inform IEHP Members of their mental health benefits and the manner in which services are accessed. See MMCD Policy No. 00-01, Rev, page 17, 18 and 19, attached as Exhibit I.
18. Confidentiality of Medical Records Information	RCMHP will maintain confidentiality of medical records in accordance with all applicable federal and state laws and regulation and contract requirements. RCMHP providers will obtain written authorization from patients and/or the patient's conservator, where a conservator	IEHP will maintain confidentiality of medical records in accordance with all applicable federal and state laws and regulation and contract requirements. IEHP providers will obtain written authorization from patients and/or the patient's conservator, where a conservator of the person

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
	of the person has been appointed, to be referred to IEHP, for release of relevant records and related case discussions regarding the Member's mental health condition and any current medications prescribed by RCMHP provider. RCMHP may make available to IEHP non-identifying patient information and quarterly or annual aggregate reports for purposes of review, evaluation and accountability.	has been appointed, to be referred to RCMHP, for release of relevant records and related case discussions regarding medical conditions and any current medications prescribed by IEHP providers. IEHP may make available to RCMHP non-identifying patient information and quarterly or annual aggregate reports for purposes of review, evaluation and accountability. IEHP and RCMHP will cooperate to develop specific protocols dealing with the sharing of information regarding substance abuse and HIV status.
19. Clinical Consultation and Training	The RCMHP will include consultation on medications to IEHP Members whose mental illness is being treated by RCMHP. Clinical consultation between the RCMHP and IEHP will include consultation on a beneficiary's physical health condition.	IEHP will provide clinical consultation and training to the RCMHP or other providers on physical health care conditions and on medications prescribed through IEHP providers, when requested by RCMHP. IEHP will provide clinical consultation to the RCMHP or other providers of mental health services on a Member's physical health condition. Such consultation will include consultation by IEHP to the RCMHP on medications prescribed by IEHP for a Plan Member whose mental illness is being treated by the RCMHP.
20. Provider Training	RCMHP conducts annual provider meetings. During these meetings multiple topics are covered, including coordination of care issues for Medi-Cal Managed Care patients. RCMHP regularly supplements the annual meetings with targeted written communication to providers as needed. RCMHP will assist IEHP in training IEHP providers about mental health specialty services provided through RCMHP and the coordination of care. RCMHP will assist in mental health training for IEHP PCPs.	IEHP will train their providers on mental health specialty services provided through RCMHP and on coordinating care with RCMHP. Coordination of Care is covered during the annual "IEHP University" provider training. Annual training is supplemented by quarterly provider newsletters and quarterly continuing education classes (CEU) which selectively include mental health topics. IEHP will assist RCMHP in training RCMHP providers and coordinating care with IEHP.
21. Quality Assurance/ Quality Improvement (Including Grievances and Complaints)	Conforming to the standards of Federal, State, and County guidelines on Quality Assurance, RCMHP will operate a Quality Assurance/Quality Improvement program, which includes the interface with IEHP and the coordination of care with their providers. Member and provider complaint and	IEHP will operate a Quality Assurance/Quality Improvement program, which includes the interface with RCMHP and the coordination of care with its providers. Member and provider grievance and complaint processes will be part of the Quality Assurance/Quality Improvement program. For a brief description of

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
	grievance process will be part of the Quality Assurance/ Quality Improvement program. Access to services will be included as part of the Quality Assurance/Quality Improvement Program. RCMHP will involve IEHP in relevant aspects of its Quality Assurance/Quality Improvement program. Grievances involving carved-out mental health services will be processed internally by RCMHP. RCMHP will involve IEHP in relevant aspects of its Quality Assurance/Quality Improvement program, including grievance and complaint resolution, whenever there appear to be overlapping issues. For a description of RCMHP Grievance Policy see Exhibit V, "RCMHP's Grievance Policy."	the grievance process, see Exhibit VI, "IEHP's Grievance Resolution Process." IEHP will involve RCMHP in relevant aspects of its Quality Assurance/Quality Improvement program.
22. Organizational Dispute Resolution	RCMHP will coordinate with IEHP on dispute resolutions and agrees to participate in a dispute resolution process in accordance to Title 9, CCR, Section 1850.505 to include: **First Level Review** • The process will be initiated within 45 calendar days from the disputed event. • RCMHP will appoint a representative to attempt to reach and implement resolution decisions. • The representative of RCMHP will arrive at a proposed resolution jointly with the IEHP representative within 10 business days of initiation • If the representatives of RCMHP and IEHP are unable to reach a joint decision or if the proposed resolution is not acceptable to both Plans, a second level review may be initiated by either Plan. **Second Level Review** • The second level review must be initiated within 10 business days of the first level decision. • RCMHP will use its Director or Director's designee as a second level reviewer.	IEHP will coordinate with RCMHP on dispute resolutions and agrees to participate in a dispute resolution process in accordance to Title 9, CCR, Section 1850.505 to include: **First Level Review** • The process will be initiated within 45 calendar days from the disputed event. • IEHP will appoint a representative to attempt to reach and implement resolution decisions. • The representative of IEHP will arrive at a proposed resolution jointly with the RCMHP representative within 10 business days of initiation. • If the representatives of IEHP and RCMHP are unable to reach a joint decision or if the decision is not acceptable to both Plans, a second level review may be initiated by either Plan. **Second Level Review** • The second level review must be initiated within 10 business days of the first level decision. • IEHP will use its CEO or CEO's designee as a second level reviewer.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	• The second level reviewer will attempt to reach a joint resolution with IEHP within 10 business days of initiation. • If the second level reviewers cannot reach a joint decision or if the decision is not acceptable to both Plans, a third party review may be initiated by either Plan. **Third Party Review** If the local dispute resolution process is not able to resolve the dispute, either Plan may request dispute resolution by forwarding to the Department of Health Care Services. RCMHP agrees to provide specialty mental health services to the beneficiary during the dispute resolution process in accordance with current regulations.	• The second level reviewer will attempt to reach a joint resolution with RCMHP within 10 business days of initiation. • If the second level reviewers cannot reach a joint decision or if the decision is not acceptable to both Plans, a third party review may be initiated by either Plan. **Third Party Review** If the local dispute resolution process is not able to resolve the dispute, either Plan may request dispute resolution by forwarding to the Department of Health Care Services. IEHP agrees to provide medically necessary services to the beneficiary during the dispute resolution process in accordance with current regulations.

REFERRAL ALGORITHM



STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

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March 16, 2000 REV.

MMCD Policy Letter No. 00-01 REV.

TO: (X) Prepaid Health Plans
(X) County Organized Health System Plans
(X) Primary Care Case Management Plans
(X) Two-Plan Model Plans
(X) Geographic Managed Care Plans

SUBJECT: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES UNDER THE MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION PROGRAM

PURPOSE

The purpose of this letter is to explain the contractual responsibilities of Medi-Cal managed care plans (Plan) in providing medically necessary Medi-Cal covered physical health care services to Plan members who may require specialty mental health services through the Medi-Cal Specialty Mental Health Services Consolidation program described in Medi-Cal regulations.

GOALS

The goals of this letter are:

- To provide Plans with information regarding the delivery of specialty mental health services to beneficiaries, including those enrolled in a Plan, under the Medi-Cal Specialty Mental Health Services Consolidation program through local mental health plans (MHP).
- To clarify the responsibility of Plans in developing a written agreement addressing the issues of interface with the MHP, including protocols for coordinating the care of Plan members served by both parties and a mutually satisfactory process for resolving disputes, to ensure the coordination of medically necessary Medi-Cal covered physical and mental health care services.

- To clarify the responsibilities of Plans in delivering medically necessary contractually required Medi-Cal covered physical health care services to Plan members who may require specialty mental health services through the Medi-Cal Specialty Mental Health Services Consolidation program.

BACKGROUND

In Fiscal Year 1991-92, legislation was enacted that allowed the Department of Health Services (DHS), as the single state agency with the authority to administer the Medicaid program in California, to establish new managed care programs for the delivery of Medi-Cal services to beneficiaries.

Subsequent legislation required DHS, in consultation with DMH, to ensure that all systems for Medi-Cal managed care include a process for screening, referral, and coordination with medically necessary mental health services. The statute designated DMH as the state agency responsible for the development and implementation of a plan to provide local mental health managed care for Medi-Cal beneficiaries; and further required DMH to implement managed mental health care through fee-for-service (FFS) or capitated rate contracts negotiated with MHPs. A MHP could include a county, counties acting jointly, any qualified individual or organization, or a non-governmental agency contracting with DMH and sharing in the financial risk of providing mental health services; however, counties were given the right of first refusal for MHP contracts.

DMH, with input from a broad range of stakeholders, developed a plan for the provision of Medi-Cal managed mental health care at the local level that consolidated two separate systems of mental health care service delivery; the Medi-Cal FFS system, which allowed clients a free choice of providers, and the Short-Doyle/Medi-Cal system administered through the county mental health departments. By consolidating the two systems of care and their separate funding streams, it was felt that the Medi-Cal program would both improve care coordination and reduce administrative costs.

DMH implemented the first phase of managed mental health care, the consolidation of Medi-Cal inpatient mental health services at the county level, in January 1995.

Because it restricted Medi-Cal beneficiaries' choice of providers to the MHP in their county of residence and its network of contract providers, the new mental health program required a waiver from the federal Health Care Financing Administration

(HCFA) of provisions of the Social Security Act that otherwise guarantee beneficiaries a choice of providers.

In September 1997, HCFA approved California's request to expand Medi-Cal managed mental health care to include outpatient specialty mental health services and renewed the waiver for an additional two years. DMH implemented the second phase of Medi-Cal managed mental health care, the consolidation of psychiatric inpatient hospital services and outpatient specialty mental health and certain other services, in November 1997. A request to renew the waiver for an additional two years was submitted to HCFA by DMH in June 1999.

This comprehensive program of Medi-Cal funded mental health managed care services, which is administered by DMH through an interagency agreement with DHS, is now known as the Medi-Cal Specialty Mental Health Services Consolidation program.

Currently, the county mental health department is the MHP in all 58 counties of California, although a few Plans have elected to cover some, but not all Medi-Cal covered specialty mental health services. Two MHPs, Sutter-Yuba and Placer-Sierra, cover a bi-county area. The MHP selects and credentials its provider network, negotiates rates, authorizes specialty mental health services, and provides payment for services rendered by specialty mental health providers in accordance with statewide criteria.

Under the Medi-Cal Specialty Mental Health Services Consolidation program, MHPs are financed through a combination of state, federal and local funds. ~~**However, only funding for specified outpatient specialty mental health services and inpatient psychiatric services is provided to MHPs.**~~ MHPs receive no specific Medi-Cal funding for physical health services or any mental health services not specifically covered by the Consolidation program.

Unless otherwise excluded by contract, Plans are capitated for physical health care services, including but not limited to, those services described on pages 7 through 15 and mental health services that are within the primary care physician's scope of practice. Consistent with Plan contracts, some Plans may also receive capitation for specific mental health services such as psychologist and psychiatrist professional services, psychiatric inpatient hospital services, and long-term care services including nursing facility services for Plan members whose need for such services is based on mental illness.

As the state agency responsible for the development and implementation of local Medi-Cal managed mental health care, the California Department of Mental Health (DMH) has adopted emergency regulations entitled, "Medi-Cal Specialty Mental Health Services." These regulations are at Title 9, Division 1, Chapter 11, California Code of Regulations (CCR). Chapter 11 incorporates existing rules governing the provision of Medi-Cal inpatient psychiatric services by MHPs and adds new standards for additional services. Chapter 11 also makes specific program requirements for provision of Medi-Cal outpatient specialty mental health services by MHPs.

Field Tests

Specialty mental health services are provided to Medi-Cal beneficiaries in two counties, San Mateo and Solano, through local MHPs operated by the county mental health departments under separate field test authority from HCFA.

San Mateo County is field testing the acceptance of additional financial risk of federal reimbursement based on all-inclusive case rates for Medi-Cal inpatient hospital and outpatient services. Additionally, the MHP in San Mateo County is responsible for pharmacy and related laboratory services prescribed by psychiatrists.

Solano County is field testing various managed care concepts as a subcontractor on a capitated basis to the County Organized Health System, while also providing Short-Doyle/Medi-Cal services to beneficiaries under the regular, non-waivered Medi-Cal program.

POLICY

Consistent with contract requirements, each Plan is required to enter into a memorandum of understanding (MOU) with the MHP in each county covered by the contract. Each Plan is contractually responsible for the arrangement and payment of all medically necessary Medi-Cal covered physical health care services not otherwise excluded to Medi-Cal members who require specialty mental health services.

Memorandum of Understanding Between the Plan and the MHP

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal covered services to beneficiaries who are served by both parties is a shared Plan/MHP responsibility. Pursuant to contract requirements regarding local MHP coordination, Plans are required execute an MOU with the local MHP in each

county covered by the contract. Title 9, CCR, Section 1810.370, requires the MHP to execute an MOU with the Plan in each county served by the MHP.

The MOU is required to specify, consistent with contract requirements, the respective responsibilities of the Plan and the MHP in delivering medically necessary Medi-Cal covered physical health care services and specialty mental health services to beneficiaries. It is essential that circumstances that present a potential for unique operational difficulties be clearly addressed as components of the MOU.

It is suggested that Plans include a matrix of Plan/MHP responsibilities similar to the sample shown on Enclosure 3.

At a minimum, the MOU must address the following:

1. Referral protocols between plans, which must include:

    - How the Plan will provide a referral to the MHP when the Plan determines specialty mental health services covered by the MHP may be required;

    - How the MHP will provide a referral to a provider or provider organization outside the MHP, including the Plan, when the MHP determines that the beneficiary's mental illness does not meet the medical necessity criteria for coverage by the MHP or would be responsive to physical health care based treatment.

    - The availability of clinical consultation between a Plan and the MHP, which must include the availability of clinical consultation on a beneficiary's physical health condition. Such consultation must also include consultation by the Plan to the MHP on medications prescribed by the Plan for a Plan member whose mental illness is being treated by the MHP; and consultation by the MHP to the Plan on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the Plan.

2. Procedures for the delivery of contractually required Medi-Cal covered inpatient and outpatient specialty mental health services through the MHP including but not limited to:

- The responsibility of the MHP relating to the prescription by MHP providers of mental heath drugs and related laboratory services that are the contractual obligation of the Plan to cover and reimburse.
- The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Plan.
- Emergency room facility and related charges.
- Medical transportation services when the purpose of such transportation is to reduce the cost of psychiatric inpatient hospital services to the MHP.
- Specialty mental health services prescribed by a psychiatrist and delivered at the home of a beneficiary.
- Direct transfers between psychiatric inpatient hospital services and inpatient hospital services to address changes in a beneficiary's medical condition.

3. Procedures for the delivery by the Plan of Medi-Cal covered physical health care services that the Plan is contractually obligated to cover and are necessary for the treatment of mental health diagnoses covered by the MHP.

   These procedures must address, but are not limited to, provision of the following:

   - Outpatient mental health services within the primary care physician's scope of practice.
   - Covered ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.
   - Prescription drugs and laboratory services.
   - The Plan's obligation to provide the procedures for obtaining timely authorization and delivery of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP.
   - Emergency room facility and related services.

- Emergency and non-emergency medical transportation.
- Home health agency services.
- Long-term care services (to the extent that these services are included by Plan contract).
- Direct transfers between inpatient hospital services and psychiatric inpatient hospital services to address changes in a Plan member's mental health condition.

4. The appropriate management of Plan member care, including procedures for the exchange of medical records information, which maintain confidentiality in accordance with applicable state and federal laws and regulations.

5. A mutually satisfactory process for resolving disputes between the Plan and the MHP that includes a means for Plan members to receive medically necessary physical and mental health care services, including specialty mental health services and prescription drugs, while a dispute is being resolved.

   To the extent a Plan has not executed an MOU by the date of this letter or submitted an MOU to DHS for review and approval, the Plan must immediately submit documentation substantiating its good faith efforts to enter into an MOU with the MHP or provide justification for the delay in the submission of an MOU to DHS. The Plan shall submit monthly reports to DHS documenting the Plan's continuing good faith efforts to execute an MOU with the MHP, which provides justification for the delay in meeting this requirement. At its discretion, DHS may take steps to mediate closure to an impasse in the efforts of plan parties engaged in the MOU process.

   When enrollment in a Plan in any county is 2,000 beneficiaries or less, DHS may, at the request of the Plan or the MHP, grant a waiver from these requirements, provided that both the Plan and the MHP shall provide assurance that beneficiary care will be coordinated in compliance with Title 9, CCR, Section 1810.415.

Plan Responsibility For Medi-Cal Covered Physical Health Care Services

Medi-Cal covered services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840.

Physical health care and physical health care based treatment ~~as defined by Title 9, CCR, Section 1810.231.1~~ means health care provided by health professionals, including non-physician medical practitioners, whose practice is predominately general medicine, family practice, internal medicine, pediatrics, obstetrics, gynecology, or whose practice is predominately a health care specialty area other than psychiatry or psychology. Physical health care does not include a physician service as described in Title 22, Section 51305, delivered by a psychiatrist, a psychologist service as described in Title 22, Section 51309, or an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental service as described in Title 22, Section 51340 or 51340.1, delivered by a licensed clinical social worker, a marriage, family and child counselor, or a masters level registered nurse for the diagnosis and treatment of mental health conditions of children under age 21.

Each Plan is contractually obligated to cover medical care needed by Medi-Cal members for mental health conditions that are within the primary care physician's scope of practice.

Each Plan is contractually obligated to assist Plan members needing specialty mental health services whose mental health diagnoses are covered by the MHP or whose diagnoses are uncertain, by referring such members to the local MHP. If a member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the member to an appropriate Medi-Cal FFS mental health provider, if known to the Plan, or to a resource in the community that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or other appropriate local provider or provider organization.

A Plan may negotiate with the MHP to provide specialty mental health services to Plan members, or through an arrangement made with the concurrence of the local MHP, DMH, and DHS, elect to include responsibility for some specialty mental health services in its contract with DHS.

Enclosure 1, Medi-Cal Managed Care Plan Specialty Mental Health Coverage Alternatives, outlines the unique arrangements some Plans have with a MHP regarding mental health services. Currently, coverage for specialty mental health services is excluded under most Plan contracts.

Plans are required to provide medical case management and cover and pay for all medically necessary Medi-Cal covered physical health care services not otherwise excluded by contract for a Plan member receiving specialty mental health services

including, but not limited to, the services listed below, and must coordinate these services with the MHP. Protocols for the delivery of these services must be addressed as a component of the MOU consistent with contract requirements. This section shall not be construed to preclude the Plan from requiring that covered services be provided through the Plan's provider network or applying utilization controls to these services, including prior authorization, consistent with the Plan's contractual obligation to provide covered services.

Physician Services

The Plan shall cover and pay for physician services as described in Title 22, Section 51305, except the physician services of mental health specialists, even if the services are provided to treat an included mental health diagnosis. The Plan is not required to cover and pay for physician services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family, and child counselors, or other specialty mental health providers. **When medically necessary, the Plan shall cover and pay for physician services provided by specialists such as neurologists.**

The Plan shall cover and pay for physician services related to the delivery of outpatient mental health services~~,~~ which are within the primary care physician's scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses whose conditions do not meet the MHP medical necessity criteria.

Emergency Services and Care

The assignment of financial responsibility to the Plan or the MHP for charges resulting from ~~**emergency**~~ services to determine whether a psychiatric emergency exists under the conditions provided in Title 9, CCR, Section 1820.225~~**, and the care and treatment necessary to relieve or eliminate the emergent condition**~~ is generally determined by:

- The diagnosis assigned to the emergent condition;
- The type of professional performing the services; and
- Whether such services result in the admission of the Plan member for psychiatric inpatient hospital services **at the same or a different facility**.

It is suggested that the assignment of financial responsibility for emergency room facility charges and professional services be addressed as a component of the MOU.

Emergency Room Facility Charges and Professional Services

Financial responsibility for charges resulting from the emergency services and care of a Plan member whose condition meets the medical necessity criteria for coverage by the MHP is contractually assigned as follows:

- The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services **or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.**

- The MHP ~~shall cover and pay~~ **is responsible** for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services **at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.**

- ~~**The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria at a hospital that does not provide psychiatric inpatient hospital services, when such services and care do result in the transfer and admission of the member to a hospital or psychiatric health facility that does provides psychiatric inpatient hospital services. The Plan is not responsible for the separately billable facility charges related to the professional services of a mental health specialist at the hospital of assessment. The MHP may pay this charge, depending on its arrangement with the hospital.**~~

- **The MHP is responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric inpatient hospital services at that facility or any other facility.**

- ~~**The Plan shall cover and pay for the medical professional services required for the emergency services and care of a member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric Inpatient hospital services.**~~

- The MHP shall cover and pay for the professional services of a mental health specialist ~~**required for the emergency services and care of**~~ **provided in an emergency room to** a Plan member whose condition meets MHP medical necessity criteria **or when mental health specialist services are required to assess whether MHP medical necessity is met** ~~**when such services and care do result in the admission of the member for psychiatric inpatient hospital services.**~~

- **The Plan shall cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets MHP medical necessity criteria.**

Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a plan member whose condition does not meet MHP medical necessity criteria shall be assigned as follows:

- The Plan shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission ~~of the~~ member for psychiatric inpatient hospital services.

- Payment for the professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.

Note: Effective January 1, 2000, SB 349 (Chapter 544, Statutes of 1999), redefines the definition of emergency services and care as it applies only to health care service plans where coverage for mental health is included as a benefit. SB 349 redefines the Health and Safety Code definition of emergency services and care to include an additional screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility. The provisions of SB 349 are a clarification of the

definition of emergency services and care and a clarification of an existing responsibility and not the addition of a new responsibility. SB 349 does not change the assigned responsibilities of the Plan and the MHP to pay for emergency services as described above.

Pharmaceutical Services and Prescribed Drugs

Each Plan is contractually obligated to cover and pay for pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services or otherwise excluded under the Plan contract.

Each Plan must cover and pay for psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions.

A Plan may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists; however, application of utilization review procedures should not inhibit Plan member access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan shall ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. ~~This~~ **These** requirement**s** should be addressed as a component of the MOU.

The Plan is not required to cover and pay for prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists, unless these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited.

Enclosure 2 lists the prescription drugs that are currently excluded from **most** Plan contracts. Reimbursement to pharmacies for psychotropic drugs listed in Enclosure 2, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal FFS system whether these drugs are provided by a pharmacy contracting with the Plan or by a FFS pharmacy provider.

Laboratory, Radiological, and Radioisotope Services

Each Plan must cover and pay for medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Section 51311.

The Plan must cover and pay for these services for a Plan member who requires the services of the MHP or a Medi-Cal FFS specialty mental health services provider when necessary for the diagnosis and treatment of the Plan member's mental health condition. The Plan must also cover and pay for services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan must coordinate these services with the member's specialty mental health provider.

Home Health Agency Services

Each Plan must cover and pay for home health agency services as described in Title 22, CCR, Section 51337 **prescribed by a Plan provider** when medically necessary to meet the ~~**physical health care**~~ needs of homebound Plan members. A homebound Plan member as defined by Title 22, CCR, Section 51146 is one who is essentially confined to home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration.

The Plan is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a beneficiary. **However, home health agency services prescribed by Plan providers to treat the mental health conditions of Plan members are the responsibility of the Plan.**

Medical Transportation Services

Each Plan must cover and pay for all medically necessary emergency and non-emergency medical transportation services as described in Title 22, CCR, Section 51323 for Plan members, including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services.

Each Plan must also cover and pay for medically necessary non-emergency medical transportation services when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP.

Each MHP must arrange and pay for medical transportation when the **MHP's** purpose ~~of~~ **for** the medical transportation service is to transport a Plan member receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

Hospital Outpatient Department Services

Each Plan must cover and pay for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contracts with its subcontractors and DHS. **Separately billable outpatient services related to** ~~E~~**e**lectroconvulsive therapy**,** ~~and related services~~ **such as anesthesiologist services,** ~~provided on an outpatient basis~~ are also the contractual responsibility of the Plan.

Psychiatric Inpatient Hospital Services

Each Plan must cover and pay for all medically necessary professional services to meet the physical health care needs of Plan members who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations~~ and separately billable hospital-based ancillary services for which the Plan is otherwise contractually responsible. Such services may include, but are not limited to, prescription drugs (except antipsychotics), laboratory services, x-ray, electroconvulsive therapy and related services, and magnetic resonance imaging that are received by a Plan member admitted to a hospital or psychiatric health facility for psychiatric inpatient hospital services~~.

Plans are not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

Nursing Facility Services

If long-term care is included by contract, a Plan must cover and pay for the room, board, and all medically necessary medical and other covered services provided to a Plan member in a nursing facility in accordance with the terms of the Plan's contract for coverage of long-term care.

Because long-term care is capitated to Plans as a service irrespective of diagnosis, this responsibility also includes coverage for Plan members whose need for nursing facility services is based on mental illness. Consistent with applicable contract requirements, Plans will initiate a disenrollment request for members whose projected length of stay in a nursing facility, including skilled nursing facilities with special treatment programs for the mentally disordered, or other long-term care residential treatment facility will exceed the term of the Plan's obligation for coverage of long-term care.

Each Plan is responsible for ensuring a member's orderly transfer to the Medi-Cal FFS system upon disenrollment, and must arrange and pay for all medically necessary contractually required Medi-Cal covered services until the disenrollment is effective.

Currently, MHPs are not contractually responsible for any nursing facility services, although consideration has been given to having MHPs cover skilled nursing facility services with special treatment programs for the mentally disordered. If MHPs assume this responsibility in the future, the Plan will continue to be contractually responsible to cover and pay for all medically necessary medical and other covered services not included under the per diem rate, consistent with a Plan's coverage obligations for long-term care.

Under current federal law, states are permitted to provide Medicaid coverage to individuals 21 years of age or under in psychiatric hospitals or to individuals 65 years of age or older in Institutions for Mental Diseases (IMD) that are psychiatric hospitals or nursing facilities. **Individuals who are receiving these services on their 21st birthday may continue to be covered until the earlier of their 22nd birthday or discharge.** The Medi-Cal program has elected to cover these services (psychiatric hospital services are covered by MHPs).

The Medi-Cal program also covers skilled nursing facility services with special treatment programs for the mentally disordered (these services are billed to the Medi-Cal FFS system using accommodation codes 11, 12, 31, and 32) for beneficiaries of any age in facilities that have not been designated as IMDs. Plans, therefore, are

responsible for these services in accordance with the terms of the Plan's contract for coverage of long-term care.

Under current federal law, states are not permitted to claim federal financial participation for any services provided to beneficiaries over the age of 21 and under the age of 65 residing in IMDs. The Medi-Cal program, however, does cover all services, except the nursing facility services themselves, as state-only Medi-Cal services (e.g., prescription drugs and doctor's visits). Plans are responsible for these services in accordance with the terms of the Plan's contract. MHPs provide medically necessary specialty mental health services (typically visits by psychiatrists and psychologists). Nursing facility services provided to individuals over the age of 21 and under the age of 65 in nursing facilities that are designated IMDs are funded by county realignment and other funds and are not Medi-Cal covered services.

When coverage for long-term care is excluded by Plan contract, or upon the expiration of the Plan's obligation under its contract to provide such services, payment is handled through the Medi-Cal FFS system.

MEDI-CAL COVERED SPECIALTY MENTAL HEALTH SERVICES

Medi-Cal covered specialty mental health services are those services defined in Title 9, CCR, Section 1810.247~~**delivered by a person or entity who is licensed, certified, or otherwise recognized or authorized to provide specialty mental health services under state law governing the healing arts.**~~

The scope of Medi-Cal covered specialty mental health services **covered by MHPs** is set forth in Title 9, CCR, Sections 1810.345 and 1810.350.

Access standards for Medi-Cal covered specialty mental health services **covered by MHPs** are set forth in Title 9, CCR, Section 1810.405.

Medical Necessity Criteria

Under the Medi-Cal Specialty Mental Health Services Consolidation program, each MHP is obligated to provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries of the county served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.

The medical necessity criteria are met when:

- a beneficiary has both an included diagnosis; *and*
- the beneficiaries' condition meets specified impairment and intervention criteria.

A copy of Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210, which provide the medical necessity criteria for psychiatric inpatient hospital services, outpatient specialty mental health services, and specialty mental health services for beneficiaries under the age of 21 are included with this letter as Enclosure 4.

Referrals to the MHP may be received through beneficiary self-referral or through referral by another person or organization.

Beneficiaries, including Plan members, whose diagnoses are not included in the applicable listing of MHP covered diagnoses in Title 9, CCR, Section 1830.205(b)(1), may obtain specialty mental health services through the Medi-Cal FFS system under applicable provisions of Title 22, CCR, Division 3, Subdivision 1. However, under the Specialty Mental Health Services Consolidation program, beneficiaries, including Plan members, whose mental health diagnoses are covered by the MHP but whose conditions do not also meet the program impairment and intervention criteria are not eligible for specialty mental health care under the Medi-Cal program. These beneficiaries are only eligible for care from a primary care or other physical health provider. The Medi-Cal FFS program will deny claims from mental health professionals for such beneficiaries.

Plans can obtain additional information about the medical necessity criteria or the authorization and payment process for specialty mental health services by contacting the appropriate MHP.

<u>Specialty Mental Health Services Providers</u>

Specialty mental health services providers include, but are not limited to: licensed mental health professionals; masters level registered nurses providing EPSDT supplemental services; clinics; hospital outpatient departments; certified day treatment facilities; certified residential treatment facilities; skilled nursing facilities; psychiatric health facilities; psychiatric units of general acute care hospitals; and acute psychiatric hospitals. The Plan and the MHP are providers when employees of the Plan or the MHP provide direct services to beneficiaries.

Mental health professionals may continue to participate in the Medi-Cal FFS program, but the Medi-Cal program will only cover specialty mental health services related to mental health diagnoses that are not the responsibility of either the MHP or the Plan. Hospitals not affiliated with the MHP may provide psychiatric inpatient hospital services to Medi-Cal beneficiaries in emergency situations at FFS rates established by regulation.

Covered Specialty Mental Health Services

Covered specialty mental health services include:

- Rehabilitative Services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
- Psychiatric Inpatient Hospital Services;
- Targeted Case Management;
- Psychiatrist Services;
- Psychologist Services;
- EPSDT Supplemental Specialty Mental Health Services for children under the age of 21~~**(including services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional disturbance is related to family substance abuse)**~~; and
- Psychiatric Nursing Facility Services. **(Currently, MHPs are not contractually required to provide any nursing facility services.)**

  ~~**(Currently, MHPs are not contractually required to provide any nursing facility services.)**~~

Many MHPs also provide services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional or behavioral disturbance is related to family substance abuse.

Services Excluded From Coverage by the MHP

The MHP is not responsible to provide or arrange and pay for the services excluded from coverage by the MHP under Title 9, CCR, Section 1810.355. Plans may be responsible to arrange and pay for these services when contractually required.

Services excluded from coverage by the MHP are:

- Medi-Cal services, which are those services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, that are not specialty mental health services for which the MHP is responsible pursuant to Title 9, CCR, Section 1810.345.

- Prescribed drugs as described in Title 22, CCR, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, CCR, Section 51311, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP under applicable provisions of Title 22, Division 3, Subdivision 1.

- Medical transportation services as described in Title 22, CCR, Section 51323, except when the purpose of the medical transportation service is to transport a beneficiary receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

- Physician services as described in Title 22, CCR, Section 51305, that are not psychiatric services as defined in Title 9, CCR, Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205.

- Personal care services as defined in Title 22, CCR, Section 51183, and as may be defined by DHS as EPSDT supplemental services pursuant to Title 22, CCR, Section 51340(e)(3).

- Out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

- Specialty mental health services provided by a hospital operated by DMH or the Department of Developmental Services.

- Specialty mental health services provided to a Medicare beneficiary eligible for Medicare mental health benefits.

- Specialty mental health services provided to a beneficiary enrolled in a Plan to the extent that specialty mental health services are covered by the Plan.

- Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as specified in Title 9, CCR, Section 1820.100(a).

- Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:

    - Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, CCR, Section 54325.

    - Home and community-based waiver services as defined in Title 22, CCR, Section 51176.

    - Specialty mental health services, other than psychiatric inpatient hospital services, authorized by the California Children Services (CCS) program to treat CCS eligible beneficiaries.

    - Local Education Agency services as defined in Title 22, CCR, Section 51190.4.

    - Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.

    - Home health agency services as described in Title 22, CCR, Section 51337.

COORDINATION OF MEDI-CAL COVERED PHYSICAL HEALTH CARE SERVICES AND SPECIALTY MENTAL HEALTH SERVICES

Plan Responsibilities

The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental services as required by contract. Title 9, CCR, Section 1810.415 sets forth the requirements of the MHP in the coordination of physical and mental health care.

The Plan is responsible for the appropriate management of a Plan member's care which includes, but is not be limited to, the coordination of all medically necessary contractually required Medi-Cal covered services both within and outside the Plan's provider network, and:

- Assistance to Plan members needing specialty mental health services by referring such members to the MHP, or to an appropriate Medi-Cal FFS mental health provider or provider organization if the beneficiary is not eligible for MHP covered services or because the MHP has determined that the Plan member's mental health condition would be responsive to physical health care based treatment;
- The provision of clinical consultation and training to the MHP or other providers of mental health services on a Plan member's medical condition and on medications prescribed through Plan providers;
- Medical case management;
- The exchange of medical records information with the MHP and other providers of mental health care; and
- The coordination of discharge planning from inpatient facilities.

The Plan is required to maintain procedures for monitoring the coordination of care provided to a Plan member. When a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1) ~~, or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based~~

~~treatment~~ and the Plan initiates a referral to a local provider or provider organization outside the Plan, the Plan should document such referrals in the member's medical record. The Plan is not responsible for ensuring member access to such providers, but must maintain a current list of the names, addresses, and telephone numbers of local providers and provider organizations that is available to Plan enrollees. The MHP's role in providing or assisting the Plan in the development of this list should be addressed as a component of the MOU.

A list of such sources of referral to a local provider or provider organization may include:

- **County mental health departments**
- **County departments administering alcohol and drug programs**
- **The county health and human services agency**
- **CalWorks funded programs for mental illness or substance abuse**
- **Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers**
- **The regional center for persons who are developmentally disabled**
- **The Area Agency on Aging for referrals to services for Individuals aged 60 and over**
- **The local medical society**
- **The psychological association**
- **The mental health association**
- **Family services agencies**
- **Faith-based social services agencies**
- **Community employment and training agencies**

MHP Responsibilities

The MHP is required to make clinical consultation and training, including consultation and training on psychotropic medications, available to meet the needs of a beneficiary whose mental illness is not being treated by the MHP.

The MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist beneficiaries in receiving prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. If a Plan requires the MHP to utilize the Plan's drug formulary when psychotropic drugs are prescribed through the MHP, such requirement should be addressed as a component of the MOU.

When **the MHP determines that** a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1), or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based treatment, **the MHP is responsible to refer the member to the Plan for services covered by the Plan or to other sources of care or referral for care for services not covered by the Plan.** ~~**the beneficiary shall be referred to:**~~ **Other sources of care or referral may include:**

1. A provider outside the MHP which may include:

   - A provider with whom the beneficiary already has a patient-provider relationship;

   ~~**The Plan in which the beneficiary is enrolled;**~~

   - A provider in the area who has indicated a willingness to accept MHP referrals, including Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Clinics; or

2. An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include where appropriate:

   - The Health Care Options program described in Welfare and Institutions Code Section 14016.5;

- The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;

- Provider organizations;

- Other community resources available in the county served by the MHP. ~~which may include, but are not limited to:~~

  - ~~County mental health departments~~
  - ~~County departments administering alcohol and drug programs~~
  - ~~The county health and human services agency~~
  - ~~CalWorks funded programs for mental illness or substance abuse~~
  - ~~Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers~~
  - ~~The regional center for persons who are developmentally disabled~~
  - ~~The Area Agency on Aging for referrals to services for Individuals aged 60 and over~~
  - ~~The local medical society~~
  - ~~The psychological association~~
  - ~~The mental health association~~
  - ~~Family services agencies~~
  - ~~Faith-based social services agencies~~
  - ~~Community employment and training agencies~~

The MHP is not required to ensure a beneficiary's access to **physical health care based treatment or to** treatment from licensed mental health professionals for diagnoses not covered in Title 9, CCR, Section 1830.205(b)(1). ~~**When the situation generating a referral by the MHP to a provider or provider organization outside the MHP meets the criteria established in Title 9, Section 1850.210(i), a Notice of Action will be provided.**~~

Confidentiality of Medical Records Information

The Plan and the MHP are responsible for the development of protocols to maintain the confidentiality of beneficiary medical records, including all information, data, and data elements collected and maintained for the operation of the contract and shared with the other party, in accordance with all applicable federal and state laws and regulations and contract requirements.

Note: Recently enacted legislation, SB 19 (Chapter 526, Statutes of 1999), and AB 416 (Chapter 527, Statutes of 1999), expand provisions related to the confidentiality of medical records information in both the Civil Code and the Health and Safety Code.

Resolution of Disputes

The resolution of disputes is a shared Plan/MHP responsibility. The Plan is responsible for establishing procedures for the resolution of disputes with the MHP as required by contract. As set forth in Title 9, CCR, Section 1810.370, the MHP is responsible for establishing procedures for the resolution of disputes with the Plan.

When a Plan has a dispute with a MHP that cannot be resolved to the satisfaction of the Plan concerning its contractual obligations, state Medi-Cal laws and regulations, or an MOU with the MHP, the Plan may submit a request for resolution to DHS in accordance with the rules governing the resolution of disputes in Title 9, CCR, Section 1850.505. A dispute between a Plan and a MHP shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to Plan members.

Additional information regarding the Medi-Cal specialty mental health managed care program may be accessed via the Internet through DMH's Web site at http://www.dmh.cahwnet.gov.

The text of the emergency regulations governing the provision of Medi-Cal specialty mental health services, and other documents pertinent to DMH's rulemaking proceedings for these regulations may be accessed through the DMH, Office of Regulations Web site at http://www.dmh.cahwnet.gov/regulations/SPEC/rulemaking.htm. The regulations will remain in effect until July 1, 2000, or until they are made permanent, whichever occurs first. The public comment period for these regulations closed on December 20, 1999. After considering all the timely and relevant comments received, DMH may adopt these regulations, or may make modifications to the text with proper notice to the public.

Substantive changes between the text of the emergency regulations on which this policy letter is based and the permanent regulations adopted, if any, will be addressed in future communication to the Plans.

Should you have questions, or require additional information regarding the content of this policy letter, please contact your contract manager.

Susanne Hughes

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

Enclosure 1

MEDI-CAL MANAGED CARE PLAN
SPECIALTY MENTAL HEALTH COVERAGE ALTERNATIVES

Plan Type	Plan Name	County of Operation	Coverage Alternatives
Primary Care Case Management	Positive HealthCare Foundation	Los Angeles	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs
County Organized Health System	Partnership Health Plan of California*	Solano	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Santa Barbara Health Initiative	Santa Barbara	Covers prescription drugs including psychotropic drugs
	Health Plan of San Mateo**	San Mateo	Excludes drugs and related labs prescribed by the MHP
Geographic Managed Care	Kaiser Foundation Health Plan, Inc.	Sacramento	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Western Health Advantage	Sacramento	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs

* Solano County Mental Health has been a subcontractor on a capitated basis to the County Organized Health System in Solano under separate field test authority from HCFA since 1994. Mental health services are excluded by Partnership Health Plan in Napa County.

** The MHP in San Mateo County is financially responsible for prescription drugs and related laboratory services prescribed by the MHP under separate field test authority from HCFA.

DRUGS EXCLUDED FROM PLAN COVERAGE

Psychotropic Drugs	Drugs for the Treatment of HIV/AIDS
Amantadine HCL	Abacavir Sulfate (Ziagen)
Benztropine Mesylate	Amprenavir (Agenerase)
Biperiden HCL	Delaviridine Mesylate (Rescriptor)
Biperiden Lactate	Efavirenz (Sustiva)
Chlorpromazine HCL	Indinavir Sulfate (Crixivan)
Chlorprothixene	Lamivudine (Epivir)
Clozapine	Nelfinavir Mesylate (Viracept)
Fluphenazine Decanoate	Nevirapine (Viramune)
Fluphenazine Enanthate	Ritonavir (Norvir)
Fluphenazine HCL	Saquinavir (Fortovase)
Haloperidol	Saquinavir Mesylate (Invirase)
Haloperidol Decanoate	Stavudine (Zerit)
Haloperidol Lactate	Zidovudine/Lamivudine (Combivir)
Isocarboxazid	
Lithium Carbonate	
Lithium Citrate	
Loxapine HCL	
Loxapine Succinate	
Mesoridazine Besylate	
Molindone HCL	
Olanzapine	
Perphenazine	
Phenelzine Sulfate	
Pimozide	
Procyclidine HCL	
Promazine HCL	
Quetiapine	
Risperidone	
Thioridazine HCL	
Thiothixene	
Thiothixene HCL	
Tranylcypromine Sulfate	
Trifluoperazine HCL	
Triflupromazine HCL	
Trihexyphenidyl HCL	

SAMPLE

(For demonstration purposes only. Not Intended to be inclusive of all services to be addressed in an MOU between a Plan and a MHP.)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Psychiatric Inpatient Hospital Medical Necessity Criteria Met	Psychiatric Inpatient Hospital Medical Necessity Criteria Not Met
Psychiatric Inpatient Hospital Services - General Acute Hospitals	Facility Charges	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment
Institutions for Mental Diseases - Acute Psychiatric Hospitals	Facility Charges Patient aged 0 to 21	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 22 to 64	No MHP, MCP, or EDS payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 65 or over	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment

SAMPLE (continued)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Included Diagnosis and Meets MHP Impairment and Intervention Criteria	Excluded Diagnosis	Included Diagnosis But Does Not Meet MHP Impairment and Intervention Criteria
Emergency Departments	Facility Charges	MCP for initial triage and medical services MHP for any facility charges related to a covered psychiatric service Note: When a beneficiary is admitted to a psychiatric bed at the same facility, there is no separate payment for the ER by the MHP or the MCP	MCP	MCP
	Psychiatric Professional Services	MHP	EDS	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	MCP	MCP

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

Section 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders
(L) Somatoform Disorders
(M) Dissociative Disorders
(N) Eating Disorders
(O) Intermittent Explosive Disorder
(P) Pyromania
(Q) Adjustment Disorders
(R) Personality Disorders
(2) A beneficiary must have both (A) and (B):
(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:
1. Has symptoms or behaviors due to a mental disorder that (one of the following):
a. Represent a current danger to self or others, or significant property destruction.
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications which meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

(c) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

Section 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following mental necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specially provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Forth Edition, published by the American Psychiatric Association:

(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

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

Section 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who do meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Speciality Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code; and Title 42, Section 1396d(r), United States Code.

Behavioral Health Initial Evaluation
Coordination of Care Report

BH Form History

MEMBER INFORMATION

Name	IEHP ID	DOB	Age	Sex
Address		City	ST CA	Zip
Phone	County	Medi-Cal #		LOB

MEMBER PCP INFORMATION

Name	ID	Phone
Address	City, State	Zip

PROVIDER INFORMATION

Name	ID	Auth #	Report Date

VISIT INFORMATION

Patient Signed Release ◯ Yes ◯ No (If No, This Information Will NOT Be Forwarded To The PCP)

Initial Visit Date Concurrent BH Specialist

Major Presenting Problems - (Select At Least One From Below)

Rating Of Level Of Severity 1=Mild, 2=Moderate, 3=Severe, Leave Blank If Not Applicable

	1 2 3		1 2 3		1 2 3
Anxiety	◯◯◯	Assaultive Behavior	◯◯◯	Hallucination ☐ Auditory ☐ Visual	◯◯◯
Depression	◯◯◯	Conduct Disorder	◯◯◯	Paranoia	◯◯◯
Sleep Disorder	◯◯◯	Attention Problems	◯◯◯	Dissociative Process	◯◯◯
Weight Change	◯◯◯	Concentration Difficulty	◯◯◯	Substance Abuse	◯◯◯
Isolation	◯◯◯	Confusion	◯◯◯	Eating Disorder	◯◯◯
Obsessive/Compulsive	◯◯◯	Dementia	◯◯◯	Other	◯◯◯
Aggressive Behavior	◯◯◯	Dizziness, Light-Headed	◯◯◯		

Diagnosis (Complete At Least One (1) DX On Axis I Or II Axis IV, & Axis V)

AXIS I - Primary Diagnosis

Choose a DSM IV Code

AXIS I - Secondary Diagnosis

Choose a DSM IV Code

AXIS II - Developmental Disorders And Personality Disorders

Choose an AXIS II Code

AXIS III - Physical Disorders And Conditions - Optional (Enter A Valid Axis III Code)

AXIS IV - Severity Of Psychosocial Stressors

Search ICD-9 Codes

- ☐ Problems With Primary Support Group/Family
- ☐ Interpersonal Or Problems Related To The Social Enviornment
- ☐ Problems Related To Interaction With The Legal System/Crime
- ☐ Educational Problems
- ☐ Occupational Problems
- ☒ Housing Problems

Problems With Access To Health Care

Economic Problems

Other Psychosocial And Enviornmental Problems

AXIS V - Global Assessment Of Functioning (GAF) Current

Highest In Last Year

CURRENT MEDICATIONS (Last 6 Months As Reported To IEHP)

Medication	Quantity	Days Supplied	Date Filled
Tri-Lo-Sprintec Tablet	28	28	11/13/2009
Tri-Lo-Sprintec Tablet	28	28	9/24/2009

FINDINGS/RECOMMENDATIONS

1. Request For PCP To Provide
   - Refer Patient Back To PCP To Evaluate Physical Complaints Specify
   - Refer Patient Back To PCP To Adjust Psychotropic Medications Specify
2. Recommendation For Behavioral Health Treatment (Select At Least One From Below)
   - a. SED Evaluation
   - b. Individual Psychotherapy - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - c. Family Therapy - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - d. Group Therapy - Type
     - ADHD Parent Training Pain Management Anxiety Management
     - Depression Management Bereavement Specify
     - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - f. Psychiatric Evaluation/Psychotropic Medication Assessment - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - g. Substance Abuse Services
     - Evaluation By Substance Abuse Specialists - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - h. Evaluation For Detoxification - Practitioner Recommended
     - Self First Available IEHP Panel BH Practitioner Other Select Provider
   - i. Evaluation For Structured Outpatient Program
     - Mental Health Substance Abuse Other Program
   - j. Other Services
     - Specify

Clear Submit

Behavioral Health Coordination of Care -Update (Optional)

BH Form History

MEMBER INFORMATION

Name | IEHP ID | DOB | Age | Sex

Address | City | ST | Zip

Phone | County | Medi-Cal # | LOB

MEMBER PCP INFORMATION

Name | ID | Phone

Address | City, State | Zip

PROVIDER INFORMATION

Name | ID | Auth # | Report Date

Patient Signed Release ◯ Yes ◯ No (If No, This Information Will NOT Be Forwarded To The PCP)

CURRENT MEDICATIONS (Last 6 Months As Reported To IEHP)

Medication	Quantity	Days Supplied	Date Filled
Tri-Lo-Sprintec Tablet	28	28	11/13/2009
Tri-Lo-Sprintec Tablet	28	28	9/24/2009

CHANGES/UPDATES

1. Psychiatric Medication Changes Since Initial Evaluation:
   a. Continue Previous Medications
      ◯ Unchanged ◯ Changed Dosage ◯ Changed Frequency ◯ Other
   b. Discontinued Previous Medications
      Specify ◯ Ineffective ◯ Adverse Reaction ◯ Other
   c. Added New Medication
      Specify
   d. Describe Medication Changes If Applicable

2. Clinical Update
   ◯ Stabilized ◯ Progressing But Not Stabilized ◯ In Crisis ◯ Other

FINDINGS/RECOMMENDATIONS

1. Request For PCP To Provide
   ◯ Refer Patient Back To PCP To Evaluate Physical Complaints Specify
   ◯ Refer Patient Back To PCP To Adjust Psychotropic Medications Specify
2. Recommendation For Behavioral Health Treatment (Select At Least One From Below)
   a. ◯ SED Evaluation
   b. Individual Psychotherapy - Practitioner Recommended
      ◯ Self ◯ First Available IEHP Panel BH Practitioner ◯ Other Select Provider
   c. Family Therapy - Practitioner Recommended
      ◯ Self ◯ First Available IEHP Panel BH Practitioner ◯ Other Select Provider
   d. Group Therapy - Type

ADHD Parent Training Pain Management Anxiety Management

Depression Management Bereavement Specify

Practitioner Recommended

Self First Available IEHP Panel BH Practitioner Other Select Provider

f. Psychiatric Evaluation/Psychotropic Medication Assessment - Practitioner Recommended

Self First Available IEHP Panel BH Practitioner Other Select Provider

g. Substance Abuse Services

Evaluation By Substance Abuse Specialists - Practitioner Recommended

Self First Available IEHP Panel BH Practitioner Other Select Provider

- Evaluation For Detoxification - Practitioner Recommended

Self First Available IEHP Panel BH Practitioner Other Select Provider

Evaluation For Structured Outpatient Program

Mental Health Substance Abuse Other Program

Other Services

Specify

Clear Submit

Request For Additional Services Authorization

BH Form History

MEMBER INFORMATION

Name	IEHP ID	DOB	Age	Sex
Address		City	ST	Zip
Phone	County	Medi-Cal #		LOB

PROVIDER INFORMATION

Practitioner Requesting Initial Authorization ID

Member Signed Release ◯ Yes ◯ No (If No, This Information Will NOT Be Forwarded To The PCP)

CURRENT STATUS OF CASE

High Risk Factors (Select Either NONE Or At Least One High Risk Factor With At Least One Containment Action Plan)

1. ☐ None
2. Suicidal - Severity Level: ◯ Mild ◯ Moderate ◯ Severe
   a. Containment Plan ☐ No Harm Contract ☐ Requested IEHP Complex Case Management Assistance
   b. Higher/More Intense Level Of Care ☒ Increased OutpatientVisit Frequency
   c. Referred For Additional Services
      ☐ Intensive Outpatient Program ☐ Community Based Services
      ☐ Psychiatric Hospital Based Services ☐ Other:
3. Homicidal - Severity Level: ◯ Mild ◯ Moderate ◯ Severe
   a. Containment Plan. ☐ No Harm Contract ☐ Requested IEHP Complex Case Management Assistance
   b. Higher/More Intense Level Of Care ☒ Increased OutpatientVisit Frequency
   c. Referred For Additional Services
      ☐ Intensive Outpatient Program ☐ Community Based Services
      ☐ Psychiatric Hospital Based Services ☐ Other:
4. Gravely Disabled- Severity Level: ◉ Mild ◯ Moderate ◯ Severe
   a. Containment Plan: ☐ Requested IEHP Complex Case Management Assistance
   b. Higher/More Intense Level Of Care ☒ Increased OutpatientVisit Frequency
   c. Referred For Additional Services
      ☐ Intensive Outpatient Program ☐ Community Based Services
      ☐ Psychiatric Hospital Based Services ☐ Other:
5. Abuse Or Neglect- Severity Level: ◯ Mild ◯ Moderate ◯ Severe
   a. Containment Plan:
      ☐ Report Filed With Protective Services ☐ Requested IEHP Complex Case Management Assistance
      Date:
   b. Higher/More Intense Level Of Care ☒ Increased OutpatientVisit Frequency
   c. Referred For Additional Services
      ☐ Intensive Outpatient Program ☐ Community Based Services
      ☐ Psychiatric Hospital Based Services ☐ Other:

CRITICAL INCIDENTS SINCE LAST AUTHORIZATION

(Select Either NONE Or At Least One High Risk Factor With At Least One Containment Action Plan)

1. ☐ None
2. Suicide Attempt - Life Threatening ○ Yes ○ No
   Action Taken
   - ☐ Requested IEHP Complex Case Management Assistance
   - ☐ Member Evaluated For Psychiatric Hospitalization
   - ☐ Member Placed On 5150 Hold And Admitted
   - ☐ Outpatient Containment Of Suicide Risk-No Harm Contract
3. Adverse Medication Reaction - Life Threatening ○ Yes ○ No
   Action Taken
   - ☐ Requested IEHP Complex Case Management Assistance
   - ☐ Discontinued Medication That Caused Adverse Reaction
   - ☐ Titrated Dosage To Reduce Reaction To Acceptable Level
   - ☐ Added Additional Medication
4. Other - Life Threatening ○ Yes ○ No
   Action Taken
   - ☐ Requested IEHP Complex Case Management Assistance
   - ☐ Discontinued Medication That Caused Adverse Reaction
   - ☐ Titrated Dosage To Reduce Reaction To Acceptable Level
   - ☐ Added Additional Medication

Presenting Problems - (Select At Least One From Below)

Rating Of Level Of Severity: 1=Mild; 2=Moderate, 3=Severe, Leave Blank If Not Applicable

	1 2 3		1 2 3		1 2 3
Anxiety	○○○	Assaultive Behavior	○○○	Hallucination ☐ Auditory ☐ Visual	○○○
Depression	○○○	Conduct Disorder	○○○	Paranoia	○○○
Sleep Disorder	○○○	Attention Problems	○○○	Dissociative Process	○○○
Weight Change	○○○	Concentration Difficulty	○○○	Substance Abuse	○○○
Isolation	○○○	Confusion	○○○	Eating Disorder	○○○
Obsessive/Compulsive	○○○	Dementia	○○○	Other	○○○
Aggressive Behavior	○○○	Dizziness, Light-Headed	○○○		

Explanation Of Reduction Of Member's Symptoms And Improvement Of Member's Functioning And Goals For Additional Treatment:

Treatment Progress / Improvement

(Must Select N/A Or Select At Least One Action Taken With Progress/Improvement Rating)

1. If Applicable, How Have Chemical Dependency Issues Been Addressed?
   - ☐ N/A (Evaluated And No Presenting Substance Abuse Problem)
   - ○ Substance Abuse Counseling Provided As Part Of This Treatment
   - ○ Referral Has Been Made To Substance Abuse Practitioner Or Program

1a. Rating Of Improvement Of Substance Abuse Problem
   - ○ No Improvement - Member Still Abusing Substance
   - ○ Reduction In Quantity And Frequency Of Substance Use
   - ○ Abstinence - Member Is Sober And Committed To Recovery

2. Treatment Recommendations:
   - ○ Continue Initial Treatment Plan Unchanged
   - ○ Reduce Frequency Of Visits To Not Exhaust Benefits Before End Of Calendar Year

   Refer For Additional Service To Be Provided By:
   - ☐ PCP For Medication Management ☐ Community Resource
   - ☐ Other Plan/ Comments:

3. Member Compliance With Recommendations:
   - ○ Excellent Follow Through ○ Partial Compliance

- Non-Compliant
- Other

4 After Care Plan:

- No Further Services Are Expected To Be Needed After Treatment Is Completed
- Refer Member Back To PCP To Manage Psychotropic Medication Once Member Is Stabilized
- Refer Member To Community Resources Such As Self Help Groups
- Other Plan/Comments

CURRENT MEDICATIONS (Last 6 Months As Reported To IEHP)

Medication	Quantity	Days Supplied	Date Filled
Tri-Lo-Sprintec Tablet	28	28	11/13/2009
Tri-Lo-Sprintec Tablet	28	28	9/24/2009

Diagnosis (Complete At Least One (1) DX On Axis I Or II, Axis IV & Axis V)

AXIS I - Primary Diagnosis

Choose a DSM IV Code

AXIS I - Secondary Diagnosis

Choose a DSM IV Code

AXIS II - Developmental Disorders And Personality Disorders

Choose an AXIS II Code

AXIS III - Physical Disorders And Conditions - Optional (Enter A Valid Axis III Code)

AXIS IV - Severity Of Psychosocial Stressors

Search ICD-9 Codes

- Problems With Primary Support Group/Family
- Interpersonal Or Problems Related To The Social Enviornment
- Problems Related To Interaction With The Legal System/Crime
- Problems With Access To Health Care
- Other Psychosocial And Enviornmental Problems
- Educational Problems
- Occupational Problems
- Housing Problems
- Economic Problems

AXIS V - Global Assessment Of Functioning (GAF) Current Highest In Last Year

SERVICE REQUESTED

(Select At Least One Service)

Description	CPT Code	Requested Frequency
Medication Management	90862	Choose a Frequency
Individual Therapy (45-50 Min)	90806	Choose a Frequency
Family Therapy	90847	Choose a Frequency
Group Therapy	90853	Choose a Frequency
Other	Choose a CPT	Choose a Frequency

Next Appointment Date With Member.

Requested Authorization Start Date.

Clear Submit

Clinical Discharge Summary
(Limited Treatment or Premature Termination)

BH Form History

MEMBER INFORMATION

Name	IEHP ID	DOB	Age	Sex
Address		City	ST	Zip
Phone	County	Medi-Cal #		LOB

PROVIDER INFORMATION

Practitioner Requesting Initial Authorization ID

Member Signed Release ◯ Yes ◯ No (If No, This Information Will NOT Be Forwarded To The PCP)

STATUS OF PROBLEMS AS OF FINAL VISIT

(Select At Least One From Below)

Rating Of Level Of Severity: 1=Mild; 2=Moderate; 3=Severe; Leave Blank If Not Applicable

	1 2 3		1 2 3		1 2 3
Anxiety	◯◯◯	Assaultive Behavior	◯◯◯	Hallucination ☐ Auditory ☐ Visual	◯◯◯
Depression	◯◯◯	Conduct Disorder	◯◯◯	Paranoia	◯◯◯
Sleep Disorder	◯◯◯	Attention Problems	◯◯◯	Dissociative Process	◯◯◯
Weight Change	◯◯◯	Concentration Difficulty	◯◯◯	Substance Abuse	◯◯◯
Isolation	◯◯◯	Confusion	◯◯◯	Eating Disorder	◯◯◯
Obsessive/Compulsive	◯◯◯	Dementia	◯◯◯	Other	◯◯◯
Aggressive Behavior	◯◯◯	Dizziness, Light-Headed	◯◯◯		

REASON FOR DISCONTINUATION OF TREATMENT (Select One From Below)

◯ Member Completed Treatment Plan.

◯ Member Dropped Out Of Teatment, Reason Unknown.

◯ Member Relocated Out Of The Area.

◯ Member Was Not Interested In Or Felt No Need For Further Treatment.

◯ Other/Comments:

FOLLOW UP INTERVENTIONS (Select At Least One From Below)

☐ Member Is Not "At Risk" And Follow Up Intervetions Are Not Required At This Time

☐ Member Was Dissatisfied With The Treatment Plan Or With Practitioner - Referred To IEHP For New Practitioner Referral.

Member Is Considered To Be "At Risk" And It Is Against Clinician Advice For Member To Discontinue Treatment At This Time Due To:

- ☐ Severity Of Symptoms/Problems
- ☐ Functioning Level Is Significantly Impaired
- ☐ Ongoing Substance Abuse That Endangers Member's Health

☐ Suicidal Ideation Without Plan Or Means

☐ Other/Comments

FOLLOW UP INTERVENTIONS REQUESTED FOR "AT RISK" MEMBERS
(Select At Least One From Below For "AT RISK" Members)

☐ Clinician Requests IEHP BH Care Management To Follow-Up With Member

☐ Clinician Has Contacted Member To Recommend Further Treatment

☐ Clinician Requests IEHP BH Care Manager To Notify PCP Of Unresolved Risk Factors

☐ Other/Comments:

Clear Submit

Clinical Discharge Summary

BH Form History

MEMBER INFORMATION

Name	IEHP ID	DOB	Age	Sex
Address		City	ST	Zip
Phone	County	Medi-Cal #		LOB

PROVIDER INFORMATION

Practitioner Requesting Initial Authorization ID

Member Signed Release ◯ Yes ◯ No (If No, This Information Will NOT Be Forwarded To The PCP)

PROBLEM RATING AT DISCHARGE

Rating Of Level Of Severity. 1=Mild; 2=Moderate; 3=Severe, Leave Blank If Not Applicable

	1 2 3		1 2 3		1 2 3
Anxiety	◯◯◯	Assaultive Behavior	◯◯◯	Hallucination ☐ Auditory ☐ Visual	◯◯◯
Depression	◯◯◯	Conduct Disorder	◯◯◯	Paranoia	◯◯◯
Sleep Disorder	◯◯◯	Attention Problems	◯◯◯	Dissociative Process	◯◯◯
Weight Change	◯◯◯	Concentration Difficulty	◯◯◯	Substance Abuse	◯◯◯
Isolation	◯◯◯	Confusion	◯◯◯	Eating Disorder	◯◯◯
Obsessive/Compulsive	◯◯◯	Dementia	◯◯◯	Other	◯◯◯
Aggressive Behavior	◯◯◯	Dizziness, Light-Headed	◯◯◯		

CURRENT MEDICATIONS (Last 6 Months As Reported To IEHP)

Medication	Quantity	Days Supplied	Date Filled
Tri-Lo-Sprintec Tablet	28	28	11/13/2009
Tri-Lo-Sprintec Tablet	28	28	9/24/2009

Diagnosis (Complete At Least One (1) DX On Axis I Or II, Axis IV, & Axis V)

AXIS I - Primary Diagnosis

Choose a DSM IV Code

AXIS I - Secondary Diagnosis

Choose a DSM IV Code

AXIS II - Developmental Disorders And Personality Disorders

Choose an AXIS II Code

AXIS III - Physical Disorders And Conditions - Optional (Enter A Valid Axis III Code)

AXIS IV - Severity Of Psychosocial Stressors

Search ICD-9 Codes

- ☐ Problems With Primary Support Group/Family
- ☐ Interpersonal Or Problems Related To The Social Enviornment
- ☐ Problems Related To Interaction With The Legal System/Crime
- ☐ Problems With Access To Health Care
- ☑ Educational Problems
- ☑ Occupational Problems
- ☑ Housing Problems
- ☑ Economic Problems

☐ Other Psychosocial And Environmental Problems

AXIS V - Global Assessment Of Functioning (GAF) Current Highest In Last Year

AFTER CARE PLAN (Select At Least One From Below)

☐ Treatment Complete - No Further Behavioral Health Services Needed

☐ Referred Stable Member Back To PCP For Ongoing Psychotropic Medication Management

☐ Referred Member To Community Resources Or Self Help Groups For Ongoing Support

☐ Other/Comment

Clear Submit

Healthy Families SED Referral Form

MEMBER INFORMATION

Patient's Name: ______________________ DOB: __________ Mbr ID: ____________

Parent/Guardian Name: ______________________________ Phone: ____________

Address: ____

Patient's Primary Language: ____________ Parent/Guardian Primary Language: ____________

PROVIDER INFORMATION

Referring Party: ______________________________________ Date: ____________

Phone: ______________________ Fax: __________________________

Address: ____

Patient's Primary Care Physician: ______________________ Phone: ____________

INFORMATION

Patient's Known/Suspected Mental Health Diagnosis (If Any): ______________________

Does The Patient Have A Suspected/Known Alcohol Or Other Drug Abuse Diagnosis? ○ Yes ○ No

If "Yes", List Known/Suspected AOD Diagnosis: ______________________

Patient's Known Medical Diagnosis (If Any): ______________________

Patient's Current Medications (If Any): ______________________

Date Of Patient's Last WELL CHILD EXAM (If Known): ______________________

Is The Patient Currently Receiving In-Patient Psyciatric Services? ○ Yes ○ No

Facility Name: ____

Admit Date: ______________________ ELOS: ______________________

Admitting Diagnosis: ____

Brief Clinical: ____

Outpatient Provider: ______________________________ Phone: ____________

Concurrent Outpatient Provider: ______________________ Phone: ____________

SED Reason

Please Check The Reason(S) You Believe The Patient MAY Be Qualified For Services For Children With Severe Emotional Disturbance (SED).

- ☐ As A Result Of A Mental Disorder, The Patient Has A Substantial Impairment In The Following Areas:
  - Self Care
  - School Functioning
  - Family Relationships
  - Ability To Function In The Community
- ☐ The Patient Is At Risk For Removal From His/Her Home.
- ☐ The Mental Disorder/Impairments Have Been Present For Six Months, Or Are Likely To Continue For More Than One Year Without Treatment.
- ☐ The Patient Displays Psychotic Features, Risk Of Suicide, Or Risk Of Violence Due To Mental Disorder.

MENTAL HEALTH DEPARTMENT EVALUATION

THE FOLLOWING INFORMATION WILL FACILITATE A THOROUGH MENTAL HEALTH DEPARTMENT EVALUATION.
Please Check Applicable Boxes. Following Each Statement Is An Example Of Specific Behaviors That May Have Initiated This Referral. Please Check Any That Apply.

☐ 1. **This Child Is Or May Be A Danger To Him/Herself Or To Others.**
Child May Have Attempted Suicide; Made Suicidal Gestures; Expressed Suicidal Ideations, Is Assaultive To Other Children Or Adults, Is Reckless And Routinely Puts Self In Dangerous Situations; Attempts To Or Has Sexually Assulted Or Molested Other Children, Etc.

☐ 2. **This Child Has A History Of Severe Physical Or Sexual Abuse Or Has Been Exposed To Extreme Violent Behavior.**
Child's History Involves Either Being Subject To Or Has Witnessed Extreme Physical Abuse, Domestic Violence Or Sexual Abuse, I.E., Bruising To Unusual Areas, Being Forced To Watch Torture Or Sexual Assult, Witness To Murder, Etc

☐ 3. **This Child Has Difficult Behaviors That Are Jeopardizing His/Her Current Living And/Or Educational Setting.**
Child May Have Persistent Chaotic, Impulsive Or Disruptive Behaviors, May Have Daily Verbal Outbursts, Refuse To Follow Basic Rules; May Consistently Challenge Authority; May Require Constant Direction And Supervision In All Activities; May Be In Constant Motion Which Is Uncontrolled By Medication, May Be Truant From School Regularly And Not Respond To Limit-Setting Or Other Discipline, Etc.

☐ 4. **This Child Has Or May Have Problems With Social Adjustment.**
Child May Have A History Of Fire Setting; May Be Cruel To Animals; May Masturbate Exessively, Compulsively Or Publicly; May Appear To Hear Voices Or Respond To Internal Stimuli; May Have Repetitive Body Motions Or Vocalizations; May Have A Pattern Of Smearing Feces, Etc.

☐ 5. **This Child Has Or May Have Problems With Social Adjustment.**
The Child Is Regularly Involved In Physical Fights With Other Children Or Adults; Verbally Threatens People; Damages Possessions Of Self Or Others; Runs Away; Steals; Regularly Lies; Is Mute; Does Not Seem To Feel Guilt After Misbehavior, Etc.

☐ 6. **This Child Has Or May Have Problems Making And/Or Maintaining Healthy Relationships.**
Child Is Unable To Form Positive Relationships With Peers; May Provoke Other Children To Victimize Him/Her; Is Involved With Gangs Or Expresses The Desire To Be; Does Not Form Bond With Caregivers, Etc.

☐ 7. **This Child Has Or May Have Problems With Personal Care.**
Child Eats Or Drinks Substances That Are Not Food; Is Regularly Enuretic During Waking Hours; Refuses To Tend To Personal Hygiene To An Extreme, Etc.

☐ 8. **This Child Has Or May Have Significant Functional Impairments.**
There Is No Known History Of Developmental Disorder And The Child's Behavior Interferes With His/Her Ability To Learn At School, He/She Is Significantly Delayed In Language; Is "Unsocialized" And Incapable Of Managing Basic Age Appropriate Skills; Is Selectively Mute, Etc.

☐ 9. **This Child Has Or May Have Significant Problems Managing His/Her Feelings.**
Child Has Severe Tantrums; Screams Uncontrollably; Cries Inconsolably; Has Significant And Regular Nightmares; Is Withdrawn And Uninvolved With Others; Whines Or Pouts Excessively And Regularly; Expresses The Feeling That Others Are Out To Get Him/Her; Worries Excessively And Is Preoccupied With Minor Annoyances; Regularly Expresses Feeling Worthless Or Inferior; Frequently Appears Sad Or Depressed; Is Constantly Restless Or Over Active, Etc.

☐ 10. **This Child Has Or May Have A History Of Psychiatric Hospitalizations, Psychiatric Care And/Or Prescribed Psycotropic Medications.**
Child Has A History Of Psychiatric Care, Either Inpatient Or Outpatient, Or Is Taking Prescribed Psychotropic Medictions.

☐ 11. **This Child Is Known To Use/Abuse Alcohol And/Or Drugs.**
Child Uses Alcohol Or Other Drugs.

ADDITIONAL COMMENTS

PLEASE ADD ADDITIONAL COMMENTS Regarding Behaviors, Symptoms, Medical Condition Or Other Relevant Information:

Submit Form

MMCD Letter No. 96-07
July 5, 1996

WHAT ARE EPSDT SUPPLEMENTAL SERVICES?

EPSDT Supplemental Services are those medically-necessary services that are available to the Medi-Cal population under age 21. There are three ways in which EPSDT supplemental services may be determined medically necessary:

1. The requested EPSDT supplemental services can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population; or

2. The requested EPSDT supplemental services can meet distinct, EPSDT service specific requirements.

3. If the criteria of number one cannot be met, and if the criteria of number two above are not applicable to the service, then the requested EPSDT supplemental services must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in Title 22, CCR, Section 51340(e)(3), as summarized below:

    - The services are to correct or ameliorate defects or physical and mental illnesses or conditions discovered by the screening services.

    - The supplies, items, or equipment to be provided are medical in nature.

    - The services are not requested solely for the convenience of the Member, family, physician, or other provider of services.

    - The services are not primarily cosmetic in nature or primarily to improve the Member's appearance.

    - The services are safe and not experimental and are recognized as an accepted modality of medical practice.

    - Where alternative medically accepted modes of treatment are available, the EPSDT supplemental services are the most cost effective. The plan may determine the most cost-effectiveness setting for services on a case-by-case basis. Where the determination of cost-effectiveness involves an assessment of services not covered by the plan (e.g., home- and community-based waiver services or long-term care in a

nursing facility), the plan must coordinate the determination of cost-effectiveness with DHCS.

- The services to be provided are generally recognized as an accepted modality of medical practice or treatment, are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the medical condition of the beneficiary.

- There is scientific evidence, consisting of well-designed and conducted investigations published in peer-review journals, demonstrating that the service can be produce measurable physiological alterations beneficial to health outcomes, or in the case of psychological or psychiatric services measurable psychological outcomes concerning the short- and long-term effects of the proposed services. Opinions and evaluations published by national medical organizations, consensus panels, and other technology-evaluation bodies supporting provision of the benefit shall also be considered when available.

- The predicted beneficial outcome of the service outweighs potential harmful effects.

- The services improve the overall health outcomes as much as, or more than, established alternatives.

Examples of EPSDT supplemental services are cochlear implants. EPSDT case management services, and EPSDT supplemental nursing services. EPSDT case management services and EPSDT supplemental nursing services are discussed in more detail below.

EPSDT SUPPLEMENTAL NURSING SERVICES

EPSDT supplemental nursing services mean hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home. EPSDT supplemental nursing services are covered when they meet the medical-necessity criteria in Section 51340(e) and the following conditions are met:

- The Member for whom nursing care is requested meets any of the criteria for admission to licensed and certified health facility inpatient care settings, and his/her medical condition has stabilized such that care can safely be rendered in the home; or

The Member is newly discharged from an acute or subacute inpatient setting and is dependent upon a life-sustaining medical technology, and his/her medical condition has stabilized such that care can safely be rendered in the home.

- The nursing services are provided by licensed, skilled nursing personnel with experience and training appropriate to the needs of the Member for whom the services are to be provided.

- There is a primary caregiver in the home that is proficient in the tasks necessary to care for the Member.

- An assessment of the home environment has been conducted by a qualified home health agency or other appropriate persons. The assessment must verify that an attending physician accepts twenty-four hour responsibility for providing and coordinating medical care; the home environment supports the health and safety of the beneficiary; that space is adequate to accommodate needed equipment, supplies, and personnel; that the family caregivers have been appropriately trained; and that all necessary supports and an emergency back-up plan are in place. This assessment is the responsibility of the plan, but may be subject to prior authorization consistent with the Member meeting other criteria for EPSDT supplemental nursing services.

EPSDT supplemental nursing services should be provided at home or in an appropriate facility consistent with Title 22, CCR, Section 51340(m).

EPSDT PROGRAM – EMERGENCY REGULATIONS AS FILED WITH THE SECRETARY OF STATE ON APRIL 27, 1995 (R-14-93)

51184. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Definitions.

(a) EPSDT Screening Services means:
(1) An initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17, Sections 6800 et seq.; or
(2) A health assessment, examination, or evaluation of a Medi-Cal eligible individual under 21 years of age by a licensed health care professional acting within his or her scope of practice, at intervals other than those specified in paragraph (a) (1) to determine the existence of physical or mental illnesses or conditions; or
(3) 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 condition for a Medi-Cal eligible person under 21 years of age.

(b) EPSDT diagnosis and treatment services means only those services provided to persons under 21 years of age that:
(1) Are identified in section 1396d(r) of title 42 of the United States Code.
(2) Are available under this chapter without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal Medicaid law other than section 1396d (a) (4) (b) and section 1396a (a) (43) of title 42 of the United States Code, and
(3) Meet the standards and requirements of Sections 51003 and 51303, and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.

(c) EPSDT supplemental services means health care, diagnostic services, treatment, and other measures, that:
(1) Are identified in Section 1396d(r) of Title 42 of the United States Code.
(2) Are available only to persons under 21 years of age.
(3) Meet any one of the standards of medical necessity as set forth in paragraphs (1), (2), or (3) of Section 51340(e) and
(4) Are not EPSDT diagnosis and treatment services.

(d) EPSDT supplemental services include EPSDT case management services when provided by EPSDR case managers described in paragraph (h) (4).
(e) EPSDT diagnosis and treatment provider means any of the providers listed under Session 51051, other than EPSDT supplemental services providers.
(f) EPSDT Supplemental Services Provider means a person enrolled pursuant to Session 51242 to provide EPSDT supplemental services as defined in subsection (c).
(g) EPSDT case management services means services that will assist EPSDT eligible individuals gaining access to needed medical, social, educational, and other services.

(h) EPSDT case manager means:
(1) A targeted case management (TCM) provider under contract with a local governmental agency described in Section 14132.44 of the Welfare and Institutions Code.
(2) Entities and organizations, including Regional Centers, that provide TCM services to persons described in Section 14132.48 of the Welfare and Institutions Code.
(3) A unit within the Department designated by the Director.
(4) A child protection agency, other agency or entity serving children, or an individual provider, that the Department finds qualified by education, training, or experience. and that the Department enrolls pursuant to Section 51242 to provide EPSDT case management services.

(1) For purposes of the EPSDT program, the term "services" is deemed to include supplies, items, or equipment.

51242. EPSDT Diagnosis and Treatment Provider and EPSDT Supplemental Services Provider.

(a) An EPSDT diagnosis and treatment provider shall meet the requirements for participation in the Medi-Cal program as specified in this chapter, excepting the requirements specified in subsection (b).
(b) A provider seeking to provide EPSDT supplemental services, who is not enrolled as a provider pursuant to subsection (a), shall first submit a provider enrollment application to the Department to become an EPSDT supplemental services provider. The application shall be accompanied by a request for prior authorization, pursuant to Section 51340(c) , for the initial service the provider seeks to provide.
(c) An EPSDT case manager, defined in Section 51184 (h) (4), seeking to provide EPSDT case management services shall be considered to be an EPSDT supplemental services provider and shall comply with the requirements of this section.
(d) In order to be approved as an EPSDT supplemental services provider for the particular service sought, the provider shall supply documentation or other evidence which the Department determines establishes that all of the following conditions are met:
(1) The service to be provided meets the standard of medical necessity set forth in Section 51340 (e).
(2) The provider is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts ro provide the service, and meets any applicable requirements in federal Medicaid law to provide the particular service requested.

(e) Notwithstanding the provisions of paragraph (d) (1), and entity or individual seeking to provide EPSDT case management services pursuant to Section 51340 (j) (3) shall supply documentation enacting the Department to determine that both of the following requirements are met:

(1) The criteria specified in Section 51340 (f) are met.
(2) The entity or individual is qualified by education, training, or experience to provide EPSDT case management services to the beneficiary.

(f) The Department shall not approve an application pursuant to subsection (b) or (c) of this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner through existing Medi-Cal certified provider types or other Medi-Cal programs.
(g) Once enrolled as an EPSDT supplemental services provider, the provider shall remain enrolled only for the purpose of providing subsequent EPSDT supplemental services within his or her scope of practice, unless disenrolled.
(h) A provider who is currently enrolled as a Medi-Cal services provider shall not be required to enroll as an EPSDT supplemental services provider.

51304. Benefit Limitations

(a) Program coverage of services specified in Sections 51308, 51308.5, 51309, 51310, 51312, and 51331(a) (3) through (9), unless noted otherwise, is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.
(b) For purposed of this section, "services" means al care, treatment, or procedures provided a beneficiary by an individual practitioner on one occasion.

51340. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services.

(a) EPSDT screening services as defined in Section 51184 (a) (1) are a program benefit when provided through the Child Health and Disability Prevention program in accordance with Title 17, California Code of Regulations, Sections 6800 et seq. EPSDT screening services as defined in Sections 51184 (a) (2) and (a) (3) are covered when provided by a certified Medi-Cal provider meeting the requirements of this chapter, if such services are otherwise reimbursable under the program.
(b) EPSDT diagnosis and treatment services as defined in Section 51184 (b) are covered subject to the provisions of this chapter.
(c) EPSDT supplemental services are covered subject to prior authorization if the requirements of subsections (e) or (f), as appropriate, are met. The Department shall review requests for services resulting form EPSDT screening services for compliance with this section whether the screen was performed by a Medi-Cal provider for a non-Medi-Cal provider.
(d) Requests for prior authorization for EPSDT supplemental services pursuant to subsection (c) shall state explicitly that the request is for EPSDT supplemental services, and shall be accompanied by the following information:
(1) The principal diagnosis and significant associated diagnosis.
(2) Prognosis.
(3) Date of onset of the illness or condition, and etiology if known
(4) Clinical significance or functional impairment caused by the illness or conditions.
(5) Specific types of services to be rendered by each discipline with physicians's prescription where applicable.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
(7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care.
(8) Any other documentation available which may assist the Department in making the determinations required by this section.

(e) EPSDT supplemental services must meet one of the following standards, as determined by the Department:
(1) The standards and requirements set forth in Sections 51003 and 51303, and any specific requirements applicable to a specific service that based on the standards and requirements of those sections other than the services-specific requirements set forth in Sections 51340.1.
(2) The service-specific requirements applicable to EPSDT Supplemental Services set forth in Section 51340.1.
(3) When the standards set forth in paragraph (e) (1) or (e) (2) are not applicable to the services being requested, all of the following criteria, where applicable.

(A) The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services as defined in subsection (a) of this section.
(B) The supplies, items, or equipment to be provided are medical in nature.
(C) The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of services.
(D) The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental.
(E) The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.
(F) Where alternative medically accepted modes of treatment are available, the services are the most cost effective.
(G) The services to be provided:
(1) Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.
(2) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment of the health condition of the beneficiary.

(H) The predicted beneficial outcome of the services outweighs potential harmful effects

(I) Available scientific evidence, as described in paragraph (e)(g)1., demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

(f) (1) Notwithstanding subsection (e), EPSDT case management services as specified in paragraph (j) (3) may be covered for the EPSDT-eligible beneficiary when accompanied by the information described in subsection (d) of the Department determines that both of the following criteria are met:
(A) The service to which access is to be gained through case management is medically necessary for the EPSDT-eligible beneficiary. For purposes of this subsection, medical necessity is established if the service meets the criteria set forth in subsection (e) (1), (e) (2), or (e) (3).
(B) The EPSDT-eligible beneficiary has a medical or mental health condition or diagnosis.

(2) Requests for EPSDT case management services shall not be approved if the Department determines that EPSDT case management services appropriate to the EPSDT-eligible beneficiary's needs can reasonable be obtained through the use of family, agency, or institutional assistance that is typically used by the general public in assuring that children obtain necessary medical, social, education, or other services. In making the determination described in this paragraph, the Department may take into account the following factors:

(A) Whether or not the beneficiary has a complicated medical condition, including a history of multiple or complex medical or mental health diagnosis, frequent recent hospitalization, use of emergency rooms, or other indicators of medical or mental health conditions resulting in significant impairment.
(B) Whether or not the beneficiary has a history of one or more environmental risk factors, including:
(1) parent, guardian, or primary care giver mental retardation or mental illness, physical or sensory disability, substance abuse under age 18 years, prolonged absence, or
(2) other environmental stressors, which may result in neglect, abuse, lack of stable housing, or otherwise compromise the parent's guardian's, or primary caregiver's ability to assist the beneficiary in gaining access to the necessary medical, social educational, and other services.

(g) If reimbursement is being sought on a "by report" basis, a description of the services, the proposed unit of service, and the request dollar amount shall be included with the request for authorization, A "by report" service or item is any service for which a maximum allowance has not been established because the item is rarely billed to Med-Cal program or because the service is unusual variable or new.

(h) EPSDT supplemental services requested as a result of EPSDT screening services are exempt form the benefit limitations in Section 51304, and may be covered subject to prior authorization as defined in Section 51003 if the requirements of subsection (e) of this section are met.

(i) Regardless of the source of the referral for the service, requests for EPSDT diagnostic and treatment services and EPSDT supplemental services pursuant to the requirements of this chapter shall be reviewed pursuant to this section.

(j) (1) Requests for EPSDT case management services shall not be authorized where the Department has determined that appropriate case management services may be obtained through a targeted case management (TCM) provider under contract with a participating local governmental agency that has elected to provide case management services pursuant to Section 14132.44 of the Welfare and Instructions Code, or where TCM services are available pursuant to Section 14132.48 of the Welfare and Instructions Code.

(2) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j) (1), requests for EPSDT case management services may be referred to the unit within the Department designated by the Director.

(3) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j) (1) or (j) (2), the Department may authorize EPSDT case management services through an EPSDT case manager described in Section 51184-(h) (4).

(k) For members of Medi-Cal managed care plans, the Medi-Cal managed care plan shall determine whether EPSDT case management services are medically necessary based on subsection (f). If the plan determines EPSDT case management services are medically necessary, the plan shall refer the members to an appropriate EPSDT case manager described in paragraph (h) (1) or (h) (2) of Section 51184. Services shall first be sought pursuant to paragraph (j) (1). If services are not available pursuant to paragraph (j) (1), the plan shall provide, or arrange and pay for, the EPSDT case management services. For purposes of this subsection, Medi-Cal managed care plan means any entity that has entered into a contract with the Department to provide, or arrange for, comprehensive health care to enrolled Medi-Cal beneficiaries pursuant to Chapter 8 or Articles 2.7, 2.8, 2.9, and 2.91 of Chapter 7 of Part 3, Division 9, of the Welfare and Institutions Code.

(l) The Department shall not approve an EPSDT supplemental service pursuant to this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner as an EPSDT diagnostic and treatment service.

(m) The Department shall not approve a request for EPSDT diagnostic and treatment services or EPSDT supplemental services in home and community-based settings if the Department determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total costs incurred by the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

51340.1 Requirements Applicable to EPSDT Supplemental Services

When service-specific criteria and other requirements set forth in this section are applicable to a particular EPSDT Supplemental Service, the request for service shall be approved only when such criteria and requirements are met. Requests for all other EPSDT Supplemental Services shall be approved only when the requirements set forth in Section 51340 (e) (1) or (e) (3) are met.

(a) Dental Services

(1) Dental services, other than orthodontic services

Requests for dental services, as EPSDT Supplemental Services. including but not limited to services necessary for the relief of pain and infections, restoration of teeth or maintenance of dental health. shall be evaluated under Section 51340 (e)(1) or (e)(3) as applicable.

(2) Orthodontic services

Orthodontic services are covered only:

(A) When medically necessary pursuant to the criteria set forth in the Medi-Cal "Manual of Criteria for Medi-Cal Authorization, " Chapter 8.1. as incorporated by reference in Section 51003(e), or
(B) When medically necessary for the relief of pain and infections, restoration of teeth maintenance of dental health, or the treatment of other conditions of defects, pursuant to the criteria set forth in Section 51340 (e) (1) or (e) (3). as applicable.

(b) Hearing Service

(1) Requests for hearing services, as EPSDT Supplemental Services, including but not limited to services necessary for the diagnosis and treatment for defects in hearing, including hearing aids, shall be evaluated under Section 51340 (e)(1) or (e) (3), as possible
(2) When a hearing aid is approved under the standards of Section 51340 (e) (3), one package of six hearing aid batteries, size 675, 13, 312 or 10A, may be furnished on a quarterly basis without prior authorization. Batteries in sizes other than those listed, and hearing aid batteries provided at more frequent intervals, shall be subject to prior authorization.

51532. Early and Periodic Screening. Diagnosis. and Treatment (EPSDT) Services.

(a) Reimbursement for early and periodic screening services under the Child Health and Disability Prevention program shall be make in accordance with the provisions of the Title 17, California Code of Regulations. Sections 6800 et seq.
(b) EPSDT screening services not provided through CHDP providers shall be reimbursed up to the maximum allowance for services set forth in this article.
(c) EPSDT diagnosis and treatment services, and services authorized as EPSDT Supplemental Services in excess of the maximum number of services specified in Section 51304, shall be reimbursed up to the maximum allowance for services set forth in this article. Reimbursement for EPSDT supplemental services not set forth in this article shall be based upon a review of such services to determine their relationship to other services for which maximum allowances are set forth.
(d) Reimbursement for EPSDT case management services provided by entities or individuals serving EPSDT-eligible beneficiaries pursuant to Section 51340 (j)(3) shall not duplicate reimbursement provided under other publicly funded programs.
(e) Reimbursement for EPSDT case management services provided pursuant to Section 51340 (k) shall be in accordance with the provisions of the contracts between the Department and the Medi-Cal managed care plan.

Consumer Notices/Grievances

8

Introduction

All beneficiaries/consumers of RCDMH services shall have the right to file a grievance. A beneficiary/consumer grievance process and a Medi-Cal beneficiary appeal process provide mental health beneficiaries or their representatives and other consumers of mental health services, with a method for resolving their concerns. Throughout the grievance and appeal processes, beneficiaries/consumers will be informed of their rights and of the steps available to them to exercise those rights.

Beneficiary Informing Materials

The RCMHP contract providers will provide beneficiaries with a copy of the informing materials upon request, when the beneficiary initially accesses services, and annually thereafter as long as they remain in treatment. The informing materials contain a description of services available, the process for obtaining the services, beneficiary rights, the right to request a change of providers, confidentiality rights, advance directive information, a list of network providers and a description of the beneficiary problem resolution process. The information provided will include both the grievance and appeals processes and will state that a Medi-Cal beneficiary may request a State Fair Hearing after they have completed the problem resolution process.

The Grievance Procedure and Appeal Procedure pamphlets and forms will be readily accessible and visibly posted in prominent locations in beneficiary and staff areas, including beneficiary waiting areas. Self addressed envelopes for mailing grievances and/or appeals to Outpatient QI will be located next to the descriptions of the Grievance Procedure and the Appeal Procedure. The grievance, appeals, and self-addressed envelopes must be available to the beneficiary and/or beneficiary representative without the beneficiary and/or beneficiary representative having to make a verbal or written request to anyone.

A notice will be conspicuously displayed in all mental health facilities advising beneficiaries to contact the contract provider, contract provider management, clinician, clinic supervisor, program manager, Patient Rights Advocate, CARES, or Outpatient QI if they wish to register a grievance and/or appeal. Grievance and/or appeal information will be available through the CARES's 24-hour statewide toll free number, (800) 706-7500, as well as through the Outpatient QI Grievance Line, (800) 660-3570.

The beneficiary may authorize another person to act on his/her behalf. For example, the beneficiary may ask the service provider, a friend, a family member, legal representative, or Patients' Rights staff. At the beneficiary's request, that person may act on the beneficiary's behalf in the use of the complaint grievance/appeal process.

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

Grievance Process

A beneficiary or beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider, the CARES, or Outpatient QI. An example of a grievance might be as follows: the quality of care of services provided, aspects of interpersonal relationships such as rudeness of an employee, etc.

When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log (Attachment #22) within one (1) working day and immediately fax a copy of the grievance to Outpatient QI at (951) 358-7710. Although a beneficiary is not required to complete a grievance form, it will be necessary for the provider to write pertinent information on the form to fax to Outpatient QI. Outpatient QI will also register the grievance in their grievance log within one (1) working day.

When the beneficiary/consumer mails a grievance form directly to Outpatient QI, the program will register the receipt of the grievance in the grievance log within one (1) working day.

The grievance log will indicate: (a) the name of the beneficiary/consumer, (b) the date of the receipt of the grievance, (c) the nature of the problem, and (d) final disposition of the grievance, including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance.

A letter acknowledging the receipt of the grievance will be sent by Outpatient QI to the beneficiary/consumer within ten (10) working days. Beneficiaries/beneficiary representatives can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

Every effort to provide for resolution of the beneficiary's/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary/consumer, or the beneficiary's representative and the therapist, case manager, program supervisor, or other persons involved in the matter at hand. If the contract provider reaches resolution of the beneficiary's grievance, the contract provider will notify Outpatient QI of the resolution. Outpatient QI will review and approve the resolution.

The contract provider and/or Outpatient QI will insure that the person reviewing a grievance, also known as the decision-maker, will not have been involved in any previous level of review or decision making with a grievance.

The beneficiary/representative/consumer will be sent a written decision on the grievance within sixty (60) calendar days of receipt of the grievance by Outpatient QI. Outpatient QI will also send a written notification to those contract providers cited by the beneficiary/consumer or otherwise involved in the grievance regarding the final disposition of the beneficiary's grievance.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary/representative/consumer requests an extension, or if Outpatient QI on behalf of the MHP determines that there is a need for additional information and that the delay is in the beneficiary's/consumer's interest. Outpatient QI will send a written notification to the

beneficiary/representative/consumer and the contract provider when an extension has occurred. The written notification will explain the reason for the extension.

A Notice of Action (NOA) letter will be sent to the Medi-Cal beneficiary/beneficiary's representative advising them of their right to request a State Fair Hearing if they are not notified of the grievance decision within sixty (60) calendar days.

Outpatient QI and the contract provider will record the final disposition of the grievance in their grievance log. The record will include the date the decision was sent to the beneficiary or document the reason(s) that there has not been a final disposition of the grievance.

If a beneficiary/beneficiary representative or consumer is dissatisfied with the grievance decision, the beneficiary/beneficiary representative or consumer may be referred to Outpatient QI for further review.

Appeal Procedures

Non-expedited Appeal – Medi-Cal Beneficiaries:

An appeal may be filed, orally or in writing, with the contract provider, contract management, the CARES or Outpatient QI. An appeal is a request for a review of an action by the authorization unit (CARES). An action is defined as the modification or denial of a requested service from a beneficiary and/or a reduction, suspension, or termination of a previously authorized service. An oral appeal must be followed up with a written, signed appeal. Medi-Cal beneficiaries may file for a State Fair Hearing after they have completed the problem resolution process. Forms and self-addressed envelopes will be available at all county-operated or contracted mental health facilities. Beneficiaries/beneficiary representatives can request assistance with the appeal process or obtain information on the status of a pending appeal by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

The beneficiary/beneficiary's representative may begin the appeal process, orally or by completing an appeal request form and a release of information form, when applicable. Oral appeals must be followed up with written, signed appeal and a release of information form, when applicable. Self-addressed envelopes addressed to Outpatient QI will be available for beneficiary/beneficiary's representative to use to submit their appeal request.

The appeal form should indicate if the beneficiary is in any Medi-Cal funded residential treatment program. The Expedited Appeals block should be checked on the appeal form when taking the time for a "standard" appeal decision could jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. If the Expedited Appeals block is checked on the appeal form, the appeal will be processed within the Expedited Appeal guidelines.

The beneficiary/beneficiary's representative will be given a reasonable opportunity to present evidence and allegations of fact or law in regard to the appeal requested in person or in writing to Outpatient QI.

The beneficiary/beneficiary's representative will also be given a reasonable opportunity, when requested, to examine the beneficiary's case file, including medical records and any other documents or records considered applicable to the appeal process.

Outpatient QI will receive and process all appeal requests. Contract providers will fax the appeal to Outpatient QI upon receipt of the appeal. The appeal will be processed as follows:

- Outpatient QI will enter the appeal into the Appeal Log within one (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary/beneficiary's representative, or documentation of the reason(s) that there has not been a final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been a final disposition of the grievance.
- A letter acknowledging the receipt of the appeal will be sent to the beneficiary within ten (10) working days. The letter will also inform a Medi-Cal beneficiary of his/her right to request a State Fair Hearing after they have completed the problem resolution process. Outpatient QI will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

Outpatient QI will notify the involved inpatient facility or contract provider of the pending appeal. A decision about the appeal may be reached through discussions between the beneficiary, or the beneficiary's representative and the RCDMH program, contract providers, or other persons involved in the matter at hand.

Outpatient QI will insure that the person reviewing an appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the appeal.

Outpatient QI will be responsible for notifying the beneficiary/beneficiary's representative of the decision in writing within forty-five (45) calendar days of the receipt of the appeal. The notice will contain the following:

- The results of the appeal resolution process.
- The date that the appeal decision was made.
- If the appeal is not resolved wholly in favor of the Medi-Cal beneficiary, the notice will also contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing for a State Fair Hearing. The notice will also inform the Medi-Cal beneficiary of their right to request and receive benefits while the State Fair Hearing is pending and the procedure for making the request.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary request an extension and Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will also send a written notification to the beneficiary and/or the beneficiary's representative and all other affected parties when an extension has occurred. The written notification will explain the reason for the extension.

If the Medi-Cal beneficiary/beneficiary's representative and/or provider are not notified of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension form

the Medi-Cal beneficiary, a Notice of Action form will be sent to the Medi-Cal beneficiary/beneficiary's representative advising them of their right to request a State Fair Hearing. The Notice of Action letter will be sent on the date that the 45-calendar day period expires.

Outpatient QI will record the final disposition of the appeal, including the date the decision was sent to the beneficiary/beneficiary's representative, or document the reason(s) that there has not been a final disposition of the appeal in the Appeal Log. Notification efforts will be documented in the log if the beneficiary/beneficiary's representative cannot be contacted orally or in writing.

Outpatient QI will notify those providers cited by the beneficiary/beneficiary's representative or otherwise involved in the appeal of the final disposition of the beneficiary's appeal.

Expedited Appeal: Medi-Cal Beneficiary

An appeal will be handled in an expedited manner when Outpatient QI determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

The beneficiary's mental health specialty services will continue until there is a response to the expedited appeal from Outpatient QI, unless the beneficiary poses a threat to the safety of other beneficiaries receiving services in a residential or outpatient facility. Expedited appeals received by RCDMH program or contract provider will be faxed to Outpatient QI.

A beneficiary/beneficiary's representative will be allowed to file the request for an expedited appeal orally, without a written follow-up, or by using the Appeal form and checking the "expedited appeal" box on the form.

Outpatient QI will register the receipt of the expedited appeal in the Appeal Log within one (1) working day of receipt and indicate that the appeal is an expedited appeal request.

When Outpatient QI receives the expedited appeal from the beneficiary/beneficiary's representative, Outpatient QI will have three (3) working days from receipt to review the expedited appeal and to seek resolution with the beneficiary/beneficiary's representative either in person or by telephone, Outpatient QI will insure that the person reviewing the expedited appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the expedited appeal.

By the end of the third (3) working day, a written notification summarizing the discussion and the proposed resolution of the expedited appeal shall be given to the beneficiary/beneficiary's representative. The letter will contain the following:

- The results of the expedited appeal resolution process.
- The date that the expedited appeal decision was made.
- If the expedited appeal is not resolved wholly in favor of the Medi-Cal beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

- The availability of assistance to complete the form for a State Fair Hearing will be given to any Medi-Cal beneficiary/beneficiary's representative who wishes to appeal the expedited appeal decisions.

Timeframes may be extended up to fourteen (14) calendar days if the beneficiary request an extension or Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will send written notification to the beneficiary/beneficiary's representative and all other affected parties when either party has requested an extension. The written notification will explain the reason for the extension.

If Outpatient QI denies a request for an expedited resolution of an appeal, Outpatient QI will: (a) transfer the appeal to the timeframe for a standard appeal resolution and (b) make a reasonable effort to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process and follow up within two (2) calendar days with a written notice.

Grievances Regarding CARES or ACT

When a complaint is received from the Department of Social Services (DPSS) against a contract provider of the MHP and/or an employee of the Department of Mental Health (DMH), the complaint will be logged by the recipient of the complaint and processed in accordance with the grievance procedure.

When a complaint is received from a beneficiary/beneficiary's representative about an employee of the CARES and/or the ACT the beneficiary/beneficiary's representative will be encouraged to call the supervisor of that employee. The beneficiary/beneficiary's representative will be asked if they would like to file a grievance. All complaints/grievances will be processed in accordance with the grievance procedure.

If a beneficiary/beneficiary's representative is dissatisfied with the grievance decision the beneficiary/ beneficiary's representative may be referred to QI for further review.

Outpatient Quality Improvement (Outpt QI) – Grievance Process and Appeal Process Review:

QI will have a process in place to monitor the grievance process and appeal process to identify and address systemic problems or weaknesses. QI will forward a summary of the issues identified in the grievance or appeal processes to the QI Committee (QIC) and to RCDMH management for review and, if applicable, implementation of needed system changes.

State Fair Hearing:

State and Federal law guarantees Medi-Cal beneficiaries a right to a State Fair Hearing after they have completed the problem resolution process. Beneficiaries are to be notified, orally if possible, and in writing when services are being denied, terminated, or reduced. The Notice of Action (NOA) will inform Medi-Cal beneficiaries of their right to request State a Fair Hearing within ninety (90) calendar days of the date of the notice. In addition, if the beneficiary requests a State Fair

Hearing within ten (10) days of the date of the notice, the beneficiary is entitled to continue to receive services until the Fair Hearing decision is made under the Aid Paid Pending clause when:

The CARES reduces or terminates services, and
The beneficiary is currently receiving services.

The request for a State Fair Hearing is completed by the Medi-Cal beneficiary and mailed directly to the Administrative Adjudications Division in Sacramento. Hearings are held within thirty (30) days of the request, and involved parties are notified ten (10) days prior to the hearing. The Department will prepare a position paper concerning the issues, which must be given to the beneficiary/beneficiary's representative at least two (2) days prior to the hearing.

Notice of Denial, Termination, or Reduction of Services:

The provider shall fully inform beneficiaries orally and in language accessible to them of any proposed denial, termination, or reduction in their mental health treatment or service. Any written communication with a beneficiary regarding a denial, termination, or reduction of services will be written in clear, concise language, in a format understandable to the beneficiary/consumer.

Written notice shall be provided at the time of the change of service when a change in the level of mental health services is prescribed by the beneficiary's/consumers' treating professional (See Definitions Section for "denial," "termination," "reduction in services," and "notice of action").

The provider shall specify the service(s) to be denied, terminated, or reduced, the reasons therefore and the date of action. Reasons given may include:

The beneficiary/consumer no longer meets the medical necessity requirements for eligibility for a specific mental health service.
The beneficiary/consumer has obtained maximum therapeutic benefit and mental health services are no longer indicated.

The beneficiary/consumer has willfully and persistently failed to comply with the agreed-upon and prescribed treatment plan.

The program does not provide the services the patient requests.

The provider shall make all appropriate efforts to assist beneficiaries in preparing for the action, including, but not limited to, pointing out alternative resources and/or support such as self-help groups and free community services.

Enforcement:

Mental health providers must abide by the decisions of the QIC and/or State Fair Hearing regarding treatment services provided to their beneficiaries.

The Mental Health Director is responsible for assuring that the QIC recommendation or the State Fair Hearing decision is followed. Failure to implement the recommendation or decision could

result in disciplinary action, fines or revocation of contract as imposed by the Mental Health Director.

Confidentiality:

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/consumer records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone not specifically authorized by law to have access.

Definitions

Reduction in Service: Any reduction in the mode or method of services, including but not limited to a reduction in the frequency or duration or in accessibility of location of provider.

Beneficiary/Consumer Assistant: A person appointed by each provider of mental health services located at the provider site whose function it is to assist beneficiaries with the grievance procedure. The beneficiary/consumer assistant may be an employee of the provider and may have other responsibilities in addition to assisting beneficiaries.

Denial of Service: A refusal on the part of the provider, provider staff, or managed care system to deliver the type, mode or method of mental health treatment or services requested by the applicant of a requested service, beneficiary/consumer, or of a person lawfully entitled to consent for treatment on the beneficiary's/consumers' or consumer representative's behalf.

State Fair Hearing: The formal hearing described in "Beneficiary/Consumer Notices," Section 431.200 et seq. of the federal Regulations and Section 10950 et seq. of the Welfare and Institutions Code.

Mental Health Director: The County-designated Mental Health Director or the County-designated Regional Program Manager providing the managed care service for a county.

Notice of Action: Formal written and whenever possible oral notification to the beneficiary/consumer of any denial, change or termination of treatment or services. The notice should specify the proposed action and reasons therefore, effective dates of the action and grievance procedures available.

Patients' Rights: The persons designated in the Welfare and Institutions Code Section 5500 et seq. to protect the rights of all recipients of mental health services.

Termination of Service: The cessation or suspension of any mode or method of treatment of services the beneficiary/consumer has been receiving due to a decision made by the mental health care provider and/or managed care system.

GRIEVANCE LOG

Date Received	Beneficiary Name	Complainant Name	Description of Complaint	Agreed Resolution Deadline	Resolution Date	How Resolved

Consumer Notices/Grievances

Introduction

All beneficiaries/consumers of RCDMH services shall have the right to file a grievance. A beneficiary/consumer grievance process and a Medi-Cal beneficiary appeal process provide mental health beneficiaries or their representatives and other consumers of mental health services, with a method for resolving their concerns. Throughout the grievance and appeal processes, beneficiaries/consumers will be informed of their rights and of the steps available to them to exercise those rights.

Beneficiary Informing Materials

The RCMHP contract providers will provide beneficiaries with a copy of the informing materials upon request, when the beneficiary initially accesses services, and annually thereafter as long as they remain in treatment. The informing materials contain a description of services available, the process for obtaining the services, beneficiary rights, the right to request a change of providers, confidentiality rights, advance directive information, a list of network providers and a description of the beneficiary problem resolution process. The information provided will include both the grievance and appeals processes and will state that a Medi-Cal beneficiary may request a State Fair Hearing after they have completed the problem resolution process.

The Grievance Procedure and Appeal Procedure pamphlets and forms will be readily accessible and visibly posted in prominent locations in beneficiary and staff areas, including beneficiary waiting areas. Self addressed envelopes for mailing grievances and/or appeals to Outpatient QI will be located next to the descriptions of the Grievance Procedure and the Appeal Procedure. The grievance, appeals, and self-addressed envelopes must be available to the beneficiary and/or beneficiary representative without the beneficiary and/or beneficiary representative having to make a verbal or written request to anyone.

A notice will be conspicuously displayed in all mental health facilities advising beneficiaries to contact the contract provider, contract provider management, clinician, clinic supervisor, program manager, Patient Rights Advocate, CARES, or Outpatient QI if they wish to register a grievance and/or appeal. Grievance and/or appeal information will be available through the CARES's 24-hour statewide toll free number, (800) 706-7500, as well as through the Outpatient QI Grievance Line, (800) 660-3570.

The beneficiary may authorize another person to act on his/her behalf. For example, the beneficiary may ask the service provider, a friend, a family member, legal representative, or Patients' Rights staff. At the beneficiary's request, that person may act on the beneficiary's behalf in the use of the complaint grievance/appeal process.

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

Grievance Process

A beneficiary or beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider, the CARES, or Outpatient QI. An example of a grievance might be as follows: the quality of care of services provided, aspects of interpersonal relationships such as rudeness of an employee, etc.

When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log (Attachment #22) within one (1) working day and immediately fax a copy of the grievance to Outpatient QI at (951) 358-7710. Although a beneficiary is not required to complete a grievance form, it will be necessary for the provider to write pertinent information on the form to fax to Outpatient QI. Outpatient QI will also register the grievance in their grievance log within one (1) working day.

When the beneficiary/consumer mails a grievance form directly to Outpatient QI, the program will register the receipt of the grievance in the grievance log within one (1) working day.

The grievance log will indicate: (a) the name of the beneficiary/consumer, (b) the date of the receipt of the grievance, (c) the nature of the problem, and (d) final disposition of the grievance, including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance.

A letter acknowledging the receipt of the grievance will be sent by Outpatient QI to the beneficiary/consumer within ten (10) working days. Beneficiaries/beneficiary representatives can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

Every effort to provide for resolution of the beneficiary's/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary/consumer, or the beneficiary's representative and the therapist, case manager, program supervisor, or other persons involved in the matter at hand. If the contract provider reaches resolution of the beneficiary's grievance, the contract provider will notify Outpatient QI of the resolution. Outpatient QI will review and approve the resolution.

The contract provider and/or Outpatient QI will insure that the person reviewing a grievance, also known as the decision-maker, will not have been involved in any previous level of review or decision making with a grievance.

The beneficiary/representative/consumer will be sent a written decision on the grievance within sixty (60) calendar days of receipt of the grievance by Outpatient QI. Outpatient QI will also send a written notification to those contract providers cited by the beneficiary/consumer or otherwise involved in the grievance regarding the final disposition of the beneficiary's grievance.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary/representative/consumer requests an extension, or if Outpatient QI on behalf of the MHP determines that there is a need for additional information and that the delay is in the beneficiary's/consumer's interest. Outpatient QI will send a written notification to the

beneficiary/representative/consumer and the contract provider when an extension has occurred. The written notification will explain the reason for the extension.

A Notice of Action (NOA) letter will be sent to the Medi-Cal beneficiary/beneficiary's representative advising them of their right to request a State Fair Hearing if they are not notified of the grievance decision within sixty (60) calendar days.

Outpatient QI and the contract provider will record the final disposition of the grievance in their grievance log. The record will include the date the decision was sent to the beneficiary or document the reason(s) that there has not been a final disposition of the grievance.

If a beneficiary/beneficiary representative or consumer is dissatisfied with the grievance decision, the beneficiary/beneficiary representative or consumer may be referred to Outpatient QI for further review.

Appeal Procedures

Non-expedited Appeal – Medi-Cal Beneficiaries:

An appeal may be filed, orally or in writing, with the contract provider, contract management, the CARES or Outpatient QI. An appeal is a request for a review of an action by the authorization unit (CARES). An action is defined as the modification or denial of a requested service from a beneficiary and/or a reduction, suspension, or termination of a previously authorized service. An oral appeal must be followed up with a written, signed appeal. Medi-Cal beneficiaries may file for a State Fair Hearing after they have completed the problem resolution process. Forms and self-addressed envelopes will be available at all county-operated or contracted mental health facilities. Beneficiaries/beneficiary representatives can request assistance with the appeal process or obtain information on the status of a pending appeal by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

The beneficiary/beneficiary's representative may begin the appeal process, orally or by completing an appeal request form and a release of information form, when applicable. Oral appeals must be followed up with written, signed appeal and a release of information form, when applicable. Self-addressed envelopes addressed to Outpatient QI will be available for beneficiary/beneficiary's representative to use to submit their appeal request.

The appeal form should indicate if the beneficiary is in any Medi-Cal funded residential treatment program. The Expedited Appeals block should be checked on the appeal form when taking the time for a "standard" appeal decision could jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. If the Expedited Appeals block is checked on the appeal form, the appeal will be processed within the Expedited Appeal guidelines.

The beneficiary/beneficiary's representative will be given a reasonable opportunity to present evidence and allegations of fact or law in regard to the appeal requested in person or in writing to Outpatient QI.

The beneficiary/beneficiary's representative will also be given a reasonable opportunity, when requested, to examine the beneficiary's case file, including medical records and any other documents or records considered applicable to the appeal process.

Outpatient QI will receive and process all appeal requests. Contract providers will fax the appeal to Outpatient QI upon receipt of the appeal. The appeal will be processed as follows:

- Outpatient QI will enter the appeal into the Appeal Log within one (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary/beneficiary's representative, or documentation of the reason(s) that there has not been a final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been a final disposition of the grievance.
- A letter acknowledging the receipt of the appeal will be sent to the beneficiary within ten (10) working days. The letter will also inform a Medi-Cal beneficiary of his/her right to request a State Fair Hearing after they have completed the problem resolution process. Outpatient QI will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

Outpatient QI will notify the involved inpatient facility or contract provider of the pending appeal. A decision about the appeal may be reached through discussions between the beneficiary, or the beneficiary's representative and the RCDMH program, contract providers, or other persons involved in the matter at hand.

Outpatient QI will insure that the person reviewing an appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the appeal.

Outpatient QI will be responsible for notifying the beneficiary/beneficiary's representative of the decision in writing within forty-five (45) calendar days of the receipt of the appeal. The notice will contain the following:

- The results of the appeal resolution process.
- The date that the appeal decision was made.
- If the appeal is not resolved wholly in favor of the Medi-Cal beneficiary, the notice will also contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing for a State Fair Hearing. The notice will also inform the Medi-Cal beneficiary of their right to request and receive benefits while the State Fair Hearing is pending and the procedure for making the request.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary request an extension and Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will also send a written notification to the beneficiary and/or the beneficiary's representative and all other affected parties when an extension has occurred. The written notification will explain the reason for the extension.

If the Medi-Cal beneficiary/beneficiary's representative and/or provider are not notified of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension form

the Medi-Cal beneficiary, a Notice of Action form will be sent to the Medi-Cal beneficiary/beneficiary's representative advising them of their right to request a Sate Fair Hearing. The Notice of Action letter will be sent on the date that the 45-calendar day period expires.

Outpatient QI will record the final disposition of the appeal, including the date the decision was sent to the beneficiary/beneficiary's representative, or document the reason(s) that there has not been a final disposition of the appeal in the Appeal Log. Notification efforts will be documented in the log if the beneficiary/beneficiary's representative cannot be contacted orally or in writing.

Outpatient QI will notify those providers cited by the beneficiary/beneficiary's representative or otherwise involved in the appeal of the final disposition of the beneficiary's appeal.

Expedited Appeal: Medi-Cal Beneficiary

An appeal will be handled in an expedited manner when Outpatient QI determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

The beneficiary's mental health specialty services will continue until there is a response to the expedited appeal from Outpatient QI, unless the beneficiary poses a threat to the safety of other beneficiaries receiving services in a residential or outpatient facility. Expedited appeals received by RCDMH program or contract provider will be faxed to Outpatient QI.

A beneficiary/beneficiary's representative will be allowed to file the request for an expedited appeal orally, without a written follow-up, or by using the Appeal form and checking the "expedited appeal" box on the form.

Outpatient QI will register the receipt of the expedited appeal in the Appeal Log within one (1) working day of receipt and indicate that the appeal is an expedited appeal request.

When Outpatient QI receives the expedited appeal from the beneficiary/beneficiary's representative, Outpatient QI will have three (3) working days from receipt to review the expedited appeal and to seek resolution with the beneficiary/beneficiary's representative either in person or by telephone. Outpatient QI will insure that the person reviewing the expedited appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the expedited appeal.

By the end of the third (3) working day, a written notification summarizing the discussion and the proposed resolution of the expedited appeal shall be given to the beneficiary/beneficiary's representative. The letter will contain the following:

- The results of the expedited appeal resolution process.
- The date that the expedited appeal decision was made.
- If the expedited appeal is not resolved wholly in favor of the Medi-Cal beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

- The availability of assistance to complete the form for a State Fair Hearing will be given to any Medi-Cal beneficiary/beneficiary's representative who wishes to appeal the expedited appeal decisions.

Timeframes may be extended up to fourteen (14) calendar days if the beneficiary request an extension or Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will send written notification to the beneficiary/beneficiary's representative and all other affected parties when either party has requested an extension. The written notification will explain the reason for the extension.

If Outpatient QI denies a request for an expedited resolution of an appeal, Outpatient QI will: (a) transfer the appeal to the timeframe for a standard appeal resolution and (b) make a reasonable effort to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process and follow up within two (2) calendar days with a written notice.

Grievances Regarding CARES or ACT

When a complaint is received from the Department of Social Services (DPSS) against a contract provider of the MHP and/or an employee of the Department of Mental Health (DMH), the complaint will be logged by the recipient of the complaint and processed in accordance with the grievance procedure.

When a complaint is received from a beneficiary/beneficiary's representative about an employee of the CARES and/or the ACT the beneficiary/beneficiary's representative will be encouraged to call the supervisor of that employee. The beneficiary/beneficiary's representative will be asked if they would like to file a grievance. All complaints/grievances will be processed in accordance with the grievance procedure.

If a beneficiary/beneficiary's representative is dissatisfied with the grievance decision the beneficiary/ beneficiary's representative may be referred to QI for further review.

Outpatient Quality Improvement (Outpt QI) – Grievance Process and Appeal Process Review:

QI will have a process in place to monitor the grievance process and appeal process to identify and address systemic problems or weaknesses. QI will forward a summary of the issues identified in the grievance or appeal processes to the QI Committee (QIC) and to RCDMH management for review and, if applicable, implementation of needed system changes.

State Fair Hearing:

State and Federal law guarantees Medi-Cal beneficiaries a right to a State Fair Hearing after they have completed the problem resolution process. Beneficiaries are to be notified, orally if possible, and in writing when services are being denied, terminated, or reduced. The Notice of Action (NOA) will inform Medi-Cal beneficiaries of their right to request State a Fair Hearing within ninety (90) calendar days of the date of the notice. In addition, if the beneficiary requests a State Fair

Hearing within ten (10) days of the date of the notice, the beneficiary is entitled to continue to receive services until the Fair Hearing decision is made under the Aid Paid Pending clause when:

The CARES reduces or terminates services, and
The beneficiary is currently receiving services.

The request for a State Fair Hearing is completed by the Medi-Cal beneficiary and mailed directly to the Administrative Adjudications Division in Sacramento. Hearings are held within thirty (30) days of the request, and involved parties are notified ten (10) days prior to the hearing. The Department will prepare a position paper concerning the issues, which must be given to the beneficiary/beneficiary's representative at least two (2) days prior to the hearing.

Notice of Denial, Termination, or Reduction of Services:

The provider shall fully inform beneficiaries orally and in language accessible to them of any proposed denial, termination, or reduction in their mental health treatment or service. Any written communication with a beneficiary regarding a denial, termination, or reduction of services will be written in clear, concise language, in a format understandable to the beneficiary/consumer.

Written notice shall be provided at the time of the change of service when a change in the level of mental health services is prescribed by the beneficiary's/consumers' treating professional (See Definitions Section for "denial," "termination," "reduction in services," and "notice of action").

The provider shall specify the service(s) to be denied, terminated, or reduced, the reasons therefore and the date of action. Reasons given may include:

The beneficiary/consumer no longer meets the medical necessity requirements for eligibility for a specific mental health service.
The beneficiary/consumer has obtained maximum therapeutic benefit and mental health services are no longer indicated.

The beneficiary/consumer has willfully and persistently failed to comply with the agreed-upon and prescribed treatment plan.

The program does not provide the services the patient requests.

The provider shall make all appropriate efforts to assist beneficiaries in preparing for the action, including, but not limited to, pointing out alternative resources and/or support such as self-help groups and free community services.

Enforcement:

Mental health providers must abide by the decisions of the QIC and/or State Fair Hearing regarding treatment services provided to their beneficiaries.

The Mental Health Director is responsible for assuring that the QIC recommendation or the State Fair Hearing decision is followed. Failure to implement the recommendation or decision could

result in disciplinary action, fines or revocation of contract as imposed by the Mental Health Director.

Confidentiality:

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/consumer records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone not specifically authorized by law to have access.

Definitions

Reduction in Service: Any reduction in the mode or method of services, including but not limited to a reduction in the frequency or duration or in accessibility of location of provider.

Beneficiary/Consumer Assistant: A person appointed by each provider of mental health services located at the provider site whose function it is to assist beneficiaries with the grievance procedure. The beneficiary/consumer assistant may be an employee of the provider and may have other responsibilities in addition to assisting beneficiaries.

Denial of Service: A refusal on the part of the provider, provider staff, or managed care system to deliver the type, mode or method of mental health treatment or services requested by the applicant of a requested service, beneficiary/consumer, or of a person lawfully entitled to consent for treatment on the beneficiary's/consumers' or consumer representative's behalf.

State Fair Hearing: The formal hearing described in "Beneficiary/Consumer Notices," Section 431.200 et seq. of the federal Regulations and Section 10950 et seq. of the Welfare and Institutions Code.

Mental Health Director: The County-designated Mental Health Director or the County-designated Regional Program Manager providing the managed care service for a county.

Notice of Action: Formal written and whenever possible oral notification to the beneficiary/consumer of any denial, change or termination of treatment or services. The notice should specify the proposed action and reasons therefore, effective dates of the action and grievance procedures available.

Patients' Rights: The persons designated in the Welfare and Institutions Code Section 5500 et seq. to protect the rights of all recipients of mental health services.

Termination of Service: The cessation or suspension of any mode or method of treatment of services the beneficiary/consumer has been receiving due to a decision made by the mental health care provider and/or managed care system.

GRIEVANCE LOG

Date Received	Beneficiary Name	Complainant Name	Description of Complaint	Agreed Resolution Deadline	Resolution Date	How Resolved