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

469

FROM: Department of Mental Health

SUBMITTAL DATE:
August 13, 2013

SUBJECT: Amend and approve the Memorandum of Understanding between Inland Empire Health Plan and the Department of Mental Health.

RECOMMENDED MOTION: Move that the Board of Supervisors:

1. Approve the First Amendment to the Memorandum of Understanding (MOU) between Inland Empire Health Plan and the Department of Mental Health for Medi-Cal and Medicare Dual Choice beneficiaries for FY 2013/2014;
2. Authorize the Chairman of the Riverside County Board of Supervisors to sign the MOU; and
3. Authorize the Director of the Department of Mental Health to sign ministerial amendments and renewals for this MOU with Inland Empire Health Plan for Medi-Cal and Medicare Dual Choice and Dual Eligible mental health services through December 31, 2016.

BACKGROUND: On February 7, 2012, Agenda Item 3.19, the Riverside County Board of Supervisors approved the MOU between Inland Empire Health Plan and the Department of Mental Health to provide a coordination of mental and physical health services. Since the approval of the MOU, the Department of Mental Health has been working with Inland Empire Health Plan to update the current MOU to an 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 and Dual Eligible beneficiaries.
(Continued on Page 2)

JW:WC

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:	13/14

SOURCE OF FUNDS:

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature BY: Elizabeth J. Olson

FORM APPROVED COUNTY COUNSEL
BY: ELENA M. BOEVA DATE 8-7-13

Departmental Concurrence

	Policy	Consent
Dep't Recomm.:	☒	☐
Per Exec. Ofc.:	☒	☐

2013 AUG 14 AM 10:14

Prev. Agn. Ref.: 09/02/08 agenda item 3.108; 02/07/12 agenda item 3.19

District: All

Agenda Number: 3-55

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

SUBJECT: Amend and approve the Memorandum of Understanding between Inland Empire Health Plan (IEHP) and the Department of Mental Health (DMH).

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 DMH.

In addition to the above, the Medi-Cal and Medicare programs are partnering to launch a three-year demonstration project to promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both of the public health insurance programs, "dual eligible beneficiaries." The program Cal MediConnect will commence January 1, 2014 between IEHP and DMH.

Dual eligible beneficiaries are people who qualify for both public health insurance programs, Medicare and Medi-Cal. In California, as many as 70%, of the dual eligible beneficiaries are age 65 and older with the majority being women. Approximately 30% are young people with disabilities. The goal of the Cal MediConnect program is to improve care coordination for dual eligible beneficiaries and drive high quality care that helps people stay healthy and in their homes. This will help create a person-centered health care system that is sustainable by shifting services out of institutional settings and into the home and community. The Cal MediConnect program is part of California's larger Coordinated Care Initiative (CCI) which was enacted in July 2012 through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012)."

Therefore DMH is requesting that the Riverside County Board of Supervisors approve the first amendment to the MOU between IEHP and DMH to provide mental health services to Medi-Cal and Medicare Dual Choice and Dual Eligible beneficiaries.

PERIOD OF PERFORMANCE:
This first amendment to the MOU shall commence on January 1, 2014 and shall continue through December 31, 2016.

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

E. MEDICAL SERVICES DEPARTMENT

5. Memorandum Of Understanding (MOU) With The County Of Riverside Through Its Department of Mental Health For The Provision Of Mental Health Services To Medi-Cal, Medicare DualChoice, and IEHP DualChoice (Medicare – Medi-Cal) Members – First Amendment

   a. Recommended Action
   That the Governing Board of the Inland Empire Health Plan authorize the Chief Executive Officer of IEHP, or designee, to approve the First Amendment of the Memorandum of Understanding, after legal review and approval, with The County Of Riverside through its Department of Mental Health for the provision of Mental Health Services to Medi-Cal, Medicare DualChoice, and IEHP DualChoice (Medicare – Medi-Cal) Members for the Coordinated Care Initiative (CCI), effective date to be determined.

   b. Contact
   William Henning, DO, Chief Medical Officer

   c. Background
   IEHP has established a relationship between the Riverside County Department of Mental Health (RCDMH) and IEHP through the execution of a Memorandum of Understanding (MOU) in May 2001 under Resolution 01-79. This 2001 MOU was later amended in October 2002 under Resolution 02-193, in June 2003 under Resolution 03-82 and in July 2008 under Resolution 08-139 to expand existing services to include Medicare DualChoice Members.

   In December 2011, a new MOU was executed (Resolution 11-310) based on the consolidation of previously executed Amendments.

Minute Order of the Inland Empire Health Plan Governing Board	
On motion of Member Zorn, seconded by Member Williams and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended. Ayes: Anderson, Ashley, Ovitt, Rutherford, Williams, Zorn Nays: 0 Absent: Tavaglione Recused: 0 Vacancies: 0 Date: May 13, 2013	**VICKIE HARGROVE** **SECRETARY TO THE GOVERNING BOARD** **BY:** Vickie Hargrove **DATED: May 13, 2013**
Prev. Agn. Ref.: 01-79, 02-193, 03-82, 08-139, 11-310	**Agenda Number:** E.5. (Consent); Ref. No. **13-92**

Inland Empire Health Plan IEHP A Public Entity Est. 1994 Governing Board

In June 2012, the state passed the CCI, whose goal is to integrate the delivery of medical, behavioral and long-term support services (LTSS) for eligible beneficiaries in California. Eligible beneficiaries include individuals with Medi-Cal only and individuals with both Medicare and Medi-Cal also known as Dual Eligibles. The purpose of the CCI is to provide better care and coordination for people with Medi-Cal only and Dual Eligibles. Through the CCI, enrolled Dual Eligibles and Medi-Cal members utilizing LTSS will have one point of contact for all their covered benefits. The CCI will serve the state's low-income seniors and people with disabilities and is set to reshape California's Medi-Cal care delivery system. On March 27, 2013, California entered into a MOU with the Centers for Medicare and Medicaid Services (CMS) as part of a demonstration project. Under this MOU, the CCI is now called Cal MediConnect and is expected to begin no earlier than October 1, 2013.

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

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

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California's 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. This amendment allows IEHP to coordinate care with the County per the CCI.

d. Discussion
IEHP has been meeting collaboratively through its quarterly JOMs with RCDMH around the provisions of the duals demonstration.

e. Fiscal Impact
This MOU does not contain a funding component. There is no budget for this MOU.

f. Attachments
None

g. Reviewed By Counsel
Staff Counsel

FIRST AMENDMENT

TO THE MEMORANDUM OF UNDERSTANDING

BETWEEN

INLAND EMPIRE HEALTH PLAN

AND

COUNTY OF RIVERSIDE - DEPARTMENT OF MENTAL HEALTH

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

WHEREAS, the Inland Empire Health Plan, a public entity of the State of California, hereinafter referred to as IEHP, and County of Riverside – Department of Mental Health, hereinafter referred to as RCMHP, agree to amend the Memorandum of Understanding ("Agreement") between them dated **June 30, 2012**, to be effective as of January 1, 2014:

NOW THEREFORE, the parties agree as follows:

A. Section 6.0, ("TERM"), Paragraph 6.01 hereby extends the existing term as follows:

"In addition to the existing term, the term of this Agreement is extended from January 1, 2014 and shall continue in effect through December 31, 2016, unless terminated as stated above or as specified in Section 6 ("Termination")."

B. The TABLE OF CONTENTS is herby deleted in its entirety and replaced by the new a TABLE OF CONTENTS, attached hereto.

C. Paragraph 1.01.4 of Section 1 RCMHP RESPONSIBILITIES, is hereby added to read as follows:

1.01.04 "For the Coordinated Care Initiative (CCI) population, RCMHP will perform according to IEHP established Behavioral Health policies and procedures as provided in the IEHP BH Department Program Description and Provider Manual."

D. ATTACHMENT A, ACTIVITIES DESCRIPTION GRID, is hereby deleted in its entirety and replaced by the new ATTACHMENT A, ACTIVITIES DESCRIPTION GRID, attached hereto.

E. ATTACHMENT C – CCI MOU ATTACHMENT is hereby added as ATTACHMENT C – CCI MOU ATTACHMENT, attached hereto. Any amendment or attachment to the MOU which contains conflicting language shall be interpreted as superseded by Attachment C.

F. A new EXHIBIT VI, SHO-31-001-MENTAL HEALTH PARITY IN CHIP; is herby added as attached hereto.

G. A new EXHIBIT VII, HFP PLAN MEMO ON MENTAL HEALTH PARITY, is hereby added as attached hereto.

H. All subsequent reference to the population served under this MOU shall be amended to include the IEHP DualChoice (Medicare – Medi-Cal) Members of the County of Riverside.

I. All other terms and conditions of said Agreement are to remain in full force and effect.

(THE BALANCE OF THIS PAGE IS LEFT INTENTIONALLY BLANK)

I. CERTIFICATION OF AUTHORITY TO EXECUTE THIS AMENDMENT

RCMHP certifies that the individual signing below has the authority to execute this AMENDMENT on behalf of RCMHP and may legally bind RCMHP to the terms and conditions of this AMENDMENT, and any attachments hereto.

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment to the Memorandum of Understanding as set forth below.

RIVERSIDE COUNTY

By: _____
Jerry A Wengerd, Director
RCMHP

Date: 8-13-13

By: _____
Chairperson, Board of Supervisors

Date: _____

INLAND EMPIRE HEALTH PLAN

By: _____
Bradley P. Gilbert, MD
Chief Executive Officer

Date: 8/12/13

By: _____
SIGNATURE ON BEHALF OF IEHP GOVERNING BOARD APPROVED IN RESOLUTION 13-93
Chair, IEHP Governing Board

Date: _____

Attest: _____
Secretary, IEHP Governing Board

Date: 8-12-13

Approved as to Form

PAMELA J. WALLS
County Counsel

By: _____
Deputy County Counsel
Attorneys for Inland Empire Health Plan

Date: 8-12-13

MEMORANDUM OF UNDERSTANDING

TABLE OF CONTENTS

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

ACTIVITIES DESCRIPTION GRID
INDEX

	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 as it applies to all CCI Members. An electronic interface will be established to exchange data.	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.	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)

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	00-01 REV (Attached as Exhibit I). RCMHP will authorize outpatient and inpatient specialty mental health services to Medi-Cal beneficiaries enrolled in 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.	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 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. As part of ongoing training operations with RCMHP, IEHP will provide RCMHP with annual updates to IEHPs policies and procedures. This would include operational and/or benefit changes/information as part of the quarterly JOMs.
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	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)**
	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. 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 as it applies to all CCI Members. An electronic interface will be established to exchange data. 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,	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 provide 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)**
	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.	
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).

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
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 as it applies to all CCI Members. RCMHP will also have access to the prescription history, labs and other clinical information available through the IEHP Secure Website. An electronic interface will be established to exchange data. RCMHP providers will prescribe, as medically appropriate, 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.)	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. 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 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.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	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 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.	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 the Member's PCP.
10. Emergency Room Services – In and Out of Area		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

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
		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 in psychiatric Nursing Facility settings.	IEHP will be responsible for all medically necessary non-specialty professional and medical services not included under the IMD daily 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 is responsible for the transportation costs when RCMHP is responsible for the costs of hospitalization and 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.	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

	Riverside County Mental Health Plan (RCMHP)	Inland Empire Health Plan (IEHP)
		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 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. RCMHP will provide the medically necessary specialty mental health services for developmentally disabled members who have a coexisting qualifying BH condition.	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 when RCMHP is responsible for the cost of hospitalization. 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

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
		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 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.	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 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	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

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	condition.	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 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. RCMHP will have a system of sharing information with IEHP on the dispensation of Fair Hearing cases. For a description of RCMHP Grievance Policy see Exhibit V,	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. As part of this process, upon receiving RCMHP's report on the resolution of grievances, IEHP will report the resolution to the State. IEHP will have a system of sharing information with RCMHP on the dispensation of Fair Hearing cases. For a brief description of 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.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	"RCMHP's Grievance Policy."	
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. • 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	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. • 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.

	Riverside County Mental Health Plan (RCMHP)	**Inland Empire Health Plan (IEHP)**
	accordance with current regulations.	

ATTACHMENT C

CCI MOU ATTACHMENT

1. PARTIES

This (or addendum to existing MOU) is entered into by and between the INLAND EMPIRE HEALTH PLAN hereinafter referred to as "PLAN", and the RIVERSIDE COUNTY MENTAL HEALTH DEPARTMENT responsible for the provision of Medi-Cal specialty mental health and/or Drug Medi-Cal services (if separate) hereinafter referred to as "COUNTY."

2. TERMS

This memorandum shall commence on January 1, 2014 and shall continue through December, 31 2016.

3. TASKS, RESPONSIBILITIES AND/OR OBLIGATIONS

A. Roles and Responsibilities

1. Covered Services are listed in the "Behavioral Health Benefits in the Duals Demonstration" matrix developed by DHCS. PARTIES may include this matrix as an attachment to this MOU addendum.

2. Determination of Medical Necessity

   a. The PLAN and COUNTY will follow the medical necessity criteria for Medi-Cal specialty mental health 1915(b) waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

   b. To determine medical necessity for Drug Medi-Cal Substance Abuse Services, the PARTIES will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

3. Assessment Process

   The PLAN and COUNTY shall develop and agree to written policies and procedures regarding agreed-upon screening and assessment processes that comply with all federal and state requirements including the Care Coordination Standards and Behavioral Health Coordination Standards.

4. Referrals

    a. The PLAN and COUNTY shall develop and agree to written policies and procedures regarding referral processes, including the following:

        i. The COUNTY will accept referrals from PLAN staff, providers and members' self-referral for determination of medical necessity.

        ii. The PLAN will accept referrals from the COUNTY when the service needed is one provided by the PLAN and not the COUNTY and the beneficiary does not meet the Medi-Cal specialty mental health and/or Drug Medi-Cal medical necessity criteria.

5. Authorization of Services

    The PLAN will work with the COUNTY to determine if authorization of Medicare- covered behavioral health services is required. Any Medicare treatment authorization decisions will be made as expeditiously and as timely as the beneficiary's condition requires.

6. Provider Credentialing

    The COUNTY will provide verification of professional licensure, the National Provider Identifier (NPI), and other information as needed to confirm COUNTY and its contractors are Medicare eligible and certified providers eligible providers.

7. Payment Mechanism

    The reimbursement mechanism between COUNTY and PLAN shall be determined locally and agreed upon by both parties, as specified in this MOU addendum and subject to federal timeliness and other requirements.

The PLAN shall reimburse the COUNTY for Medicare-covered mental health services rendered by the COUNTY.

The COUNTY will recover the federal Medi-Cal reimbursement for Medi-Cal specialty mental health services after receiving the PLAN'S payment consistent with the provisions of the demonstration and the current Medi-Cal specialty mental health 1915(b) waiver and California' Medicaid State Plan.

The PLAN shall provide information necessary for coordination of benefits in order for the COUNTY to obtain appropriate reimbursement under the Medi-Cal program.

8. Rates

   The PLAN shall provide the COUNTY with payment for authorized medically necessary rendered services covered by Medicare at the most current published Medicare rates. For services that IEHP specifically authorizes, services provided by Licensed Marriage and Family Therapists (LMFTs) will be at the same rates as Licensed Clinical Social Workers (LCSWs).

9. Dispute Resolution Process

   The PLAN and COUNTY agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the PLAN and the State Department of Health Care Services (DHCS) and Centers for Medicare
   & Medicaid Services (CMS).

10. Telephone Access

    The PLAN is responsible for maintaining a telephone line to answer Member inquiries about services. The COUNTY is responsible for maintaining a 24-7 crisis line with a live person available to assess the need for urgent or emergency services.

B. Information Exchange

1. COUNTY and PLAN will develop and agree to Information sharing policies and procedures that include milestones over the three years and agreed upon roles and responsibilities for sharing personal health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3) and other pertinent state and federal laws and regulations, including the Health Insurance Portability and Accountability Act and 42 CFR part 2, governing the confidentiality of mental health , alcohol and drug treatment information. These policies and procedures shall be attached to the MOU by 12/31/13.

2. The PLAN will create a list of demonstration enrollees who are receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services to track their care coordination and service delivery to the extent possible under state and federal privacy laws.

C. Care Coordination

The PLAN and COUNTY will develop and agree to policies and procedures for coordinating medical and behavioral health care for beneficiaries enrolled in the PLAN and receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the COUNTY that may include the following. These policies and procedures shall be attached to the MOU by 4/30/2014.

1. An identified point of contact from each PARTY who will initiate and maintain ongoing care coordination, including agreement on who has primary responsibility for care planning.

2. COUNTY will participate in Interdisciplinary Care Teams (ICTs) for members receiving county-administered services and identified as needing an ICT, in accordance with a beneficiary's decisions about appropriate involvement of providers and caregivers on the ICT.

3. The COUNTY would request participation from the PLAN in developing behavioral health care plans.

4. The PLAN will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or wellbeing, change in level of care or request for change of providers, and for coordinating with the COUNTY behavioral health providers, when necessary.

5. The PLAN will have regular meetings (at least quarterly) to review the care coordination process, such as the effectiveness of exchange of patient health information.

6. The PLAN will coordinated with the COUNTY to perform on an annual review, analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

D. Shared Accountability

Shared Accountability between the PLAN and COUNTY aims to promote care coordination. Shared accountability builds on the performance-based withhold of 1%, 2%, and 3% in the capitation rates respectively for years one, two and three of the demonstration. By meeting specified quality measures, the PLAN can earn back the withheld capitation revenue by meeting specified quality objectives. Under this Shared Accountability strategy, one withhold measure each year will be tied to behavioral health coordination with the COUNTY.

1. The PLAN and COUNTY agree to the Shared Accountability Performance Metrics, as specified in the three-way contracts between CMS, DHCS and the PLAN. These measures will be updated upon confirmation, but generally include:

a. Year 1 (1/1/14 - 12/31/14):

ii. Execution of the MOU or MOU amendment prior to the launch of the demonstration;

iii. Evidence of revised written policies and procedures for assessments, referrals, coordinated care planning, and information exchange to reflect inclusion of behavioral health coordination in the demonstration. Information sharing policies and procedures should include milestones for increased sharing over the three years, and also include a process for identifying and tracking of demonstration enrollees who receive behavioral health services through the COUNTY.

iv. [TBD] percent of demonstration enrollees identified as receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services who have individual care plans that include evidence of collaboration with the primary behavioral health provider at the county, indicating that care is being coordinated between the PARTIES.

b. Year 2 (1/1/15-12/31/16): [TBD] percent reduction from the baseline in emergency department (ED) visits for beneficiaries with serious mental illness or indication of need for substance use treatment. (Further development of exact specifications for the measure will be reflected in three-way contracts).

c. Year 3 (1/1/16-12/31/16): [TBD] percent reduction (greater than Year 2) from the baseline in ED visits for beneficiaries with serious mental illness or indication of need for substance use treatment.

2. The PLAN and COUNTY agree that if the specified shared accountability measure is met in each year, the PLAN will provide an incentive payment to the COUNTY under mutually agreeable terms. This payment will be structured in a way so it does not offset the county's Certified Public Expenditure (CPE).

1. Provider and Member Education

The PLAN and COUNTY will develop, in coordination with one another, education materials and programs for their members and providers about the availability of behavioral health services, including roles and responsibilities in the demonstration and care coordination policies and procedures. At a minimum, education will include initial and regularly scheduled provider trainings (at least annually), and a provider manual that includes information regarding access to services, the beneficiary problem resolution processes, authorization process, provider cultural and linguistic

requirements, regulatory and contractual requirements, and other activities and services needed to assist beneficiaries in optimizing their health status, including assistance with self-management skills or techniques, health education and other modalities to improve health status.

Behavioral Health Benefits in the Duals Demonstration

Coverage Responsibility Matrix

Updated February 27, 2013

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

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

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

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California's 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

To determine medical necessity for Drug Medi-Cal Substance Abuse Services, health plans and counties will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

Coverage Matrix 1: Mental Health Benefits

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

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.
+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

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

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

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

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

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

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

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

Coverage Matrix 2: Substance Use Disorder Benefit

	Type of Service	Benefit Coverage	Demonstration Responsibility
Inpatient Acute and Acute Psychiatric Hospitals	Detoxification	Medicare	Health Plan
	Treatment of Drug Abuse[1] (Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90)	Medicare	Health Plan
Outpatient	**Alcohol Misuse Counseling: one alcohol misuse screening (SBIRT) per year. Up to four counseling sessions may be covered if positive screening results. *Must be delivered in a primary care setting.*[2]**	Medicare	Health Plan
	Group or individual counseling by a qualified clinician	Medicare	Health Plan
	Subacute detoxification in residential addiction program outpatient	Medicare	Health Plan
	Alcohol and/or drug services in intensive outpatient treatment center	Medicare	Health Plan
	Extended Release Naltrexone (vivitrol) treatment	Medicare	Health Plan
	Methadone maintenance therapy	Drug Medi-Cal	County Drug & Alcohol[3]
	Day care rehabilitation	Drug Medi-Cal	County Drug & Alcohol
	Outpatient individual and group counseling *(coverage limitations)*[4]	Drug Medi-Cal	County Drug & Alcohol
	Perinatal residential services	Drug Medi-Cal	County Drug & Alcohol

[1] Medicare inpatient detoxification and/or rehabilitation for drug substance abuse when it is medically necessary. Coverage is also available for treatment services provided in the hospital outpatient department to patients who, for example, have been discharged for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Click here to learn more.

[2] Medicare coverage explanation: Click here to learn more.

[3] In San Diego and Orange Counties, county alcohol and drug do not provide these services. Providers have direct contracts with the State.

[4] Title 22, Section 51341.1 limits DMC individual counseling to the intake, crisis intervention, collateral services and treatment and discharge planning.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 13-001
ACA #24

January 16, 2013

RE: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans

Dear State Health Official:
Dear State Medicaid Director:

This letter provides guidance on the applicability of the requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, Pub.L. 110-343)[1, 2] to Medicaid non-managed care benchmark and benchmark-equivalent plans (referred to in this letter as Medicaid Alternative Benefit plans) as described in section 1937 of the Social Security Act (the Act), the Children's Health Insurance Programs (CHIP) under title XXI of the Act, and Medicaid managed care programs as described in section 1932 of the Act. The Centers for Medicare & Medicaid Services (CMS) previously issued a State Health Official (SHO) letter on November 4, 2009, concerning section 502 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub.L. 111-3)[3]. This letter issues new guidance on the application of MHPAEA in Medicaid and expands upon the guidance for CHIP.

Legislative History and Background

Starting in 1996, Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical benefits.

The Mental Health Parity Act of 1996 (MHPA, Pub.L. 104-204) addressed aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by group health plans (or health insurance coverage offered in connection with such plans). The Balanced Budget Act of 1997 (BBA, Pub.L. 105-33) added sections 1932(b)(8) and 2103(f)(2) of the Act to apply certain aspects of MHPA to Medicaid managed care organizations (MCOs) and CHIP benefits.

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[1] https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf.
[2] See 29 CFR 2590.712((c)(4). See also FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/pdf/faq-aca7.pdf.
[3] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

MHPAEA extended the MHPA requirements to substance use disorder benefits in addition to mental health benefits. MHPAEA also added new requirements regarding financial requirements and treatment limitations in addition to the limitations on aggregate annual and lifetime dollar limits.

In 2009, section 502 of CHIPRA amended section 2103(c) of the Act by adding paragraph (6), which incorporates, by reference, provisions added to section 2705 of the Public Health Service Act (PHSA) by MHPAEA.[4] Consequently, the mental health and substance use disorder parity requirements of MHPAEA apply to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans.

The Affordable Care Act (Pub.L. 111-148) expanded the application of MHPAEA to benefits in Medicaid non-managed care benchmark and benchmark-equivalent state plan benefits pursuant to section 1937 of the Act (referred to in this letter as Medicaid Alternative Benefit plans) (see section 2001(c)(3) of the Affordable Care Act, adding section 1937(b)(6)). The application of MHPAEA to Medicaid non-managed care Alternative Benefit plan benefits was effective on March 23, 2010. Also effective as of that date, Medicaid Alternative Benefit plans that are benchmark-equivalent plans must include mental health and substance abuse services as a basic service (see section 2001(c) of the Affordable Care Act).

MHPAEA's requirements include:

- Financial requirements that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits. The statute defines "predominant" as the most common or frequent of such type of limitation or requirements.
- There are no separate cost sharing requirements that apply only to mental health or substance use disorder benefits.
- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits is made available within a reasonable timeframe to participants and beneficiaries upon request.
- If a plan or coverage provides out-of-network coverage for medical/surgical benefits, it provides out-of-network coverage for mental health or substance use disorder benefits.

On February 2, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) published an Interim Final Rule (IFR) under MHPAEA. The IFR is

[4] The mental health parity provisions are currently found in PHSA section 2726, after Title XXVII of the PHSA was reorganized and amended by the Affordable Care Act.

applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. In the IFR, the Departments interpreted the statutory requirement precluding more restrictive treatment limitations for mental health or substance use disorder benefits to apply to both quantitative and non-quantitative treatment limitations. Examples of quantitative treatment limits include a limit on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Examples of non-quantitative treatment limits that were identified in the IFR include preauthorization requirements and medical management standards.

Application of Mental Health/Substance Use Disorder Parity Requirements to Medicaid Alternative Benefit Plans

All Medicaid Alternative Benefit plans (including benchmark equivalent and Secretary–approved benchmark plans) are required to meet the provisions within MHPAEA, regardless of whether services are delivered in managed care or non-managed care arrangements. This includes Alternative Benefit plans for individuals in the new low-income Medicaid expansion group, effective January 1, 2014. Specifically:

- Section 1932(b)(8) of the Act applies parity requirements to MCOs (see below for more details regarding requirements for Medicaid MCOs).
- Section 1937(b)(6) of the Act, as added by the Affordable Care Act, directs that approved section 1937 Medicaid non-managed care Alternative Benefit plans that provide both medical/surgical benefits and mental health or substance use disorder benefits comply with MHPAEA[5].

In order to comply with the MHPAEA provisions regarding financial requirements, states with Medicaid Alternative Benefit plans should review Attachment 4.18 of their Medicaid state plans to ensure that financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket expense limits) applicable to mental health or substance use disorder benefits provided through such plans are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits in the Medicaid Alternative Benefit plan.

Likewise, to comply with the MHPAEA requirements on treatment limitations, states with approved Medicaid Alternative Benefit plans should review these plans to determine whether any types of treatment limitations imposed in these benefit plans on coverage of mental health or substance use disorder benefits are more restrictive than those imposed on medical/surgical benefits. This should include a review of both quantitative and non-quantitative treatment limitations.

Finally, states must assure that Medicaid Alternative Benefit plans apply the MHPAEA requirements regarding the availability of out-of-network coverage and the availability of information regarding criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

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[5] See State Health Official letter describing Alternative Benefit plans under section 1937 as modified by the Affordable Care Act, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

States with Alternative Benefit plans for children should already meet the requirements for MHPAEA for children. States that enroll children in a Medicaid Alternative Benefit plan are directed by section 1937(a)(1)(A)(ii) of the Act to assure that eligible children under age 21 receive the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit offered through a Medicaid Alternative Benefit plan or through a combination of the Medicaid Alternative Benefit plan and wrap-around services. Section 1937(b)(6)(B) of the Act provides that states extending Medicaid coverage for individuals under age 21 through Medicaid non-managed care Alternative Benefit plans that include the EPSDT benefit shall be deemed to satisfy the mental health and substance use disorder parity requirements with respect to the individual. CMS will also deem Medicaid Alternative Benefit managed care plans to be compliant with MHPAEA, to the extent they provide coverage for children, regardless of whether the MCO provides full EPSDT services or the state assures EPSDT through a wrap-around arrangement.

States with Medicaid Alternative Benefit plans that are not in compliance with the parity requirements described above should take steps to come into compliance with the those requirements.

Application of Mental Health/Substance Use Disorder Parity Requirements to CHIP

For CHIP programs, section 2103(c)(6) of the Act (amended by section 502 of CHIPRA) applies the MHPAEA provisions of the PHSA to the CHIP state plan. Thus, for CHIP programs, mental health and substance use disorder parity requirements apply to all delivery systems, including fee-for-service and managed care. To the extent that the state CHIP plan provides full coverage of the EPSDT benefit as defined in section 1905(r) of the Act, the MHPAEA requirements shall be deemed to be met under section 2103(c)(6)(B) of the Act. Otherwise, MHPAEA applies to the CHIP state plan in the same manner as the law applies to health insurance issuers and group health plans.

States not providing full EPSDT benefits under their CHIP state plan need to review CHIP state plans, contracts, and demonstrations/waiver projects in order to come into compliance with MHPAEA. States may want to consider (and potentially modify) the services offered in section 6 of the CHIP state plan. That section describes the coverage offered with respect to the amount, duration, and scope of services covered, as well as any exclusions or limitations. For example, treatment limitations on mental health services in sections 6.2.10 and 6.2.11 or substance use disorder benefits in sections 6.2.18 and 6.2.19 must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits such as those in sections 6.2.1 and 6.2.2. Medical management techniques used within CHIP, such as pre-authorization requirements or a step therapy approach described in section 3.2 of the state plan, applied to mental health or substance use disorder services must be comparable to and applied no more stringently than medical management techniques that are applied to medical/surgical benefits.

Similarly, states need to review the financial requirements in section 8.2 of the CHIP state plan where states identify any deductibles, coinsurance, co-pays, or other out-of-pocket cost-sharing charges and the services to which those charges apply. Finally, states need to assure that the MHPAEA requirements regarding the availability of out-of-network coverage and the

availability of information regarding criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits apply under the CHIP state plan.

States with CHIP plans that are not in compliance with the parity requirements described above should take steps to come into compliance with those requirements.

Application of Mental Health/Substance Use Disorder Parity Requirements to Managed Care Organizations

The CMS noted in its November 2009 SHO letter that mental health and substance use disorder parity requirements apply to MCOs (defined in section 1903(m) of the Act) that contract with the state to provide both medical/ surgical and mental health or substance use disorder benefits. In light of Medicaid regulations that direct states to reimburse MCOs based only on state plan services, CMS will not find MCOs out of compliance with MHPAEA to the extent that the benefits offered by the MCO reflect the financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements set forth in the Medicaid state plan and as specified in CMS approved contracts. However, this does not preclude state use of current Medicaid flexibilities to amend their Medicaid state plans or demonstrations/waiver projects to address financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements in ways that promote parity.

Any additional or alternative treatment limitations put in place by the MCO, however, must comply with mental health and substance use disorder parity requirements. For example, MCOs must meet the following requirements:

- Medical management techniques used by the MCO, such as pre-authorization requirements, which are applied to mental health or substance use disorder benefits must be comparable to and applied no more stringently than the medical management techniques that are applied to medical/surgical benefits.
- Any benefits offered by an MCO beyond those specified in the Medicaid state plan also must be compliant with MHPAEA.
- In accordance with MHPAEA and federal Medicaid managed care regulations at 42 CFR 438 Subpart F, the criteria for medical necessity determinations made under the plan for mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request. The reasons for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits must be provided to plan participants and beneficiaries upon request within a reasonable time.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits. States are responsible for assessing their contracts with all MCOs that offer medical and surgical benefits and mental health or substance use disorder benefits, to ensure that plans comply with the provisions of MHPAEA as set forth above.

In addition to MCOs, which are statutorily-defined, CMS has, by regulation, recognized entities known as Prepaid Inpatient Hospital Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These entities provide a more limited set of state plan services (in some instances through a carve-out arrangement). CMS urges states with these arrangements to apply the principles of parity across the whole Medicaid managed care delivery system when mental health and substance use disorders services are offered through a carve-out arrangement. CMS intends to issue additional guidance that will address this issue and will continue to consider additional regulatory changes that may be necessary to properly implement MHPAEA.

MCOs that are not in compliance with the parity requirements described above should take steps to come into compliance with those requirements. States should assess their contracts with all MCOs which offer medical and surgical benefits and mental health or substance use disorder benefits to assure that plans comply with the provisions of MHPAEA. CMS will offer technical assistance to states regarding strategies for PIHPs and PAHPs to implement MHPAEA.

If you have any questions about the guidance provided in this letter, please contact Ms. Barbara Coulter Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann
Director

cc:

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MEMORANDUM

February 9, 2013

TO: Healthy Families Program (HFP) Health Plans

FROM: Terresa Krum, Chief Deputy Director

SUBJECT: Changes regarding Mental Health Parity Requirements

The purpose of this letter is to provide information on the most recent changes in federal requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA).

The Centers for Medicare and Medicaid Services (CMS) issued guidance under MHPAEA for the Children's Health Insurance Program (CHIP) in a letter dated January 16, 2013 which may impact the delivery of mental health services. A copy of the January 16, 2013 letter is attached for ease of reference.

MRMIB has reviewed the current mental health benefits defined in regulation and believes that they are compliant with the new guidance. However, the guidance also explains that treatment limitations that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits. Treatment limitations include both *quantitative* limits, such as a limit on frequency of treatment, as well as *qualitative* limits, such as preauthorization requirements and medical management standards. In addition, there can be no separate treatment limitations that apply only to mental health or substance use disorder benefits.

The new guidance also explains that the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits must also be made available within a reasonable timeframe to participants and beneficiaries upon request.

For CHIP, mental health and substance abuse parity requirements apply to all delivery systems, including fee-for service and managed care. HFP health plans must ensure that any pre-authorization requirements for medical necessity applied to mental health or substance abuse services are comparable to and applied no more stringently than medical management techniques that are applied to medical/surgical benefits and that the reasons for determinations are made available upon request within a reasonable timeframe. In addition, where HFP health plans are utilizing subcontractors to deliver mental health benefits, plans must also ensure that their subcontractors are compliant with these new requirements.

This memorandum is for your information only. We recommend that you review the January 16, 2013 guidance letter, the related federal statutes and related federal regulations to determine if you need to make any modifications to your mental health delivery system to comply with these changes.

If you have any questions regarding this matter, please contact Ellen Badley, Deputy Director, Benefits and Quality Monitoring Division at ebadley@mrmib.ca.gov or (916) 323-4130.

Cc: Janette Casillas, Executive Director
Ellen Badley, Deputy Director Benefits and Quality Monitoring
Laura Rosenthal, Chief Counsel