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

ITEM
3.55
(ID # 7398)

MEETING DATE:
Tuesday, August 28, 2018

FROM : RUHS-BEHAVIORAL HEALTH:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH: Ratify and Execute the Memorandum of Understanding between Inland Empire Health Plan and Riverside University Health System – Behavioral Health. District: All, [$450,000 for FY18/19, $350,000 Annually for FY19/20 Through FY22/23, $1,850,000 Total] 100% State

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and execute the Memorandum of Understanding (MOU) between Inland Empire Health Plan (IEHP) and Riverside University Health System – Behavioral Health (RUHS-BH) for Medi-Cal and Medicare Dual Choice Beneficiaries for the term January 1, 2018 through June 30, 2019 in the amount of $450,000 annually; and
2. Authorize the Director of RUSH-BH to sign ministerial amendments and renewals for this MOU, not to exceed $350,000 annually through June 30, 2023.

ACTION: Policy

Steve Steinberg 7/31/2018

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Tavaglione, Washington, Perez and Ashley
Nays:	None
Absent:	None
Date:	August 28, 2018
xc:	Behavioral Health

Kecia Harper-Ihem
Clerk of the Board
By: _____ Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$450,000	$350,000	$1,850,000	$0
NET COUNTY COST	$0	$0	$ 0	$0
SOURCE OF FUNDS: 100% State			**Budget Adjustment:** No	
			For Fiscal Year: 18/19 – 22/23	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

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

On August 20, 2013 (3-55), the Board of Supervisors approved the First Amendment to the MOU between the IEHP and RUHS-BH to create an all-inclusive MOU to reflect both parties' agreement and understanding of the services to be rendered to both Medi-Cal and Medicare Dual Choice and Dual Eligible beneficiaries. On July 29, 2014 (3-33) the Board approved the Second Amendment to the MOU to incorporate the terms and conditions pursuant to Senate Bill (SB) X1 1 (Hernandez, Chapter 4, Statutes of 2013), which became effective January 1, 2014. The State of California Department of Health Care Services (DHCS) expanded the array of Medi-Cal mental health services available to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional or behavioral functioning from any mental health condition. MCPs will provide these outpatient services while MHPs provide Medi-Cal specialty mental health services. On January 17, 2017 (3.28), the Board approved the Third Amendment to the MOU establishing the protocols for clients receiving substance abuse services pursuant to the 1115 Medi-Cal Waiver for the Drug Medi-Cal Organized Delivery System.

The attached MOU with IEHP combines the previous amendments into one documents, updates forms to current business processes and adds transportation and Eating Disorder services. IEHP and RUHS-BH recognize an increase need for eating disorder services and will equally share the cost of these services which includes Psychiatric Inpatient, Residential, Partial Hospitalization and Intensive Outpatient. The term of the MOU has been extended to June 30, 2019 with the option to renew through June 30, 2023.

Impact on Citizens and Businesses

These services are a component of the Department's system of care aimed at improving the health and safety of consumers and the community.

Additional Fiscal Information

IEHP will reimburse RUHS-BH at 100% of the Medi-Cal/Medicare allowable amount for all Mental Health and Substance Abuse billable services. RUHS-BH will reimburse IEHP fifty percent (50%) of the cost for Eating Disorder services, not to exceed $450,000 for the term January 1, 2018 through June 30, 2019 and $350,000 annually thereafter through June 30, 2023. There are no additional County funds required.

Melissa Noone, Associate Management Analyst 8/20/2018

Gregory P. Priamos, Director County Counsel 8/2/2018

MEMORANDUM OF UNDERSTANDING

BETWEEN

INLAND EMPIRE HEALTH PALN

AND

RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH

(MENTAL HEALTH SERVICES FOR MEDI-CAL, IEHP DUALCHOICE CAL MEDICONNECT PLAN [MEDICARE – MEDICAID PLAN] MEMBERS AND SUBSTANCE ABUSE TREATMENT UNDER THE DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER)

AUG 28 2018 3.55

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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 the County of Riverside through its Riverside University Health System – Behavioral Health (hereinafter referred to as "RUHS-BH").

INTRODUCTION

RUHS-BH and 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 concerned with the community's health, especially as it relates to the most vulnerable populations. With a common interest in the community's health, RUHS-BH 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 RUHS-BH and IEHP.

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

1. **RUHS-BH RESPONSIBILITIES**

   The following specialty mental health services are the responsibility of RUHS-BH: all 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 psychologist and other disciplines as per the mental health plan. FFS/MC inpatient specialty mental health services.

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

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

      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 RUHS-BH is an IEHP Member, RUHS-BH 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 RUHS-BH services and requirements.

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

2. **IEHP RESPONSIBILITIES**

   IEHP network physicians will provide outpatient mental health within Primary Care Physician's (PCP) scope of practice. IEHP will provide non-specialty mental health services as identified in the Medi-Cal Coverage and Population Matrix and APL-17-018 (Attachment E; Exhibit VI). 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 provisions 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 RUHS-BH, 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 Attachments AI - AIII.

2.01.02 Inform Members of the availability of county mental health services and referrals through RUHS-BH.

2.01.03. The Clinical Director of Behavioral Health will serve as the primary liaison between IEHP and RUHS-BH. 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 RUHS-BH for each service listed in Attachments AI - AIII.

2.01.04. RUHS-BH 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 RUHS-BH and IEHP.

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

3. **JOINT OPERATING MEETINGS**

Meetings including the RUHS-BH Medical Director and/or the Program Chief, the Behavioral Health Services Supervisor, the IEHP Medical Director and/or the Director of Health Administration and/orClinical Manager of Behavioral Health and/or the County Programs BH Liaisons will be held on at least a quarterly basis to review all aspects of this MOU. At one of those meeting each year, items to be re-negotiated or negotiated in relation to the MOU will be introduced.

4. **REIMBURSEMENTS**

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

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

4.03. RUHS-BH 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 statues related to confidentiality. Where permitted by law, RUHS-BH 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, RUHS-BH 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 RUHS-BH 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 RUHS-BH including payments 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 RUHS-BH of any claim that is incomplete or contested with 45 days of receipt of IEHP of the claim.

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

4.07. RUHS-BH 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%.

4.08. RUHS-BH shall be responsible to reimburse IEHP for 50% of the inpatient, residential, partial hospitalization, intensive outpatient, facility and professional services fees for IEHP Members meeting the medical necessity criteria for Eating Disorders.

4.08.01. IEHP will adjudicate facility and professional claims against pre-authorizations for Eating Disorder Services, and reimburse the claimants at 100% of the allowable amount.

4.08.02. On a quarterly basis, claims packets, which includes a cover letter, a summary report, and copies of claims images will be sent to RUHS-BH Finance contact requesting reimbursement at 50% of facility and professional fees as indicated in the claims images and summary report.

4.08.03. RUHS-BH will review IEHP's quarterly claim package (quarterly report, summary page and UB04 Claim Forms) and shall remit payment within 30 business days from the receipt of claims package.

5. **TERM**

It is mutually agreed and understood that the obligations of IEHP is limited by and contingent upon the availability of the DHCS funding for the Medi-Cal Managed Care Plan. IEHP shall notify RUHS-BH in writing within 30 days of learning of any discontinuation of funding.

5.01. This MOU shall be effective January 1, 2018 and shall continue in effect until June 30, 2019. The term may be extended for up to four additional one 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 additional one year periods, the MOU shall terminate on June 30, 2023. In no event shall this MOU be extended past June 30, 2023 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 60 days written notice and may be terminated for cause by either party by giving 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 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 12 months written notice thereof to the other County Board of Supervisors given that the JPA cannot be terminated until all terms of indebtness incurred by IEHP have been paid or adequate provisions 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.

7. **RESOLUTION OF DISPUTES**

Disputes between IEHP and RUHS-BH that cannot be resolved at the second level review as defined in Attachments AI - AIII, shall be forwarded to the State Department of Health Care Services consistent with the procedures defined in CCR Title 9, Section 1850.505 "Resolutions of Disputes Between MHP's and Medi-Cal Managed Care Plans."

7.01. Consistent with the terms specified in Attachments AI - AIII, 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 provision of the dispute resolution process defined in this section and in Section 22 of Attachment A .

8. **HOLD HARMLESS**

RUHS-BH will indemnify and hold IEHP harmless from loss, costs or expenses by the negligent or wrongful acts or omissions of Riverside County officers, agents, employees occurring in the performance of this MOU. IEHP will indemnify and hold harmless RUHS-BH 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. RUHS-BH agrees to hold harmless IEHP Members and the California Department of Health Care Services for financial liability by IEHP for services provided by RUHS-BH to IEHP Members under the terms of this MOU.

9. **ACCESS TO BOOKS AND RECORDS**

RUHS-BH 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. RUHS-BH 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**

RUHS-BH and IEHP shall observe all Federal, State and County requirements and applicable law concerning the confidentiality of records. RUHS-BH 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 not 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. **NONDISCRIMNATION**

Services and benefits shall be provided by RUHS-BH and IEHP to individuals without reference otherwise to their religion, color, sex, national origin, age, physical or mental handicaps or conditions. RUHS-BH 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**

The MOU constitutes the entire MOU between the parties hereto with respect to the subject matter hereof and all prior 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:
Inland Empire Health Plan
10801 6th St. Ste 120
Rancho Cucamonga, CA 91730
(909) 890-2000
Attn: Bradley P. Gilbert, MD
Chief Executive Officer

To RUHS-BH
Riverside University Health System – Behavioral Health
P.O. Box 7549
Riverside, CA 92513-7549
(951) 358-4501
Attn: Steve Steinberg
Behavioral Health Director

15. **ASSIGNMENT**

This MOU and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by RUHS-BH or IEHP and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein by 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 RUHS-BH 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, RUHS-BH 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 regulations promulgated there under by the DMHC, the Health Maintenance Organization Act of 1973 and the regulations promulgated there under by the United State Department of Health and Human Services and the Waxman-Duffy Prepaid Health Plan Act and 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 be come applicable after the procedure in Paragraph 7 ("RESOLUTION OF DISPUTES") has been completed.

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 be come 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.

18. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**
IEHP and RUHS-BH 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 RUHS-BH agree to cooperate in accordance with the terms and intent of this MOU for implementation of relevant law (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 RUHS-BH's reference.

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

RIVERSIDE COUNTY

By: _____
Steve Steinberg,
RUHS-BH Director

Date: _____

By: _____
~~John Tavaglione,~~ CHUCK WASHINGTON
Chairperson, Board of Supervisors

Date: AUG 28 2018

Attest:
Kecia Harper-Ihem, Clerk of the Board

By: _____
Deputy

Approved as to Form and Consent:

By: _____
Eric Stopher, Deputy County Counsel

Date: 8/7/18

INLAND EMPIRE HEALTH PLAN

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

Date: 3/27/18

By: _____
Chair, IEHP Governing Board

Date: 3/27/18

By: _____
Secretary, IEHP Governing Board

3/27/18

By: _____
Steve Sohn, IEHP Managing Counsel

Date: 3-27-18

ACTIVITIES DESCRIPTION GRID FOR MENTAL HEALTH SERVICES
INDEX

	RUHS-BH	IEHP
1. Care Manager Liaison	RUHS-BH will provide workspace, equipment and technical assistance to support IEHP care manager liaison in the execution of his/her responsibilities. RUHS-BH 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 RUHS-BH. 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 RUHS-BH; and e. Representing RUHS-BH's interest in the interpretation of RUHS-BH and IEHP policies, procedures and referral processes as they apply to IEHP Members who may also meet RUHS-BH eligibility criteria.	IEHP will present liaison candidates to RUHS-BH for approval. In collaboration with RUHS-BH, IEHP will assign a care manager liaison for onsite location at RUHS-BH to: a. Serve to represent IEHP's interest in the interpretation of RUHS-BH and IEHP policies, procedures and referral processes as they apply to IEHP Members who may also meet RUHS-BH's eligibility criteria; b. Provide coordination of care for IEHP Members eligible for RUHS-BH and other related community resources; c. Serve as a resource person and trainer to Members, RUHS-BH 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/RUHS-BH Members; and g. Participate in both RUHS-BH 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, RUHS-BH shall have secure access to Electronic Health Histories and may use Coordination of Care Web Forms (Exhibit II.1 through Exhibit II.3) 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 RUHS-BH 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.1 through Exhibit II.3) to share pertinent prescription, lab and clinical data with other authorized providers.
3. Services Provided	The scope of services provided by RUHS-BH 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).	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).

	RUHS-BH	IEHP
	RUHS-BH 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. RUHS-BH 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.	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 RUHS-BH 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. IEHP will provide non-specialty mental health services as identified in APL-17-018 (Exhibit VI). IEHP will refer Members who need specialty mental health services to the appropriate FFS/MC mental health provider. Beginning January 1, 2014, IEHP is responsible for the delivery of certain mental health services through the IEHP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that are outside the PCP's scope of practices. Services include: 1. Individual and group mental health evaluation and treatment (psychotherapy); 2. Psychological testing, when clinically indicated to evaluate a mental health condition; 3. Outpatient services for the purposes of monitoring drug therapy; 4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and, 5. Psychiatric consultation. As appropriate, IEHP and the provider will work with RUHS-BH to assure Members receive appropriate referrals for excluded diagnoses. As part of ongoing training operations with RUHS-BH, IEHP will provide

	RUHS-BH	IEHP
		RUHS-BH with annual updates to IEHP's policies and procedures. This would include operational and/or benefit changes/information as part of the quarterly Joint Operations Meetings (JOM). IEHP and RUHS-BH will include the Member in his/her treatment and demonstrate this by documenting the Member's participation in and agreement with treatment, including the client plan. IEHP and SBDBH also encourage beneficiary engagement and participation in an integrated care program, as medically necessary.
4. Diagnostic Evaluation and Triage	RUHS-BH 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. RUHS-BH'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, RUHS-BH authorizes services and provides Member with a choice of providers. When medical necessity criteria are not met, CARES staff will refer Member back to 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.	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.
5. Referrals (Referral Algorithm attached as Attachment B)	RUHS-BH 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, RUHS-BH Access Unit (CARES) will arrange for the provisions of specialty mental health services by a RUHS-BH provider. With Member consent, RUHS-BH will exchange relevant information with IEHP, via a secure website, when requests for mental health services are received for the Member through self-referral or through any other outside agency (including	Following a PCP's diagnostic evaluation, IEHP, and/or the PCP will refer to IEHP 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. IEHP will then make a determination on the appropriate level of care for the Member. If the Member appears to meet specialty mental health criteria then IEHP will refer the Member to RUHS-BH Access Unit (CARES) . If the Member has a mild to moderate condition, then the Member will be

	RUHS-BH	IEHP
	schools, court of law, correctional facilities, etc.) For coordination of care purposes, IEHP will share this information with the Member's PCP. 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 RUHS-BH and IEHP providers to ensure coordination of care. RUHS-BH may utilize the Coordination of Care Web Forms (Exhibit II.1 through Exhibit II.3) for this purpose as it applies to all CCI Members. An electronic interface will be established to exchange data. When RUHS-BH medical necessity criteria are not met, RUHS-BH will refer Members back to IEHP 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.1 through Exhibit II.3) to arrange for a referral through IEHP case management.	referred to an IEHP network behavioral health provider. IEHP will provide RUHS-BH 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.1 through Exhibit II.3) to share pertinent clinical data with other authorized providers.
6. Service Authorizations	RUHS-BH will authorize evaluation and/or treatment services by mental health specialists, who are employed by, credentialed by and/or contracted with RUHS-BH, for services that meet medical necessity criteria. This will be done through the RUHS-BH Access Unit (CARES). RUHS-BH will not authorize services for which IEHP is responsible. IEHP case management staff will be available to assist network IPAs and RUHS-BH 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 RUHS-BH for those Members receiving care from RUHS-BH. IEHP will not authorize services for which RUHS-BH is responsible. IEHP case management staff will be available to assist network IPAs and RUHS-BH in coordinating care and obtaining appropriate service authorizations.

	RUHS-BH	IEHP
7. EPSDT Supplemental Services	RUHS-BH 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, RUHS-BH is responsible for arranging EPSDT supplemental services provided by specialty mental health professionals. RUHS-BH 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.1, "MMCD Letter No. 96-074", Exhibit III.2, MMCD APL 18-007, and Exhibit IV, "Title 22, CCR Sections 51184, 51242, 51304, 51340, 51340.1, and 51532."	When RUHS-BH determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, IEHP may refer the child to the PCP or in-network BH provider. Referrals to RUHS-BH for an appropriate linked program will be made for treatment of conditions outside the IEHP provider's scope of practice. Complex Care Management services will be available to assist with care coordination with RUHS-BH for cases that are outside of the PCP's scope of practice. IEHP case management assists RUHS-BH and Members by providing links to known community providers of supplemental services (e.g., support groups). Complex Care Management services will assist in care coordination with CCS eligible cases. Per APL 18-007, IEHP will "cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for individuals under the age of 21 including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services." See Exhibit III.2, APL 18-007 – EPSDT.
8. Psychotropic Medications and Formulary	RUHS-BH will submit a credentialing application for specialty mental health physicians who will be prescribing medications to IEHP Members. RUHS-BH may utilize the Coordination of Care Web Forms (Exhibit II.1 through Exhibit II.3) to notify IEHP of the medications prescribed for Members as it applies to all CCI Members. RUHS-BH 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. RUHS-BH 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	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 RUHS-BH 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 RUHS-BH 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 RUHS-BH and

	RUHS-BH	IEHP
	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 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 RUHS-BH prescription history through the IEHP Secure Website, and offer the use of Coordination of Care Web Forms (Exhibit II.1 through Exhibit II.3) for coordination of prescription medications with the Member's PCP.
9. Laboratory Services, Radiological and Radioisotope Services	RUHS-BH providers may use an RUHS-BH 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. RUHS-BH providers will be informed of the process for submitting claims. This information will be disseminated to RUHS-BH providers primarily through provision of a Provider Manual and through provider meetings conducted by RUHS-BH 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. RUHS-BH is not responsible for the costs of medically necessary radiologic and/or radioisotope services, treatment, or evaluation of a Member's mental health condition.	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 RUHS-BH providers, the PCP and RUHS-BH Central Access Unit to coordinate these services. IEHP will provide RUHS-BH 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.1 through Exhibit II.3) 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

	RUHS-BH	IEHP
		facility. IEHP and/or its delegate shall cover and pay for all in and out of area professional services including 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	RUHS-BH 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. Transportation (Note: Medical Transportation Services are defined in Title 22, CCR, Section 51151.)	RUHS-BH 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 RUHS-BH.	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 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 the **non-emergency medical transportation** services necessary to provide IEHP Members with access to Medi-Cal

	RUHS-BH	IEHP
		covered services, subject to written prescription by a Medi-Cal mental health provider. 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 SBDBH's cost of providing service). Per APL 17-010 (Exhibit VII), Effective October 1, 2017 • IEHP will provide **Non-Medical Transportation (NMT)** for ALL Medi-Cal services, including those not covered by IEHP (ie., carve-outs). This includes dental, specialty mental health, and substance abuse treatment. o Examples: Passenger Car, Taxicab, Private Vehicle o For Members who are able to safely travel in a standard vehicle. Member must attest that they do not have a valid driver's license or working vehicle, are unable to travel or wait for services alone, or have a physical, cognitive, mental, or developmental limitation.
13. Home Health Agency Services	If RUHS-BH determines an IEHP Member requires medically necessary specialty mental health services as part of home health care, RUHS-BH will arrange for these services.	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

	RUHS-BH	IEHP
		mental health conditions of IEHP Members are the responsibility of IEHP.
14. Services for Developmentally Disabled Members	RUHS-BH 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, RUHS-BH will inform IEHP, its delegated entity, and the PCP of such referrals. RUHS-BH 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 including intellectual disabilities, autism, and mental diagnosis due to medical conditions when specialty mental health criteria is not met, 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)	RUHS-BH is responsible for hospital-based ancillary services as outlined in Attachment C.2. 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	RUHS-BH will be reimbursed by IEHP for authorized mental health services.	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	RUHS-BH 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 RUHS-BH 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	MHP will arrange for appropriate management of a Member's care, including the exchange of copies or summaries of medical records, with the Member's other health care providers or providers of specialty mental health services. MHP will maintain the confidentiality of medical records in accordance with applicable State and federal laws and regulations. (Title 9).	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 RUHS-BH, for release of relevant records and

	RUHS-BH	IEHP
	RUHS-BH may make available to IEHP non-identifying patient information and quarterly or annual aggregate reports for purposes of review, evaluation and accountability.	related case discussions regarding medical conditions and any current medications prescribed by IEHP providers. IEHP may make available to RUHS-BH non-identifying patient information and quarterly or annual aggregate reports for purposes of review, evaluation and accountability. IEHP and RUHS-BH will cooperate to develop specific protocols dealing with the sharing of information regarding substance abuse and HIV status.
19. Clinical Consultation and Training	The RUHS-BH will include consultation on medications to IEHP Members whose mental illness is being treated by RUHS-BH when requested by IEHP. Clinical consultation between the RUHS-BH and IEHP will include consultation on a beneficiary's physical health condition.	IEHP will provide clinical consultation and training to the RUHS-BH or other providers on physical health care conditions and on medications prescribed through IEHP providers, when requested by RUHS-BH. IEHP will provide clinical consultation to the RUHS-BH or other providers of mental health services on a Member's physical health condition. Such consultation will include consultation by IEHP to the RUHS-BH on medications prescribed by IEHP for a Plan Member whose mental illness is being treated by the RUHS-BH.
20. Provider Training	RUHS-BH conducts annual provider meetings. During these meetings multiple topics are covered, including coordination of care issues for Medi-Cal Managed Care patients. RUHS-BH regularly supplements the annual meetings with targeted written communication to providers as needed. RUHS-BH will assist IEHP in training IEHP providers about mental health specialty services provided through RUHS-BH and the coordination of care. RUHS-BH will assist in mental health training for IEHP PCPs as requested.	IEHP will train their providers on mental health specialty services provided through RUHS-BH and on coordinating care with RUHS-BH. 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 RUHS-BH in training RUHS-BH providers and coordinating care with IEHP as requested.
21. Quality Assurance/ Quality Improvement (Including Grievances and Complaints)	Conforming to the standards of Federal, State, and County guidelines on Quality Assurance, RUHS-BH 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.	IEHP will operate a Quality Assurance/Quality Improvement program, which includes the interface with RUHS-BH 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 RUHS-BH's report on the resolution of grievances, IEHP will report the resolution to the State. IEHP will have a system of sharing information with RUHS-BH on the dispensation of Fair Hearing cases. For a brief description of the grievance

	RUHS-BH	IEHP
	RUHS-BH 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 RUHS-BH. RUHS-BH 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. RUHS-BH will have a system of sharing information with IEHP on the dispensation of Fair Hearing cases. For a description of RUHS-BH Grievance Policy see Exhibit V, "RUHS-BH's Grievance Policy."	process, see Exhibit VI, "IEHP's Grievance Resolution Process." IEHP will involve RUHS-BH in relevant aspects of its Quality Assurance/Quality Improvement program.
22. Organizational Dispute Resolution	RUHS-BH 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** 1. The process will be initiated within 45 calendar days from the disputed event. 2. RUHS-BH will appoint a representative to attempt to reach and implement resolution decisions. 3. The representative of RUHS-BH will arrive at a proposed resolution jointly with the IEHP representative within 10 business days of initiation 4. If the representatives of RUHS-BH 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** 1. The second level review must be initiated within 10 business days of the first level decision. 2. RUHS-BH will use its Director or Director's designee as a second level reviewer. 3. The second level reviewer will attempt to reach a joint resolution with IEHP within 10 business days of initiation. 4. 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.	IEHP will coordinate with RUHS-BH 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** 1. The process will be initiated within 45 calendar days from the disputed event. 2. IEHP will appoint a representative to attempt to reach and implement resolution decisions. 3. The representative of IEHP will arrive at a proposed resolution jointly with the RUHS-BH representative within 10 business days of initiation. If the representatives of IEHP and RUHS-BH 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** 1. The second level review must be initiated within 10 business days of the first level decision. 2. IEHP will use its CEO or CEO's designee as a second level reviewer. 3. The second level reviewer will attempt to reach a joint resolution with RUHS-BH within 10 business days of initiation. 4. 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.

	RUHS-BH	IEHP
	Third Party Review 1. 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. 2. RUHS-BH agrees to provide specialty mental health services to the beneficiary during the dispute resolution process in accordance with current regulations.	**Third Party Review** 1. 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. 2. IEHP agrees to provide medically necessary services to the beneficiary during the dispute resolution process in accordance with current regulations. 3. If IEHP is unable to resolve a dispute with RUHS-BH, IEHP may submit a written "Request for Resolution" signed by the Chief Executive Officer (CEO) or his or her designee, to DHCS. The Request for Resolution must be submitted within 15 calendar days of the completion of the dispute resolution process described above. A Request for Resolution should be submitted via secure email to the DHCS' Managed Care Quality and Monitoring Division (MCQMD) and Mental Health Services Division (MHSD). REQUEST FOR RESOLUTION SUBMISSION REQUIREMENTS: A Request for Resolution submitted to DHCS must contain all of the following: 1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party; 2. History of attempts to resolve the issue with the RUHS-BH; 3. Justification for IEHP's desired remedy; and If applicable, any additional documentation that IEHP deems relevant to resolve the disputed issue(s).
23. Coordination of the Expanded Medi-Cal Mental Health Services	RUHS-BH will be responsible for conducting a multidisciplinary clinical team oversight process for clinical operations to include: screening, assessment, referrals, care management, care coordination, and exchange of medical information. Coordination of care for inpatient mental health treatment is to be provided by RUHS-BH, including a notification process between RUHS-	IEHP will be responsible for participating in a multidisciplinary clinical team oversight process for clinical operations to include: screening, assessment, referrals, care management, care coordination, and exchange of medical information. IEHP will accept referrals from RUHS-BH staff, providers, and members' self-referral for assessment, makes a determination of medical necessity

	RUHS-BH	IEHP
	BH and IEHP within 24 hours of admission and discharge to arrange for appropriate follow-up services. RUHS-BH will coordinate with IEHP to update Member care plans. RUHS-BH will provide coordination of care for inpatient mental health treatment and will notify IEHP within 24 hours of admission and discharge to arrange for appropriate follow-up services. RUHS-BH will have a process for updating the Member's care plan and coordinating with outpatient mental health providers. Members who are assessed for specialty mental health services and do not meet criteria will be transitioned appropriately to IEHP. As part of quarterly JOMs, RUHS-BH will review referral, care coordination and information exchange protocols and processes and monitor Member engagement and utilization. RUHS-BH will also review referral and care coordination processes to improve quality of care. RUHS-BH will share reports summarizing quality findings during this review process to improve quality of care, as determined in collaboration with DHCS. These reports will address the systematic strengths and barriers to effective collaboration between RUHS-BH and IEHP. Reports will track cross-system referrals, beneficiary engagement, and service utilization to be determined in collaboration with DHCS which includes the number of disputes between IEHP and RUHS-BH, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by members from RUHS-BH as well as quality strategies to address duplication of services.	for outpatient services, and provides referrals within IEHP's mental health provider network. See Exhibit II.2 for the mutually agreed upon screen tool per APL 17-018 (Exhibit VI). This screening assessment tool is subject to revision by IEHP upon notification to RUHS-BH. Members transitioning from inpatient mental health treatment to outpatient treatment will remain in treatment within RUHS-BH unless coordination of care between IEHP Care Management and RUHS-BH agree that the member no longer meets Specialty Mental Health Criteria and is appropriate for transition to the IEHP outpatient provider network. IEHP will have a process for updating the Member's care plan and coordinating with outpatient mental health providers. Members who are assessed for specialty mental health services and meet criteria will be transitioned appropriately to RUHS-BH. As part of quarterly JOMs, IEHP will review referral, care coordination and information exchange protocols and processes and monitor Member engagement and utilization. IEHP will also review referral and care coordination processes to improve quality of care. IEHP will share reports summarizing quality findings during this review process to improve quality of care, as determined in collaboration with DHCS. These reports will address the systematic strengths and barriers to effective collaboration between RUHS-BH and IEHP. Reports will track cross-system referrals, beneficiary engagement, and service utilization to be determined in collaboration with DHCS which includes the number of disputes between RUHS-BH and IEHP, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by Members from IEHP as well as quality strategies to address duplication of services. Effective January 1, 2014, IEHP will also provide the following outpatient mental health benefits to Members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual as set forth in MMCD All Plan Letter 17-018 (Exhibit VI) including:

	RUHS-BH	IEHP
		• Individual and group mental health evaluation and treatment (psychotherapy); • Psychological testing, when clinically indicated to evaluate a mental health condition; • Outpatient services for the purposes of monitoring drug therapy; • Psychiatric consultation; and Outpatient laboratory, drugs, supplies, and supplements, excluding medications listed in Attachment 2 of MMCD All Plan Letter 17-018.

ACTIVITIES DESCRIPTION GRID FOR SUBSTANCE ABUSE TREATMENT UNDER DRUG MEDI-CAL ORGANIZED DELVIERY SYSTEM WAIVER INDEX

	RCMHP	IEHP
1. Services Provided	The Scope of Services provided by RCMHP under the terms of this agreement shall equal the services identified as the California Bridge to Health Reform Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Waiver Standard Terms and Conditions (STCs), which outlines a continuum of care for substance use disorder treatment services. RCMHP will authorize services to Medi-Cal beneficiaries meeting medical necessity criteria and enrolled in IEHP pursuant to this agreement and to State and Federal regulations. Services will be provided with or without referral by IEHP and its plan partners. RCMHP will be responsible to provide substance use disorder services meeting criteria outlined in State Regulations CCR Title 22, Division 3, Subdivision 1, Chapter 3, Article 4, Section 51341.1; and CCR Title 9, Division 4, as applicable. A Member may receive substance use disorder services when medical necessity and diagnosis has been established as defined by regulations.	IEHP will provide access and linkage to physical health care services to shared consumers. As appropriate, IEHP and the provider will work with RCMHP to assure Members receive appropriate referrals for substance use disorders and substance use and misuse prevention services. IEHP will provide communication linkages to Primary Care Physicians for the use of medication assisted interventions and MD to MD consults for appropriate treatment planning and case conferencing needs.

	RCMHP	IEHP
	RCMHP will work with IEHP and the Member's PCP to obtain appropriate substance use disorder services.	
2. Referrals	RCMHP will accept Medi-Cal referrals from IEHP staff, providers, and IEHP Members (self-referral) seeking substance use disorder services for IEHP Members. Once a client assessment has been completed by RCMHP, and the appropriate ASAM Criteria level of care has been determined, appropriate referrals will be initiated to service providers through either a RCMHP clinic or a Contract Agency, such as: 1. Individual Prevention Services (Level 0.5) 2. Withdrawal Management Level3.2-WM 3. Residential Treatment Levels 3.1, 3.3, and 3.5 4. Intensive Outpatient Treatment Services 9-19 Hours weekly for adults and 6-19 Hours a week for adolescents 5. Outpatient Treatment Services up to 9 hours weekly for adults and adolescents 6. Perinatal Treatment Options 7. Recovery Services 8. Medication Assisted Treatment (Residential and Outpatient) A Certified Alcohol and Drug Counselor or LPHA will assess Members, and place Members into the appropriate treatment modality When medical necessity criteria are met, RCMHP will authorize services and provide Member with a choice of providers. When medical necessity criteria are not met, SU CARES staff will refer Member to prevention services. Should the Member decline RCMHP's referral to prevention services, the Member shall be referred back to IEHP BH case management. With Member's written consent, RCMHP will notify IEHP and the Member's PCP, when a request for substance use disorder 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	Upon completion of a screening and Universal Release of Information containing current CFR42 Part II language, IEHP will refer a member who requires further substance use disorder assessment to RCMHP using the IEHP web-portal. IEHP has put in place an incentive mechanism for Primary Care Providers to complete comprehensive substance abuse, physical, and mental health screening, including ASAM Level 0.5 SBIRT services. IEHP will be responsible for providing a medical and psychiatric screening and clearance, prior to referral to RCMHP. Once IEHP identifies a need for substance use disorder services, the referral to RCMHP shall be fast-tracked. IEHP will cooperate with RCMHP to place consumers in the appropriate level of treatment, including but not limited to residential treatment levels 3.7 and 4.0 and assist RCMHP with placement, as needed. IEHP liaisons shall serve as the primary contact with RCMHP care coordination representatives for purposes of referrals and case management. Outreach to consumers will be initiated by RCMHP.

	RCMHP	IEHP
	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.	
3. Case Management	RCMHP will provide substance abuse treatment case management for IEHP Members admitted to RCMHP clinics or Provider facilities. RCMHP will provide primary practitioners and case management personnel to meet with IEHP liaisons and case managers to review cases onsite, as well as discuss and share treatment plans and progress. RCMHP will provide case management and direct linkage between levels of care and connection to Primary care. RCMHP shall take the lead of substance abuse treatment case management. RCMHP will provide case management services as follows: a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; b. Transition to a higher or lower level of SUD care; c. Development and periodic revision of a client plan that includes service activities; d. Communication, coordination, referral and related activities; e. Monitoring the beneficiary's progress; f. Patient advocacy, linkages to physical and mental health care, and transportation to primary care services. Treatment need and medications needed by the Member shall be identified by IEHP PCP. In the event of a delay or barrier to treatment by RCMHP or a contracted provider, RCMHP shall contact IEHP directly for the necessary information.	IEHP will provide web portal access to RCMHP case managers to coordinate care at the point of delivery. IEHP will provide medical case management for Members as necessary. IEHP will provide case management liaisons and case managers to review cases onsite, as well as discuss and share treatment plans and progress. IEHP Liaisons will assist RCMHP to: a. Provide coordination of care for IEHP Members eligible for RCMHP and other related community resources; b. Arrange case conferences in response to service and benefit questions arising out of either agency; c. Assist with the collection analysis of data and preparing case management reports; d. Assist with tracking continuity of care for identified IEHP/RCMHP Members; and e. Participate in both RCMHP and IEHP staff meetings, and in external meetings with other health service providers as assigned. f. As a component of case management, IEHP can provide total cost of care to assist RCMHP to demonstrate effectiveness of SUD program. Treatment need and medications needed by the Member shall be identified by IEHP PCP.

	RCMHP	IEHP
4. Clinical Consultation and Consultation on Medicine	The RCMHP will include consultation on medications to IEHP Members whose mental illness is being treated by RCMHP when requested by IEHP. Clinical consultation between the RCMHP and IEHP will include consultation on a beneficiary's physical health condition. This meeting will take place on a monthly basis at a centralized location, to be determined by RCMHP.	IEHP will provide clinical consultation to 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.
5. Biopsychosocial Assessment	RCMHP will provide a risk severity rating as well as an immediate need profile which will assist in pre-determining the appropriate ASAM Criteria level of care that beneficiary requires. RCMHP will initiate a referral to the appropriate level of care and assist the Member in enrolling in the facility. RCMHP or contracted provider will provide a complete biopsychosocial assessment and ASAM Assessment at intake with diagnosis and medical necessity statement with an MD or LPHA. When an IEHP member is identified as having a possible co-occurring disorder, a referral will be initiated with IEHP or RCMHP for behavioral health services.	IEHP and/or delegated entities will arrange and pay for appropriate medical assessments for Members to identify co-morbid physical and behavioral health (mental and SUD) conditions. The PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological and/or substance use disorder symptoms or refer the Member for specialty physical health for sub treatment. Complex Care management services will be made available for cases that are referred to specialty physical care and will coordinate with RCMHP.
6. Confidentiality	RCMHP will maintain confidentiality of medical records and other protected health information (PHI) in accordance with all applicable Federal and State laws and regulations and contract requirements, including but not limited to; 42 Code of Federal Regulations (CFR), Chapter 1, Subchapter A, Part 2. RCMHP will adhere to current policies and procedures ensuring the confidentiality of the medical records. RCMHP providers will obtain an appropriate signed consent to release information for each stakeholder, including IEHP, involved with the Member's recovery, signed by the Member. RCMHP may make available to IEHP non-identifying Member	IEHP will maintain confidentiality of medical records and other protected health information (PHI) in accordance with all applicable Federal and State laws and regulations and contract requirements, including, but not limited to; 42 CFR, Chapter 1, Subchapter A, Part 2. IEHP will adhere to current policies and procedures ensuring the confidentiality of the medical records. IEHP providers will obtain an appropriate signed consent to release information for each stakeholder, including RCMHP, involved with the Member's recovery, signed by the Member. IEHP may make available to RCMHP non-identifying Member information and quarterly reports fro purposes of review, evaluation

	RCMHP	IEHP
	information and quarterly reports for purposes of review, evaluation and accountability. After the consent to release information is signed, RCMHP will share Member information such as: diagnosis, care goals, treatment plan, treating facility name and license number (if applicable), treating provider title or license, utilization data, prescribed medications, summary progress report, treatment status, as requested by IEHP, for the purposes of coordination of care. RCMHP will cooperate with IEHP to develop specific protocols dealing with the sharing of information regarding substance use disorders.	and accountability. After the consent to released information is signed, IEHP will share Member information via the provider web portal, ad hoc reporting through IEHP Liaisons, or provide access to IEHP Nurse and Behavioral Health Care Managers and Liaisons, as needed. IEHP will cooperate with RCMHP to develop specific protocols dealing with the sharing of information regarding substance use disorders.
7. Care Coordination/ Interdisciplinary Care Team	RCMHP will participate in Interdisciplinary Care Teams (ICTs) for Members receiving county administered services and identified as needing an ICT, in accordance with a member's decision about appropriate involvement of providers and caregivers on the ICT. RCMHP will work with IEHP to perform, on an annual basis, a 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.	IEHP will participate in Interdisciplinary Care Teams (ICTs) for members receiving county-administered services and identified as need an ICT, in accordance with a Member's decision about appropriate involvement of providers and caregivers on the ICT. IEHP 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 RCMHP providers, when necessary. IEHP will coordinate with RCMHP to perform and 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.
8. 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	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

	RCMHP	IEHP
	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.	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.

ACTIVITIES DESCRIPTION GRID FOR EATING DISORDER SERVICES
INDEX

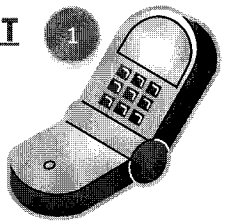
	RUHS-BH	IEHP
1. Services Provided	RUHS-BH will authorize services to Medi-Cal beneficiaries meeting medical necessity criteria for Eating Disorder services and enrolled in IEHP pursuant to this agreement and to State and Federal regulations. Services will be provided with or without referral by IEHP and its plan partners. A Member may receive Eating Disorder services when medical necessity and diagnosis has been established as defined by regulations. RUHS-BH will work with IEHP and the Member's PCP to coordinate appropriate Eating Disorder services.	If medical necessity is met, IEHP, in collaboration with RUHS-BH, will authorize appropriate level of care. The levels include: • Inpatient Psychiatric (Eating Disorder) • Residential • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP)
2. Referrals/Coordination	RUHS-BH will accept Medi-Cal referrals from IEHP staff, providers, and IEHP Members (self-referral) for determination of medical necessity and provide appropriate Eating Disorder services. When all medical necessity criteria are met, RUHS-BH Access Unit (CARES) will arrange for the provisions of Eating Disorder services by a RUHS-BH provider. With Member consent, RUHS-BH will notify a Member's PCP, when requests for Eating Disorder services are received for the Member through self-referral or through any other outside agency. 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	IEHP will accept a standard referral form from the Primary Care Physician (PCP), an Eating Disorder Program, IEHP BH Provider, or RUHS-BH Provider. The IEHP Outpatient BH Care Manager: • Coordinates with IEHP Providers and County Providers re: Member's level of care request. • Consults with Supervisor/BH Medical Director regarding any referrals for specialized Eating Disorder Treatment. • Completes LOA's when members meet criteria

	RUHS-BH	IEHP
	RUHS-BH and IEHP providers to ensure coordination of care. RUHS-BH may utilize the Coordination of Care Web Forms (Exhibit II.1 through Exhibit II.3) for this purpose as it applies to all CCI Members. An electronic interface will be established to exchange data. When RUHS-BH medical necessity criteria are not met, RUHS-BH 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).	to be admitted to a higher level of care program for Eating Disorder, for non-contracted facilities. • Connects County clinicians to PHP/IOP/Inpatient/Residential Treatment Center clinicians.
3. Intensive Care Coordination	RUHS-BH will provide Intensive Care Coordination (ICC) for IEHP Members meeting medical necessity criteria for Eating Disorder services. RUHS-BH will provide ICC and direct linkage between levels of care as determined by the RUHS-BH and IEHP Medical Directors. RUHS-BH will provide ICC as follows: a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of ICC; b. Development and periodic revision of a client plan that includes service activities; c. Communication, coordination, referral and related activities; d. Monitoring the beneficiary's progress; e. Patient advocacy, linkages to physical and mental health care, and transportation to primary care services. RUHS-BH will participate in Interdisciplinary Care Teams (ICTs) for Memebers receiving Eating Disorder services in accordance with a Member's decisions about participants on the ICT. This meeting will occur withing the first 30 days of beginning care as determined by the Member and the ICT.	The IEHP Outpatient BH Care Manager: • Coordinates with IEHP Providers and County Providers re: Member's level of care request. • Consults with Supervisor/BH Medical Director regarding any referrals for specialized Eating Disorder Treatment. • Completes LOA's when members meet criteria to be admitted to a higher level of care program for Eating Disorder, for non-contracted facilities. • *Connects County clinicians to PHP/IOP/Inpatient/Residential Treatment Center* ***clinicians.***

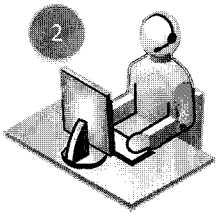
	RUHS-BH	IEHP
	RUHS-BH will work with IEHP to perform, on an annual basis, a review, analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.	
4. Clinical Consultation and Consultation on Medicine	Clinical consultation between the RUHS-BH and IEHP will include consultation on a beneficiary's progress and treatment. This meeting will take place on an every other month basis at a centralized location, to be determined by RUHS-BH.	The IEHP Utilization Review BH Care Manager will conduct review per established IEHP BH protocols to determine medical necessity. All decisions will be discussed between the BH Medical Directors of IEHP and RUHS-BH.
5. Confidentiality	RUHS-BH will arrange for appropriate management of a Member's care, including the exchange of copies or summaries of medical records with Member's other health care providers or providers of Eating Disorder services in accordance with applicable State and Federal laws and regulations (Title 9). RUHS-BH may make available to IEHP non-identifying patient information and quarterly or annual aggregate reports for purposes of review, evaluation and accountability.	IEHP will share clinical information with RUHS-BH for the purposes of health care operations, payment, and treatment, per HIPAA§164.501

Referral Algorithm and ICT Process – MCP to MHP (Tier 2 to 3)

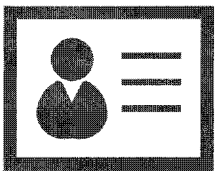
INITIAL CONTACT



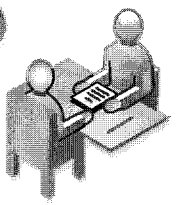
Member calls in to IEHP



IEHP BH Screens

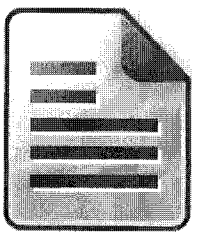


Member receives referrals to Tier 2 providers

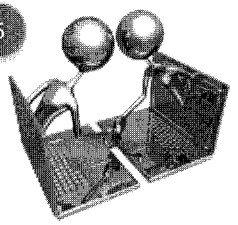


Member sees provider(s) Substance Use Services is "carved out" to the County; Member is warm transferred to RUHS-BH SUD CARES

NOTIFICATION

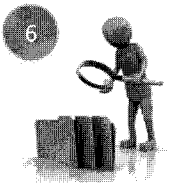


BH Utilization Management (UM) receives recommendation to transition to higher level of care

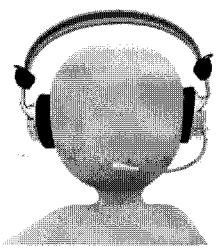


Referral processor notifies BH UM Care Manager (CM) of recommendation

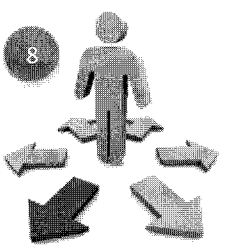
REVIEW



BH UM CM reviews provider's recommendation and Member's treatment history

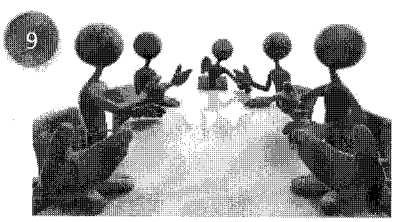


BH UM CM follows up with authorized provider(s) and/or Member to gather additional clinical information, if needed



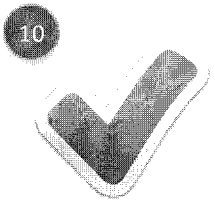
BH UM CM determines appropriate level of care

ICT



Cases are discussed at the ICT meeting held the last Tuesday of the month

DECISION

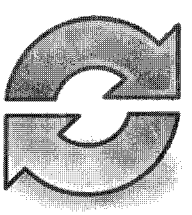


Approved

County follows up with Member to link to services
IEHP follows up with authorized provider(s)

Rejected

IEHP will follow up with provider(s) and/or Member



IEHP sends feedback to County on disposition

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 UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH responsible for the provision of Medi-Cal specialty mental health and/or Drug Medi-Cal services (if separate) hereinafter referred to as "RUHS-BH."

2. TERMS

This memorandum shall commence on April 1, 2014 and shall continue through December, 31 2017.

3. TASKS, RESPONSIBILITIES AND/OR OBLIGATIONS

A. Roles and Responsibilities

1. Covered Services are listed in the most recent version of 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 RUHS-BH 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 RUHS-BH 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 RUHS-BH shall develop and agree to written policies and procedures regarding referral processes, including the following:

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

        ii. The PLAN will accept referrals from the RUHS-BH when the service needed is one provided by the PLAN and not the RUHS-BH 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 RUHS-BH 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 RUHS-BH will provide verification of professional licensure, the National Provider Identifier (NPI), and other information as needed to confirm RUHS-BH and its contractors are Medicare eligible and certified providers eligible providers.

7. Payment Mechanism

    The reimbursement mechanism between RUHS-BH 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 RUHS-BH for Medicare-covered mental health services rendered by the RUHS-BH.

The RUHS-BH 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 RUHS-BH to obtain appropriate reimbursement under the Medi-Cal program.

8. Rates

   The PLAN shall provide the RUHS-BH 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 RUHS-BH 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 RUHS-BH 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. RUHS-BH 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.

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 RUHS-BH 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 RUHS-BH that may include the following.

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. RUHS-BH 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 RUHS-BH 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 RUHS-BH 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 RUHS-BH 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 RUHS-BH 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 RUHS-BH.

1. The PLAN and RUHS-BH 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 (4/1/14 - 12/31/15):

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 RUHS-BH.

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 (1/1/16-12/31/16): [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 (1/1/17-12/31/17): [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 RUHS-BH agree that if the specified shared accountability measure is met in each year, the PLAN will provide an incentive payment to the RUHS-BH 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 RUHS-BH 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:

- DMH INFORMATION NOTICE NO: 10-11 May 6, 2010;
- DMH INFORMATION NOTICE NO: 10-23 Nov. 18, 2010;
- DMH INFORMATION NOTICE NO: 11-06 April 29, 2011

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.

Current Medications + Add Medication

Medication	Quantity	Days Supplied	Date Filled
Out of medication	Medication running out in # days		

(Required) Safety Risk Assessment ☐ None

1. Suicidal	○ None ○ Mild ○ Moderate ○ Severe
2. Homicidal	○ None ○ Mild ○ Moderate ○ Severe
3. Gravely Disabled	○ Yes ○ No
4. Non-Suicidal Self Injury	○ Mild ○ Moderate ○ Severe
5. History of Psychiatric Hospitalization	○ None ○ Within last 30 days ○ Within last 3 months
6. History of running away	○ Yes ○ No
IEHP Immediate Intervention	☐ Crisis Intervention ☐ Crisis Response Team ☐ Emergency Responders

Behavioral / Mental Health Services Requested

☐ Individual Therapy ☐ Medication Evaluation ☐ Medication Management

☐ Substance Abuse Treament Program ☐ Other _____

Member / Client Provider Choice

Submit Cancel

Medi-Cal MHSUD Delivery System

Attachment E – Medi-Cal Coverage and Population Matrix

Inland Empire Health Plan

Medi-Cal Managed Care Plan (MCP)
IEHP & Molina

Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services

MCP services to be carved-in effective 1/1/14

- ✓ Individual/group mental health evaluation and treatment (psychotherapy)
- ✓ Psychological testing when clinically indicated to evaluate a mental health condition
- ✓ Psychiatric consultation for medication management
- ✓ Outpatient laboratory, supplies and supplements
- ✓ Screening, Brief Intervention and Referral to Treatment (SBIRT)
- ✓ Drugs, excluding anti-psychotic drugs (which are covered by Medi-Cal FFS)

County Mental Health Plan (MHP)
RUHS-BH & SBDBH

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental health Services

Outpatient Services

- ✓ Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
- ✓ Medication Support
- ✓ Day Treatment Services and Day Rehabilitation
- ✓ Crises Intervention and Crises Stabilization
- ✓ Targeted Case Management
- ✓ Therapeutic Behavior Services

Residential Services

- ✓ Adult Residential Treatment Services
- ✓ Crises Residential Treatment Services

Inpatient Services

- ✓ Acute Psychiatric Inpatient Hospital Services
- ✓ Psychiatric Inpatient Hospital Professional Services
- ✓ Psychiatric Health Facility services

County Alcohol and Other Drug Programs (AOD)
RUHS-BH & SBDBH

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services

Outpatient Services

- ✓ Outpatient Drug Free
- ✓ Intensive Outpatient (newly expanded to additional populations)
- ✓ Residential Services (newly expanded to additional populations)
- ✓ Narcotic Treatment Program
- ✓ Naltrexone

New Services

- ✓ Voluntary Inpatient Detoxification Services

Source: DHCS

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

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-8076

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 requirements 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**electroconvulsive 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.

Specialty Mental Health Services Providers

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(l), 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

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.

Exhibit 1

Enclosure 2

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

Exhibit I

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

Enclosure 4

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.

Enclosure 4

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.

Enclosure 4

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 Coordination of Care Web Forms
Authorization Request

BH Authorization Request Form

* denotes a required field

Member/Provider Identification

*IEHP ID:	IEHPID
*Are you submitting a correction to an existing authorization?	Yes / No
*Requesting Provider:	

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Referral Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567):	
*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider.	Yes / No

Please attach completed Release of Information form in the Supporting Documents section below. **Click here to print the release.**

*Discussed referral with Member who is in agreement.	☐

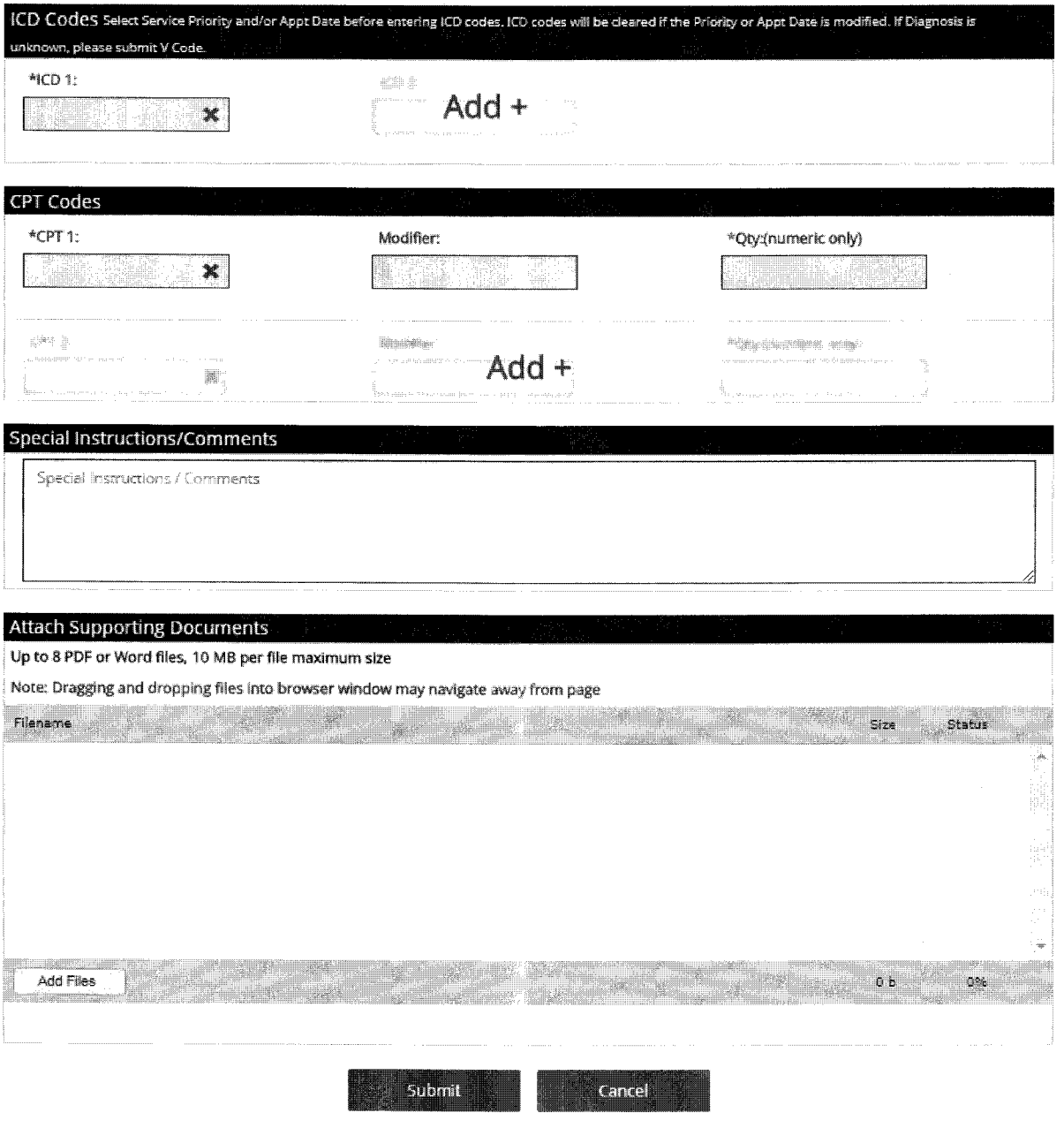
Service Information

*Service Requested:	BH Medication Consult & Treatment
*Has the Member been on medication before?	Yes / No
*Is the Member currently on medication?	Yes / No
*Please Specify	
*Is the Member currently in psychotherapy (talk therapy)?	Yes / No
*Servicing Provider: (Must refer to specialist within network)	Any-In-Network

Service Priority

*Is the Authorization a patient request?	Yes / No
*Service Priority (Medi-Cal: Decision within 5 Business Days) (CMC: Decision within 14 Calendar Days)	Expedited / Standard Pre-Service / Standard Post-Service Appt Date: MM/DD/YYYY

Behavioral Health Coordination of Care Web Forms
Authorization Request



Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Coordination of Care Treatment Plan

Welcome to the Behavioral Health Coordination of Care Treatment Plan. Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid IEHP ID, authorization number, select a Behavioral Health Service Provider and select a Request for Additional Services option.

* denotes a required field

Request Information

*IEHP ID:

*Authorization Number

*Requesting Provider

*Request For Additional Services: Continue with Medication Management

Next Scheduled Visit Date (if applicable)

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Member PCP Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Diagnosis

*Primary Diagnosis

*Secondary Diagnosis

Additional Diagnosis

Physical Disorders and/or Medical Conditions

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Current Medications

*Is the Member currently taking mental health medication NOT listed below? Yes | No

*Drug Name	*Dosage Form	*Strength (mg/ml)	*Quantity

Add Medication +

Pharmacy Information (Past 6 Months)

Drug Name	Prescriber	Filled By	Qty	Filled On

Pre...

Unfilled Prescriptions (Past 1 Month)

No Records Found (1 month prior)

CPT Codes

*CPT 1:	Modifier:	*Qty:(numeric only)

Add +

Visit Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567): Phone Number (e.g. 9991234567)

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider. Yes | No

Please attach completed Release of Information form in the Supporting Documents section below. Click here to print the release.

*Discussed referral with Member who is in agreement.

*Co Treating BH Provider Other Than Self: Yes | No

Search Available BH Providers

*Have you addressed clinical concerns with other BH Providers for this Member? Select One

*Have you been in communication with the Member's prescriber of psychotropic medication? Select One

*Have you communicated medical concerns with Members primary care doctor(s)? Select One

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Tier 3 Screening

The following questions are intended to identify Members who need to be transitioned to a County Mental Health System for a higher level of care and/or Member meets Tier 3 Criteria

***Does the Member have any of the following conditions?**

- [x] Pervasive Developmental Disorder, except Autistic Disorder
- [ ] Disruptive Behavior and Attention Deficit Disorders
- [ ] Feeding and Eating Disorders of Infancy and Early Childhood
- [ ] Elimination Disorder
- [ ] Other Disorders of Infancy, Childhood or Adolescence
- [ ] Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to General Medical Condition
- [ ] Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- [ ] Somatoform Disorders
- [ ] Factitious Disorders
- [ ] Dissociative Disorders
- [ ] Paraphilias
- [ ] Gender Identity Disorders
- [ ] Eating Disorders
- [ ] Impulse Control Disorders not Elsewhere Classified
- [ ] Adjustment Disorders
- [ ] Personality Disorders, excluding Antisocial Personality Disorder
- [ ] Medication-Induced Movement Disorders related to other included diagnosis
- [ ] None

***As a result of a mental disorder, does the Member have a significant impairment in any of the following life functioning areas?**

- [x] Health Care Self-Care Inadequacy
- [ ] Occupational and Academic
- [ ] Legal
- [ ] Financial
- [ ] Interpersonal / Social
- [ ] None

***Will the focus of the proposed intervention/treatment be to accomplish one or more of the following:**

- [x] Significantly remedy the impairment
- [ ] Prevent significant deterioration in an important area of life functioning
- [ ] Allow the child to progress developmentally as individually appropriate
- [ ] None

*** The mental disorder would not be responsive to primary care based treatment.** Yes

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Treatment Objectives

Please indicate the 3 continued or future treatment objectives

*Objective 1:

*Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [ ] Other

Please Specify

*Current Rating: 4 - Some Improvement

*Prior Rating: Select One

*Objective 2:

*Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [ ] Other

*Current Rating: Select One

Objective 3:

Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [ ] Other

Current Rating: Select One

*Has the Member received treatment in a higher level of care (e.g. Inpatient Psychiatric Hospitalization, Intensive Outpatient Treatment) in the last 6 months? Yes / No

*Was a standard instrument used to evaluate treatment progress? Yes / No

Name of the instrument

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Additional Clinical Information

Attach Supporting Documents

Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename	Size	Status
Add Files	0 b	0%

Submit Cancel

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

BH Authorization Request Form

* denotes a required field

Member/Provider Identification

*IEHP ID: IEHPID

*Are you submitting a correction to an existing authorization? Yes No

*Requesting Provider:

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Referral Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567):

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider. Yes No

*Discussed referral with Member who is in agreement.

Service Information

*Service Requested: Behavioral Health Treatment for Autism Spectrum Disorder

- ABA Therapy (only for confirmed ASD Diagnosis)
- Speech Therapy (only for confirmed ASD Diagnosis)
- Occupational Therapy (only for confirmed ASD Diagnosis)
- Physical Therapy (only for confirmed ASD Diagnosis)
- Other

Must attach clinical diagnosis.

*Servicing Provider: (Must refer to specialist within network) Any In-Network

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Service Priority

*Is the Authorization a patient request?

Yes

*Service Priority

(Medi-Cal: Decision within 5 Business Days)
(CMC: Decision within 14 Calendar Days)

Expedited | Standard Post-Service

Appt Date:

ICD Codes

*ICD 1:

Add +

CPT Codes

*CPT 1:

Modifier:

*Qty:(numeric only)

Add +

Special Instructions/Comment

Attach Supporting Documents

*Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename | Size | Status

Add Files

0 b

Submit | Cancel

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Coordination of Care Treatment Plan

Welcome to the Behavioral Health Coordination of Care Treatment Plan. Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid IEHP ID, authorization number, select a Behavioral Health Service Provider and select a Request for Additional Services option.

* denotes a required field

Request Information

*IEHP ID:	IEHPID
*Authorization Number	
*Requesting Provider	
*Request For Additional Services	Continue with Autism Services
Next Scheduled Visit Date (if applicable)	

Member Information

Name:	Gender:	DOB:	Age:
Address.	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Member PCP Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Diagnosis

*Primary Diagnosis	
*Secondary Diagnosis	
Additional Diagnosis	
Physical Disorders and/or Medical Conditions	

Exhibit II.2

Behavioral Health Coordination of Care Web Forms
Continuation of Care and Treatment Plan

Current Medication

*Is the Member currently taking mental health medication NOT listed below? Yes / No

*Drug Name	*Dosage Form	*Strength (mg/ml)	*Quantity	

Add Medication +

Visit Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567): Phone Number (ie. 9991234567)

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider. Yes / No

Please attach completed Release of Information form in the Supporting Documents section below. Click here to print the release.

*Discussed referral with Member who is in agreement.

*Co Treating BH Provider Other Than Self: Yes / No

Search Available BH Providers

*Have you addressed clinical concerns with other BH Providers for this Member?

*Have you been in communication with the Member's prescriber of psychotropic medication?

*Have you communicated medical concerns with Members primary care doctor(s)?

Additional Clinical Information

Attach Supporting Documents

*Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename	Size	Status
Add Files	0 b	0%

Submit Cancel

Behavioral Health Coordination of Care Web Forms
No Further Treatment Requested

Coordination of Care Treatment Plan

Welcome to the Behavioral Health Coordination of Care Treatment Plan. Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid IEHP ID, authorization number, select a Behavioral Health Service Provider and select a Request for Additional Services option.

* denotes a required field

Request Information

*IEHP ID:	IEHPID
*Authorization Number	
*Requesting Provider	
*Request For Additional Services	No Further Treatment Requested *
Next Scheduled Visit Date (if applicable)	

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Member PCP Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:

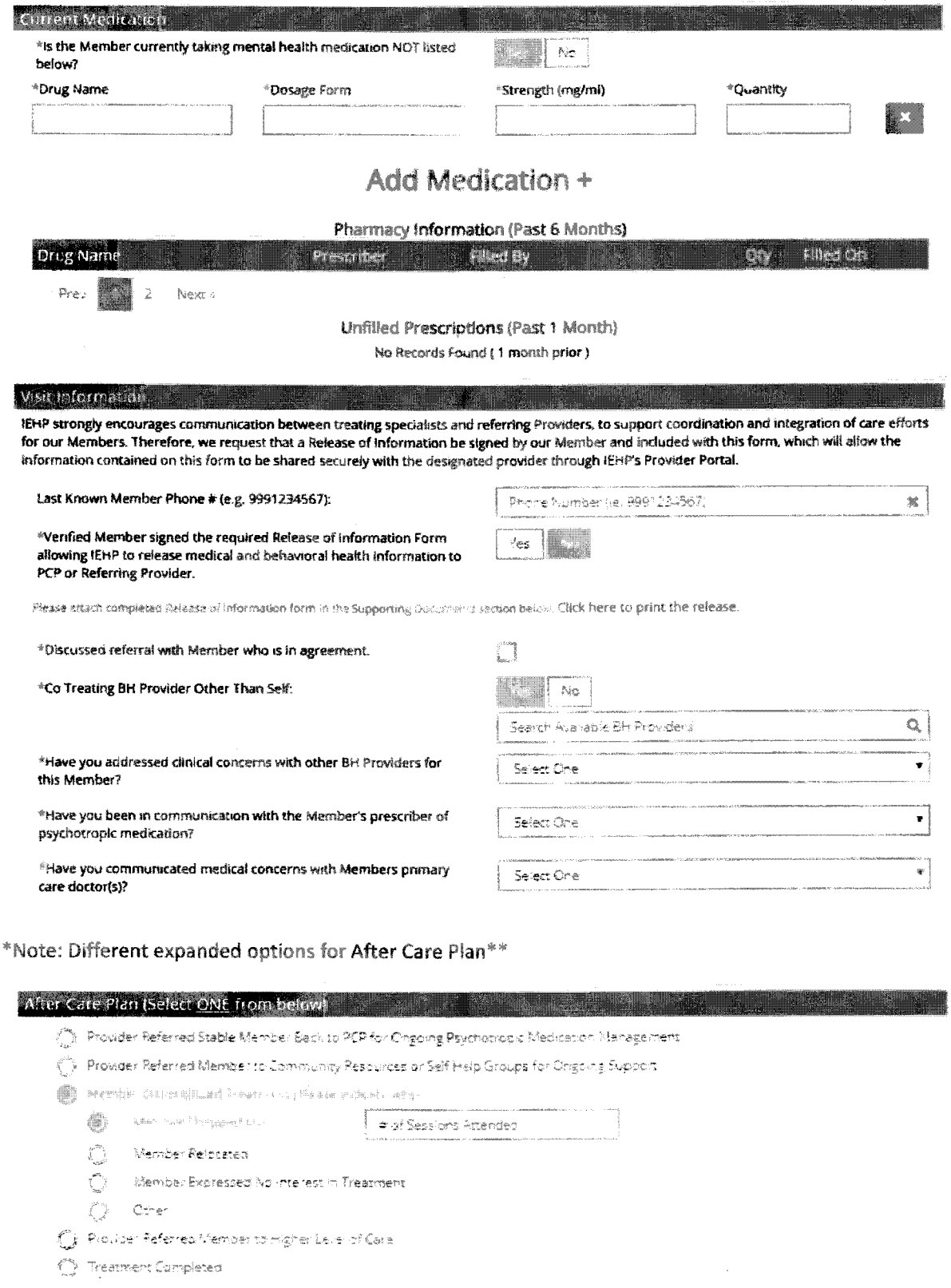
Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Diagnosis

*Primary Diagnosis	
*Secondary Diagnosis	
Additional Diagnosis	
Physical Disorders and/or Medical Conditions	

Behavioral Health Coordination of Care Web Forms
No Further Treatment Requested



Note: Different expanded options for After Care Plan

Exhibit II.3

Behavioral Health Coordination of Care Web Forms
No Further Treatment Requested

After Care Plan (Select ONE from below)

- ○ Provider Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- ○ Provider Referred Member to Community Resources or Self Help Groups for Ongoing Support
- ○ Member Discontinued Treatment (Please Indicate Why)
- ◉ [illegible] Higher Level of Care
  - ○ County Mental Health Program
  - ◉ Other: Please Specify
- ○ Treatment Completed

Additional Clinical Information

Attach Supporting Documents

Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename	Size	Status
Add Files	0 b	0%

Submit Cancel