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

ITEM: 3.25
(ID # 10979)
MEETING DATE:
Tuesday, May 25, 2021

FROM: RUHS-BEHAVIORAL HEALTH:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH: Ratify and Approve the Addendum to the Memorandum of Understanding Between Inland Empire Health Plan and Riverside University Health System – Behavioral Health, All Districts. [Increase of $2,150,000 for FY20/21, and $1,150,000 for FY 21/22 and FY 22/23; $4,450,000 Total Cost Increase, 100% State Funds]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the Memorandum of Understanding (MOU) between Inland Empire Health Plan (IEHP) and Riverside University Health System – Behavioral Health (RUHS-BH) for the Medi-Cal and Medicare Dual Choice Beneficiaries for FY 20/21 to: 1) increase the amount by $2,150,000 from $300,000 to $2,500,000 for FY20/21; 2) increase by $1,150,000 to $1,500,000 for FY21/22 and FY22/23; 3) accept $153,000 from IEHP for the Health Homes Program through December 31, 2021; and 4) authorize the Director of RUHS-BH to execute the Addendum; and
2. Authorize the Director of RUHS-BH to sign ministerial amendments and renewals for this MOU, not to exceed $1,500,000 annually through June 30, 2023.

ACTION: Policy

Matthew Chang
Matthew Chang, Director 5/19/2021

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes:	Jeffries, Spiegel, Washington, Perez, and Hewitt
Nays:	None
Absent:	None
Date:	May 25, 2021
xc:	RUHS-BH

Kecia R. Harper
Clerk of the Board
By: _____
Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$2,150,000	$1,150,000	$4,450,000	$0
NET COUNTY COST	$0	$0	$ 0	$0
SOURCE OF FUNDS: 100% State Funds			**Budget Adjustment:** No	
			For Fiscal Year: 20/21–22/23	

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.

On August 28, 2018 (3.55), the Board approved the new MOU with IEHP that combined the previous amendments into one document, updated forms to current business processes and added transportation and Eating Disorder services effective through June 30, 2023. RUHS-BH in collaboration with IEHP are working to enhance the service delivery continuum for eating disorder services, and have additionally experienced a significant increase in the volume and severity of eating disorder cases throughout the pandemic. Claims for services provided have exceeded the Board authorized amount of $350,000; therefore, RUHS-BH is requesting the Board to ratify and approve an increase to the aggregate for FY20/21 through FY22/23.

In addition, this amendment will add the Health Homes Program (HHP) to the MOU. This program serves eligible Medi-Cal Members with complex medical needs and chronic conditions who may benefit from intensive care management and coordination, and coordinates the full range of physical health, behavioral health, and community-based long-term services and supports. In joining IEHP's network of Community Based Care Management Entities (CB-CME's) that participate in HHP, RUHS-BH will address consumers' health needs by delivering behavioral health care services with a person-centered, comprehensive approach.

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

There are sufficient appropriations in the Department's budget. There are no additional County funds required.

Aggregate	Current Annual Maximum Amount	Increase	New Annual Maximum Amount
FY20/21	$350,000	$2,150,000	$2,500,000
FY21/22	$350,000	$1,150,000	$1,500,000
FY22/23	$350,000	$1,150,000	$1,500,000
Total Increase		$4,450,000	$5,500,000

Alonzo Barrera 5/20/2021

Gregory P. Priamos, Director County Counsel 5/20/2021

Request 3.25

Estrada, Oksana

From: Melissa Noone <MNoone@ruhealth.org>
Sent: Wednesday, May 26, 2021 11:27 AM
To: Estrada, Oksana
Subject: Copy of Signed Form 11

Importance: High

Hi Oksana,

I hope you are well! Can you please provide me with the signed item M.O. 3.25 (MT#10979) approved by the BOS yesterday?

Thank you,

Melissa Noone
Administrative Services Manager
Riverside University Health System | Behavioral Health
4095 County Circle Drive | Riverside, CA 92503
Tel: 951.358.4554 | Email: mnoone@ruhealth.org

Riverside University HEALTH SYSTEM
Behavioral Health
www.rcdmh.org

THIS ADDENDUM TO THE MEMORANDUM OF UNDERSTANDING ("Addendum") constitutes part of the Memorandum of Understanding made and entered between Inland Empire Health Plan, a Joint Powers Agency ("IEHP") and the Riverside County Department of Behavioral Health ("RUHS-BH" or "PROVIDER") (jointly referred to as "Parties") dated August 30, 2018.

WHEREAS, California, Welfare and Institutions Code ("WIC") Sections 14127 through 14128 authorized the Department of Health Care Services ("DHCS"), subject to federal approval, to create the Health Homes Program ("HHP") for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS;

WHEREAS, DHCS's HHP implementation utilizes California's Medi-Cal Managed Care infrastructure to provide HHP services to the members enrolled in the managed care system. The HHP is structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP);

WHEREAS, IEHP participates in the HHP as a Managed Care Plan ("MCP") and the County of Riverside, through its network providers, participates in the HHP as a CB-CMEs;

WHEREAS, DHCS requires IEHP, as an MCP, to amend any existing memorandums of understanding with county mental health plans to address HHP specific information, ensure seamless access and delivery of mental health services, and identify processes for data sharing and conducting care coordination;

WHEREAS, pursuant to DHCS's All Plan Letter 18-015 ("APL"), as more specifically described in Attachment 2 of the APL, IEHP and RUHS-BH are required to ensure timely sharing of Protected Health Information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3) and in compliance with HIPAA as well as other state and federal privacy laws;

NOW, THEREFORE, the Parties agree to incorporate this Addendum as follows:

HEALTH HOMES PROGRAM

I. INTRODUCTION

The Inland Empire Health Plan's (IEHP) Health Homes Program (HHP) is a clinical service delivery model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's Primary Care Provider (PCP) and all other network providers. This integrated care team, known as the Community-Based Care Management Entity (CB-CME) provides an intensive set of services for a small subset of Medi-Cal Members, who have chronic conditions and with a certain level of acuity and who require coordination of care at the highest levels.

The HHP focuses on whole-person, complex care management, which includes changing behaviors and patterns of health care among both Providers and Members with the goal of reducing avoidable, high cost interventions and increasing the use of appropriate, timely interventions, along with improved self-care

management.

IEHP's HHP service delivery model encompasses a person-centered, comprehensive approach to addressing the Member's goals for improvement and management of behavioral and physical health, acute care, and social needs. The CB-CMEs will address the Members' health needs by delivering some medical and behavioral health care services, coordinating with Primary Care and other network Provider teams, coordinating with community-based organizations and housing agencies, and/or by referring to other resources within the community.

II. DEFINITIONS

1.01 CAPITATION PAYMENTS – shall mean payments made to PROVIDER by IEHP as a single, fixed, monthly amount. A fixed rate is paid per Member per month to cover a specified package of services, regardless of actual utilization as referenced in Attachment B, attached hereto.

1.02 COMMUNITY BASED CARE MANAGEMENT ENTITY ("CB-CME") - shall mean an organization contracted to be within IEHP's provider network, that meets DHCS' qualifications, as a type of organization authorized to serve as a CB-CME and is able to perform the duties required by DHCS.

1.03 DHCS HEALTH HOMES PROGRAM GUIDE – is the document created by DHCS and entitled Medi-Cal Health Homes Program: Program Guide, as may be periodically updated by DHCS, and identifies all of the Health Homes Program requirements.

1.04 HEALTH ACTION PLAN ("HAP") – shall mean the Member's comprehensive, individualized, person-centered care plan based on the needs and desires of the Member, which will also be designed to track referrals. The HAP incorporates the Member's needs in the areas of physical health, mental health, substance use disorder, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP will be completed within ninety (90) days of HHP enrollment and reassessed based on the Member's progress or changes in their needs. The HAP will be jointly developed by the CB-CME and IEHP, with input from the Member, the Member's family/support persons, and other network providers providing services to the Member.

1.05 HEALTH HOMES PROGRAM ("HHP") - shall mean the program created by DHCS, and approved by CMS, the objectives of which are to create health homes to coordinate the full range of physical health, behavioral health, and community-based long-term services and supports needed by Medi-Cal members with chronic conditions.

1.06 MEMBER – shall mean each individual who is enrolled at IEHP and receiving services from RUHS-BH and/or enrolled in the HHP Program.

1.07 MEMBER DATA – Shall mean any health information that is (a) created or received by a healthcare provider or health plan; (b) relates to: (i) past, present, or future physical or mental health of a Member, or (ii) the provision of health care to a Member; (c) identifies the Member, or there is a reasonable basis to believe the information can be used to identify the Member (including Protected Health Information, as that term is defined in Health Insurance Portability and Accountability Act.

1.08 PRIMARY CARE PHYSICIAN (PCP) – shall mean a physician who is responsible for supervising, coordinating and providing initial, primary and preventive care to Members, for initiating referrals, maintaining continuity of Member care, and providing health counseling and education. This means physicians who are practicing medicine in the areas of Family Practice, Pediatrics, Internal Medicine, Obstetrics-Gynecology, or General Practice.

III. DATA SHARING

A. In furtherance of the objectives of this Addendum, DBH and IEHP agree to share all necessary data as described in Attachment A, in compliance with applicable Federal and State Law and regulation, including but not limited to the relevant provisions of the Lanterman-Petris Short Act (California Welfare & Institutions Code § 5000, et seq.) (collectively referred to herein as, the "Privacy Laws"). DBH understands that failure to timely provide such data absent an extreme and/or catastrophic event(s), frustrates the purpose of HHP and is considered a material breach of this MOU. RUHS-BH shall also provide all Member Data required to support its requests for payment in accordance with the applicable Privacy Laws.

i. RUHS-BH shall contribute the following categories of Member Data in a mutually agreeable form and frequency as required by MCP for the HHP:

1. Programmatic information including assessments and care plans
2. County Behavioral Health Encounters – including inpatient, outpatient, and emergency encounters
3. Service start date
4. Service end date
5. Facility identifier – code identifying the facility at which each encounter occurred
6. Diagnosis code – International Classification of Diseases (ICD) diagnosis code(s) associated with each encounter
7. Procedure code – ICD or Current Procedural Terminology (CPT) procedure codes(s) associated with each encounter
8. Medication utilization data
9. Claims – total claims paid in association with each encounter, including professional fees, facility fees, and pharmacy costs

ii. RUHS-BH shall use reasonable and appropriate efforts to ensure that all Member Data provided to IEHP is accurate with respect to each Member.

iii. Any sharing of client information shall comply with all applicable state and federal regulations pertaining to privacy and security of Member Information including but not limited to Welfare and Institutions Code (WIC), Section 5328, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), and Code of Federal Regulations, Title 42, Part 2.

iv. Member information shared shall be covered under WIC 5328(a)(25) for mental health records if for healthcare operations, care coordination including administrative, legal, financial or

quality improvement activities; and 42 CFR Part 2.53 for substance use disorder records if for audit/evaluation purposes activities.

IV. GENERAL PROVISIONS

A. The RUHS-BH agrees to participate in the HHP as outlined in the Attachment A and B herein and be bound to all outlined requirements.

B. Any future changes or modifications to the program after the effective date of this Addendum shall be by mutual written consent of the parties.

C. The HHP shall be effective as of the date of the last signature and terminate on December 31, 2021. However, either party may terminate this Addendum specific to the HHP by providing the other with one hundred twenty (120) days prior written notice of such party's intention not to continue with the program. Upon termination of the program, this Addendum will expire. Any continuation of the HHP would require an amendment subject to Board approval.

D. It is mutually agreed and understood that the obligations of IEHP are contingent upon the availability of state and federal funds. In the event that such funds are not forthcoming for any reason, this Addendum is rendered null and void, and IEHP shall immediately notify RUHS-BH in writing. This Addendum shall be deemed terminated and of no further force and effect immediately upon IEHP's notification to RUHS-BH. In the event of such termination, RUHS-BH shall be entitled to reimbursement of costs for services rendered in accordance with this Addendum.

E. Payment to RUHS-BH will be made pursuant to the attached compensation schedule.

   i. In the event that RUHS-BH has failed to meet the metrics, goals, or objectives as outlined in the Attachment B as attached hereto, IEHP, in its sole discretion, may withhold payment, if payment has not been remitted or recoup any and all funds related to RUHS-BH's failure to meet such metrics, goals, or objectives. Recoupment may be effectuated by withholding future payments or a demand for reimbursement of the funds to be paid within ten (10) days.

F. The Health Homes program is subject to and is governed by the terms of the MOU, provided, however, that the provisions of this Addendum, shall govern, control, and supersede any contrary or conflicting term or provision of the MOU.

G. Notwithstanding the date of execution, unless otherwise referenced, this Addendum shall be effective as of the date of the last signature.

H. All other terms and conditions of the MOU, as amended, are to remain in full force and effect.

I. RUHS-BH certifies that the individual signing herein has authority to execute this Addendum on behalf of RUHS-BH and may legally bind RUHS-BH to the term and conditions of this Addendum, and any attachments hereto.

J. To the extent reasonably possible, each party agrees to maintain this Addendum as a confidential document and not to disclose the Addendum or any of its terms or reports without the approval of the other party, subject to the limitation of the Public Records Act and the Brown Act.

IN WITNESS WHEREOF, the parties hereto have signed this Addendum as set forth below.

RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH:

By: _____
Matthew Chang, MD
Director of Behavioral Health

Date: _____

TIN: _____

Approved as Form:
Gregory G. Priamos
County Counsel

By: _____
Deputy County Counsel

Date: 5/20/21

INLAND EMPIRE HEALTH PLAN:

By: _____
Jarrod B. McNaughton, MBA, FACHE
Chief Executive Officer

Date: _____

By: _____
Chair, Governing Board

Date: _____

Attest: _____
Secretary, Governing Board

Date: _____

Approved as Form:

By: _____
Anna W. Wang
General Counsel

Date: _____

IN WITNESS WHEREOF, the parties hereto have signed this Addendum as set forth below.

RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH:

By: _____
Matthew Chang, MD
Director of Behavioral Health

Date: _____

TIN: _____

Approved as Form:
Gregory G. Priamos
County Counsel

By: _____
Deputy County Counsel

Date: _____

INLAND EMPIRE HEALTH PLAN:

By: _____
Jarrod B. McNaughton, MBA, FACHE
Chief Executive Officer

Date: _____

By: _____
Chair, Governing Board

Date: _____

Attest: _____
Secretary, Governing Board

Date: _____

Approved as Form:

By: _____
Anna W. Wang
General Counsel

Date: _____

ATTACHMENT A

RIVERSIDE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

HEALTH HOMES PROGRAM COMPENSATION

I. PHASE ONE – RAMP-UP FUNDING

1. **IEHP Funding Obligation.** Pursuant to the terms and conditions of this Agreement, in addition to the Fees paid to RUHS-BH as a CB-CME Provider as outlined in Phase Two, IEHP will provide Ramp-up Funding to RUHS-BH to assist RUHS-BH in expanding its participation in the Medi-Cal Health Homes Program ("Ramp-up Funding"). The total aggregate Ramp-up Funding shall not exceed $153,000 and shall not exceed a total of six (6) Milestone payments within a nine (9) month period.

2. **Use of Funds.** RUHS-BH shall utilize the funds to hire and develop **Jefferson Wellness Center** as a CB-CME/PROVIDER to participate in the Medi-Cal Health Homes Program from effective date of this amendment to December 31, 2021.

3. **Ramp-up Funding Payments**.

   a. Payment Criteria.

      i. For each Milestone period completed, RUHS-BH is eligible to receive $25,500.00 for up to 6 months to support staffing the following CB-CME Care Team members listed below:

         - Nurse (RN) Care Manager;
         - Community Health Worker

      ii. In no event shall RUHS-BH be compensated for more than a total of six (6) Milestone payments. Each payment is tied to the Milestone date as indicated in the PHASE ONE MONTHLY MILESTONE TIMELINE.

   b. No later than five (5) business days following the end of each Milestone period provided in the PHASE ONE MONTHLY MILESTONE TIMELINE below, RUHS-BH will submit a Milestone Progress Report and invoice to IEHP in the form required by IEHP.

      i. Upon completion of the deliverables for each Milestone period, RUHS-BH shall attach an invoice to the Milestone Progress Report requesting the appropriate payment amount pursuant to Paragraph 3(a). Invoice shall include the following details:

         1. HHP Organization Name
         2. Invoice Number
         3. Date Submitted

4. Payment #
5. Employed CB-CME Care Team Member Start Dates

ii. In the event that the RUHS-BH fails to meet any of the Milestone period goals, the RUHS-BH shall have a thirty (30) day grace period to submit its invoice to IEHP for approval provided that RUHS-BH met all the goals in the successive month.

c. IEHP shall not be required to release any Ramp-up Funding payments submitted by RUHS-BH (1) sixty (60) days after the Milestone period; or (2) after the expiration of the Ramp-up Funding obligation.

d. IEHP retains the sole discretion to determine whether RUHS-BH has met each deliverable in the PHASE ONE MONTHLY MILESTONE TIMELINE. IEHP will not unreasonably withhold approval of payment based on information provided by and available to RUHS-BH and delivered to IEHP for review.

4. **Termination of Ramp-up Funding.**
   a. IEHP's funding obligation shall terminate nine (9) months from the Effective Date, provided that IEHP retains the sole discretion to terminate the Ramp-up Funding obligation at any time and for any reason.
   b. If IEHP determines, in its sole discretion, RUHS-BH failed to meet Milestone period goals for two (2) consecutive months, IEHP may immediately terminate its Ramp-up Funding obligation.
   c. In the event IEHP terminates RUHS-BH's Ramp up Funding for:

      i. RUHS-BH's failure to meet monthly Milestone goals for two (2) consecutive months, RUHS-BH shall be subject to a prorated recoupment of Ramp-up Funding by IEHP to account for expenses incurred by IEHP prior to the early withdrawal.

PHASE ONE MONTHLY MILESTONE TIMELINE

⬇ Goal Categories		Start	Milestone 1 (~30 days post contract execution)	Milestone 2 (~60 days post contract execution)	Milestone 3 (~90 days post contract execution)	Milestone 4 (~120 days post contract execution)	Milestone 5 (~150 days post contract execution)	Milestone 6 (~180 days post contract execution)	Month 7
CB-CME Care Team Hiring (Staff)		Contract Execution	0	1-2	2-3	3-4	Full Team	Full Team	Ramp- up Funding Ends / PMPM Turned On
Outreach (# of Unique Members with Outreach Attempts)			0	20	40	100	125	150	
Enrollment (# of Members Enrolled)			N/A	5	10	75	100	170	
Process Development	**Leadership: Communication**		Provider champion and administrative lead identified and committed to building the HHP	Communication between coaches and leadership regarding strengths, barriers	Communication between coaches and leadership regarding strengths, barriers	Communication between coaches and leadership regarding strengths, barriers	Communication between coaches and leadership regarding strengths, barriers	Communication between coaches and leadership regarding strengths, barriers	
	Leadership: Staff-wide Communication		Leadership has started internal communication on HHP with all staff	Ongoing communication between leadership and staff	Ongoing communication between leadership and staff	Ongoing communication between leadership and staff	Ongoing communication between leadership and staff	Ongoing communication between leadership and staff	
	Leadership: Human Resources		HR is engaged and ready to begin hiring process	Hiring process underway	Hiring underway / Staff turnover promptly addressed	Staff turnover promptly addressed	Staff turnover promptly addressed	Staff turnover promptly addressed	
	Leadership: Infrastructure		Space is identified /available for the CB-CME team	Desks, phones, computers in place	Infrastructure fully in place	Infrastructure fully in place	Infrastructure fully in place	Infrastructure fully in place	
	Processes for Enrollment and Ongoing Services		Initial Eligibility List from IEHP reviewed by clinical lead	Outreach Strategy Identified	Enrollment Process Identified	SCRs have been initiated and documented	TOC, Housing, and Referral management processes underway	TOC, Housing, and Referral management processes underway	
	Training		Leadership supports training requirements	CB-CME Team Members complete required in-person, webinar, and Computer Based Training	CB-CME Team Members complete required in-person, webinar, and Computer Based Training	CB-CME Team Members complete required in-person, webinar, and Computer Based Training	CB-CME Team Members complete required in-person, webinar, and Computer Based Training	CB-CME Team Members complete required in-person, webinar, and Computer Based Training	

ATTACHMENT A
(Continued)
HEALTH HOMES

RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH

HEALTH HOMES PROGRAM COMPENSATION

On or before the fifth (5th) day of each month following the month of service, IEHP shall pay PROVIDER the following reimbursement rate for each Member assigned to the PROVIDER who meets the eligibility criteria definition at the time of consent or the engagement definition thereafter. Retro eligibility additions and deletions are limited to three-hundred sixty-five (365) days for all Members. Retro Medicare Status changes are limited to sixty (60) days.

Effective JANUARY 1, 2021 through DECEMBER 31, 2021

STATE PROGRAMS (IEHP MEDI-CAL BENEFICIARIES THAT DO NOT HAVE MEDICARE COVERAGE OR HAVE MEDICARE PART A ONLY)
IEHP shall reimburse PROVIDER $250.00 per engaged member per month (PEMPM) for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER as of the effective date of this Agreement. The $250.00 PEMPM rate will remain in effect through March 31st, 2021. Beginning April 1st, 2021, IEHP shall reimburse PROVIDER $200.00 PEMPM for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER.

a) Eligibility criteria definition:
   1. Member is an active Medi-Cal Member;
   2. Member is eligible for HHP (meets eligibility criteria per HHP Program Guide);
   3. Member is assigned to a Primary Care Provider (PCP) at a CB-CME;
   4. Member has consented to participate and is enrolled in HHP; and

b) Engagement definition:
   1. Member has received an HHP service where the first HHP service is received within 90 days of enrollment and all ongoing HHP service are received within at least 90 days of the last HHP service received; and
   2. IEHP has received an HHP service encounter (G-code) for the Member following the timeline requirements as noted in b) 1.

MEDI-MEDI (IEHP MEDI-CAL BENEFICIARIES WITH FULL FEE FOR SERVICE (FFS) MEDICARE COVERAGE OR MEDICARE PART B ONLY)
IEHP shall reimburse PROVIDER $60.00 per engaged member per month (PEMPM) for Members who meet the eligibility criteria for the HHP and who are engaged with the CB-CME/PROVIDER as of the effective date of this Agreement:

a) Eligibility criteria definition:
   1. Member is an active Medi-Cal Member;
   2. Member is eligible for HHP (meets eligibility criteria listed on Page 14 of HHP

Program Guide);
3. Member is assigned to a Primary Care Provider (PCP) at a CB-CME;
4. Member has consented to participate and is enrolled in HHP; and

b) Engagement definition:

1. Member has received an HHP service where the first HHP service is received within 90 days of enrollment and all ongoing HHP service are received within at least 90 days of the last HHP service received; and

2. IEHP has received an HHP service encounter (G-code) for the Member following the timeline requirements as noted in b) 1.

CAL MEDICONNECT BENEFICIARIES (DUALCHOICE)

PROVIDER will not be reimbursed for Cal MediConnect Members as they are excluded from HHP.

Supplemental Payment Details

1. Payment will be provided for up to 250 IEHP enrolled Members per month per care team who meet eligibility criteria and meet the engagement definition.

2. Evidence of HHP services rendered is with the HHP code scheme as follows. All codes and definitions are subject to DHCS changes:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 minutes equals 1 UOS; Multiple UOS allowed

ATTACHMENT A
(Continued)
HEALTH HOMES

RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH

HEALTH HOMES PROGRAM COMPENSATION

Encounter Data – Providers contracted to provide HHP services shall send Encounters to IEHP on a CMS1500 claim form, or through the Provider Portal. Claims will be adjudicated as Encounters and Pay at $0. Claims submitted for services not listed above will be denied.

IEHP reimburses PROVIDER on a per engaged member per month (PEMPM) rate for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER.

ATTACHMENT B

HEALTH HOMES

RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH

HEALTH HOMES PROGRAM REQUIREMENTS

Section 1 – Provider's General Responsibilities	
Item #	**Description**
1.1	PROVIDER is intended to serve as a Community-Based Care Management Entity (CB-CME), in conjunction with IEHP, with responsibility for ensuring that an assigned Health Homes Program ("HHP") Member receives access to HHP services.
1.2	PROVIDER is responsible for providing HHP services to any of its IEHP assigned Members that are eligible for the HHP and requesting HHP services.
1.3	PROVIDER agrees to demonstrate how it will maintain a strong and direct connection to Members' primary care physicians (PCPs) and ensure the PCPs' participation in Health Action Plan (HAP) development and ongoing coordination with the CB-CME care team.
1.4	PROVIDER warrants and represents that all CB-CME duties and functions will be performed in compliance with applicable state and federal laws and regulations, DMHC requirements, DHCS Health Homes Program requirements, DHCS contract requirements, and other DHCS guidance, including APLs and Policy Letters.
1.5	PROVIDER shall not delegate the performance of any care management activity to another organization or entity without the express written consent of IEHP. In the event PROVIDER subcontracts/sub-delegates any duties under the Addendum, PROVIDER understands it retains overall responsibility for all CB-CME duties that PROVIDER has agreed to perform.
1.6	Employ and maintain a multi-disciplinary care team to specifically serve the HHP. The CB-CME care team is comprised of the following positions/disciplines: I. HHP Director (this position can be combined with other positions); II. Registered Nurse Care Manager (RN CM); III. Peer Specialist (PS); IV. Behavioral Health Specialist II (BHS); and V. Community Services Assistant (CSA) In the case of position vacancy, CB-CME will, in good faith, promptly attempt to refill vacancies on the CB-CME care team through reassignment of existing staff and/or recruitment of new staff. CB-CME's must report care team member vacancies and new hires within 7 days of notification to IEHP via the Care Team Member Change Request Form.

1.7	Identify a Primary Care Physician (PCP) champion to lead change efforts.
1.8	Clinic management oversees CB-CME care team and ensures that they meet job expectations and backgrounds outlined in the staffing model per the job descriptions for HHP Model 1 - CB-CME.
1.9	Assure that sufficient space is available for the CB-CME care team to share a team office space, as well as provide one-on-one services to patients as needed. Assure that telehealth capability and accessibility is available for the CB-CME team to use in providing HHP services to Members if needed.
1.10	PROVIDER ensures that each CB-CME care team and PCP champion conduct Systematic Caseload Review (SCR) meetings for a minimum of four (4) hours per month.

Section 2 - CB-CME Core Functions	
Item #	**Description**
2.1	Conduct outreach and engagement for eligible members according to IEHP guidance, with priority placed on highest tiered individuals per DHCS requirements.
2.2	Member must be assigned to a PCP at participating HHP Provider organization prior to enrollment into the program (This does not apply to behavioral health CB-CMEs).
2.3	Enroll and obtain consent from eligible member using a process specified by IEHP.
2.4	Assure that the CB-CME provides the following six (6) core HHP services to eligible Members as per the HHP Program Guide: I. Comprehensive and individualized care management; II. Care coordination III. Health promotion (including connection to medical, mental health, and substance use disorder care); IV. Comprehensive transitional care from inpatient to other setting (including appropriate follow-up); V. Individual and family support, including authorized representatives; and VI. Referral to relevant community and social support services (including connection to housing, transportation, healthy lifestyle supports, child care, and peer recovery support).
2.5	Practice measurement-based care as directed by IEHP which includes regular review of the web-based care management platform measure dashboards and other IEHP provided reports. Measurement-based care includes the systematic administration of standardized, validated symptom rating scales and measures including the PHQ-9, GAD-7, BAM, HbA1c, and BP for screening and ongoing monitoring, and uses the results to drive clinical decision making for an individual patient or population. For clients with an SUD diagnosis/under SUD treatment by specialty SUD providers, the American Society of Addiction Medicine (ASAM) Dimension SUD screening is the required tool (by the state) to use while undergoing SUD treatment services. The BAM would not be required for this target population but could be used alongside or in between ASAM assessments as a measurement-based care tool to drive treatment option changes and/or care management interventions. For all other clients/patients meeting the other target populations, such as, SMI, homeless, and high utilizers, the BAM is the required

	screening assessment tool as part of the CHA assessment at the time of enrollment and any time the CHA is repeated where one or both of the SUD questions are answered affirmatively for a potential risk of SUD. The BAM is used by the Care Teams as a repeatable tool comparing the scores in a measurement-based care approach.
2.6	Practice population health as directed by IEHP. Population health includes using the HIT tools provided to review specific indices for the CB-CME's caseload/population. This approach requires active monitoring of the entire caseload to determine which patients are improving and where intervention is required for patients who are not improving as expected.
2.7	The CB-CME shall complete the CHA within 90 days after HHP enrollment and annually or when/if a significant change in health status occurs. Significant changes could include; hospitalization or ED visit; detox episode; or specific medical diagnosis (e.g. diabetes).
2.8	The CB-CME shall complete a Health Action Plan (HAP) within ninety (90) days of enrollment for each enrolled Member, and will reassess and update it to reflect any changes in the Member's progress or status or health care needs (no less than quarterly). The CB-CME care team shall review and update the HAP at every contact with an enrolled Member.
2.9	The CB-CME care team shall assure comprehensive transitional care which includes contact with all HHP enrolled Members within two days of discharge from an Emergency Department or inpatient hospital and administration of TOC assessment provided in the IEHP web-based care management platform.
2.10	The CB-CME shall disenroll or step-down Members at the completion of treatment or for another qualifying disenrollment reason including: I. HHP enrollees who have demonstrated improvement in their conditions such that their outcomes demonstrate that they are well-managed and have remained out of the hospital and/or emergency department for a period of 90 days; II. HHP enrollees who have been unreachable for a period of ninety (90) days; III. HHP enrollees who no longer wish to participate in the program or who no longer benefit from the HHP services; IV. HHP enrollees who opt in to other programs which would exclude them from receiving HHP services.
2.11	Use the CHA to screen all Members for housing instability and connect Members who are homeless or at risk for homelessness with appropriate services. Housing assessment will be conducted when homelessness or housing instability is identified outside of the administration of the CHA.
2.12	CB-CME care team and PCP champion conduct Systematic Caseload Review (SCR) meetings for a minimum of four (4) hours per month.
2.13	Should IEHP determine a corrective action plan ("CAP") is needed for failure to meet the requirements of this Agreement or the Health Homes Program, PROVIDER agrees to create and implement a CAP approved by IEHP.

Section 3 - CB-CME Training and Practice Coaching Requirements	
Item #	**Description**

3.1	Each month, all the members of the CB-CME care team shall be required to participate in practice coaching to support high functioning teams. Practice coaching support could include: I. In-person or remote one-on-one with practice coach and CB-CME care team; II. Regional CB-CME care team group practice coaching; and III. Telephonic and email support as needed by the members of the CB-CME care team.
3.2	All the members of the CB-CME shall be required to complete training on IEHP's web-based care management system for the HHP and adhere to documentation expectations.
3.3	All members of the CB-CME care team must complete all five (5) DHCS required webinars as provided by IEHP within four (4) weeks of beginning work as a CB-CME care team member.
3.4	All the members of the CB-CME care team shall be required to attend the weekly HHP webinars.
3.5	All the members of the CB-CME care team shall be required to complete the onboarding process as defined by IEHP and provide services in adherence to these processes. This will include reviewing of the HHP Manual and training in the following HHP Model of Care components and standard workflows: I. Outreach and Engagement II. CHA III. HAP IV. Tier-appropriate care management V. Transitions of care after hospitalization or ED visitation VI. Other as required by IEHP
3.6	All members of the CB-CME care team shall attend the semi-annual learning sessions as provided by IEHP.
3.7	All Community Health Worker members of the CB-CME care team will receive a certificate of completion in the IEHP sponsored 9-week intensive CHW curriculum with the IEHP selected CHW training organization or equivalent complex care training as approved by IEHP.
3.8	All Community Health Worker members of the CB-CME care team will attend the monthly HHP CHW continuing education, as scheduled by CHW training organization.
3.9	All Members of the CB-CME care team will attend other support calls as scheduled by IEHP.

Section 4 - CB-CME Health Information Technology (HIT) Requirements	
Item #	**Description**
4.1	Utilize an IEHP-provided web-based care management platform to document care management activities which includes enrollment, assessments and care planning, and facilitate data and information sharing among the entire CB-CME care team (including the Member, CB-CME, and IEHP) pertaining to the provision of the six (6) core HHP services: I. Comprehensive care management;

	II. Care coordination; III. Health promotion; IV. Comprehensive transitional care; V. Individual and family support services; and VI. Referral to community and social support services.
4.2	Alternatively, CB-CMEs may utilize their own Electronic Health Record (EHR) and/or other systems to satisfy health information technology (HIT) requirements if their systems can demonstrate functionality equivalent to IEHP's web-based care management platform and support data sharing pathways with IEHP using APIs, X12, and HL7 protocols as defined by IEHP. CB-CMEs who wish to pursue this option must participate in an HIT review with IEHP to demonstrate how their system(s) will meet HHP HIT requirements.
4.3	Utilize the IEHP Provider Portal as instructed by IEHP for activities including the submission of referrals for IEHP Direct Members.
4.4	Comply with data reporting requirements as defined by IEHP and in alignment with DHCS regulatory reporting requirements. To satisfy regulatory reporting requirements, Member-level identifiers shall be required for all reports. IEHP shall provide the CB-CME with a data reporting dictionary that includes a description and definition for all reporting requirements.

Section 5 - Other CB-CME Requirements	
Item #	**Description**
5.1	Should a Member be eligible and choose to participate in the program, the CB-CME shall be responsible for securing verbal consent from the member to participate in HHP and signed authorized releases of information, to the extent required by law. The CB-CME shall maintain a record of these consents.
5.2	CB-CME will submit an encounter for each HHP service provided to each HHP Member. Please see Attachment A for a list of HHP service codes for use with encounters and for other purposes.
5.3	The CB-CME care team/HHP Member ratio is 250 Members per care team.
5.4	The aggregate care team member ratio shall not exceed 60:1 for the whole enrolled population as measured at any point in time. Ratios should be no more than as follows: i. RN Care Manager 75:1 ii. BH Care Manager 75:1 iii. Care Coordinator 75:1 iv. Community Health Worker 25:1. If due to Public Health reasons the CHW is not able to provide community-based visits, this number can be increased, as long as the total caseload for the team does not exceed 250.
5.5	Prior to enrollment into the HHP Program, the CB-CME shall adhere to the following Member contact frequency for initial outreach attempts based on the following tiers:

	i. Tier 1: Minimum one (1) contact per week ii. Tier 2: Minimum two (2) contacts per month iii. Tier 3: Minimum one (1) contact per month
5.6	After enrollment into the HHP Program, the CB-CME shall adhere to these guidelines for contact of the HHP caseload. Contact includes frequent in-person* contact between the care team member delivering HHP services and the Member. The minimum required in-person visits for the aggregated population is 260 visits per 100 enrolled Members per quarter. The contact guidelines and in-person contact requirement is as follows: i. Tier 1: one (1) contact per week with a minimum of two (2) in-person contacts per month ii. Tier 2: two (2) contacts per month with a minimum of one (1) in-person contact per month iii. Tier 3: two (2) contacts during the first month, then one (1) contact per month thereafter. The expectation is that the CB-CME care team shall review and update the HAP at every contact with an enrolled Member. *It is understood that in-person contact will not be enforced during a Public Health or other state of emergency. Telephonic contact is acceptable during this time.
5.7	CB-CME care team shall participate in IEHP-defined care team and Member experience activities.

IEHP Representations and Responsibilities

Section 6 – IEHP General Requirements	
Item #	**Description**
6.1	The overall administration of the Health Homes Program.
6.2	Provide CB-CME support for the following six core HHP services: I. Comprehensive and individualized care management; II. Care coordination and health promotion (including connection to medical, mental health, and substance use disorder care); III. Comprehensive transitional care from inpatient to other setting (including appropriate follow-up); IV. Individual and family support, including authorized representatives; V. Referral to relevant community and social support services (including connection to housing, transportation, healthy lifestyle supports, child care, and peer recovery support); and VI. Health information technology to identify eligible individuals and link services, if feasible and appropriate.
6.3	Meet all program and reporting requirements specified in the DHCS Medi-Cal Health Homes Program Guide, all applicable state and federal laws and regulations, IEHP's contract with DHCS, and other DHCS guidance and directives.

Section 7 – IEHP Core Responsibilities	
Item #	**Description**
7.1	Attribute HHP Members to CB-CMEs.
7.2	Track and share data with CB-CMEs regarding each Member's health history.
7.3	Track CMS-required quality measures and state-specific measures (see Reporting Template and Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting, or later document).
7.4	Collect, analyze, and report financial measures, health status and other measures, and outcome data for program evaluation purposes.
7.5	Provide HHP Member resources (e.g. customer service, Member grievances).
7.6	Establish and maintain a data-sharing agreement with other providers that is compliant with all federal and state laws and regulations.
7.7	Provide timely information to CB-CME about patient admissions, discharges, and transitions (ADT).
7.8	Ensure participation by HHP Members' other network providers, who are not included formally on the CB-CME care team, but who are responsible for coordinating with the CB-CME care team to conduct case conferences and provide input on the HAP. These providers are separate and distinct from the roles outlined for the CB-CME care team.
7.9	Provide CB-CMEs with access to and training on a web-based care management platform that facilitates Member stratification, care coordination, and care planning as a stand-alone tool or through integration with a CB-CME's EHR. As the license holder, IEHP has access to all IEHP Member-related data and information entered in the care management platform.
7.10	Provide CB-CMEs with access and training on the IEHP Provider Portal.
7.11	In addition to DHCS required training, IEHP will continue development and support of CB-CME training tools that are needed or preferred, including practice coaching.
7.12	Develop CB-CME reporting capabilities.
7.13	IEHP will do its reasonable due diligence to assure non-duplication of services upon Member enrollment into the HHP and ongoing.
7.14	Establish and maintain a connection with the Health Information Exchange (HIE) in order to receive and transmit Member information pertaining to hospitalization and Emergency Department utilization from other facilities and organizations to the CB-CMEs.

IEHP Oversight

Section 8 - Health Plan Oversight	
Item #	**Description**

8.1	IEHP is responsible for ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, and shall communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including CB-CMEs, as well as any delegated entities and subcontractors.
8.2	IEHP is responsible for ensuring that delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.
8.3	IEHP shall maintain strong oversight and have the right to perform regular auditing and monitoring activities to ensure and verify that the following activities are being properly performed and completed: I. Care Management; II. Systematic Caseload Review (SCR); III. Updates to the HAP as health care events unfold; and IV. All other HHP requirements.
8.4	Should IEHP determine a corrective action plan ("CAP") is needed for failure to meet the requirements of this Addendum or the Health Homes Program, PROVIDER agrees to create and implement a CAP approved by IEHP.
8.5	IEHP shall monitor PROVIDER's performance to ensure corrective actions take place in the mutually agreed-upon time frame. IEHP shall perform additional follow-up audits, as necessary, to verify the completion of a CAP. If PROVIDER fails to implement the approved CAP, IEHP reserves the right to exercise any and all remedies available under the Addendum.
8.6	PROVIDER shall monitor and oversee its subcontractors' performance of approved sub-delegated functions. IEHP reserves the right to monitor and oversee subcontractors' performance of sub-delegated functions.

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: 08.30.18

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
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	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**	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. 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.	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

SECTION	DESCRIPTION	PAGE
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4	Clinical Consultation and Consultation on Medicine	4
5	Biopsychosocial Assessment	4
6	Confidentiality	4
7	Care Coordination/ Interdisciplinary Care team	5
8	Dispute Resolution	5

	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.

Exhibit II.2

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

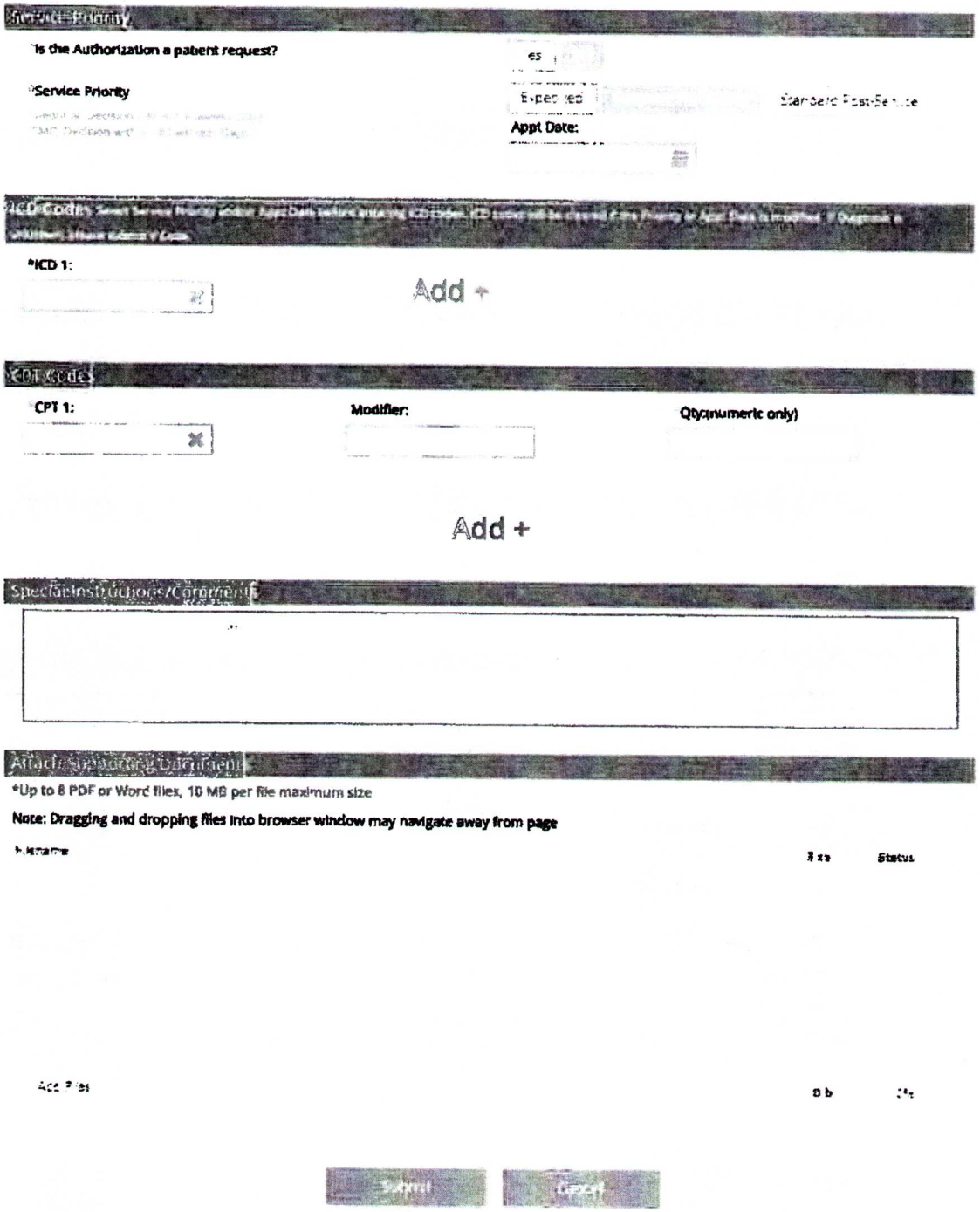

Exhibit II.2

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

BH Authorization Request Form

* denotes a required field

Member/Provider Information

IEHP ID:

*Are you submitting a correction to an existing authorization?

*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 Requested

Service Requested:

Behavioral Health Treatment for Autism Spectrum Disorder

- ABA Therapy for confirmed ASD Diagnosis
- Speech Therapy for confirmed ASD diagnosis
- Occupational Therapy for confirmed ASD Diagnosis
- Physical Therapy for confirmed ASD diagnosis
- Other

Servicing Provider:

Exhibit II.2

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

Additional Clinical Information

Attach Supporting Document

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 Reset

Exhibit II.2

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

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

***Current Rating** -- Some Improvement

***Prior Rating** Select One

***Objective 2:**

***Treatment Modality**

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [x] 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?** No

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?**

- [ ] Feeding and Eating Disorders of Infancy and Early Childhood
- [ ] Other Disorders of Infancy, Childhood or Adolescence
- [ ] Anxiety Disorders due to a General Medical Condition
- [ ] Psychotic Disorders
- [ ] Paraphilias
- [ ] Eating Disorders
- [ ] Adjustment Disorders
- [ ] Medication-Induced Movement Disorders related to other included diagnoses
- [ ] Disruptive Behavior and Impulse-Control Disorders
- [ ] Elimination Disorders
- [ ] Substance-Related Disorders
- [ ] Schizophrenia and Other Psychotic Disorders
- [ ] Somatoform Disorders
- [ ] Dissociative Disorders
- [ ] Gender Identity Disorders
- [ ] Impulse-Control Disorders Not Elsewhere Classified
- [ ] Personality Disorders (excluding Antisocial Personality Disorder)
- [ ] None

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

- [ ] Legal
- [ ] Interpersonal/Social
- [ ] Occupational/Academic
- [ ] Financial
- [ ] None

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

- [ ] Prevent the imminent progressive deterioration that would result in significant impairment in the areas listed above
- [ ] None

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

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? No

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

Add Medication +

Pharmacy Information (Past 6 Months)

Drug Name	Prescriber	Filled By	Qty	Filled On

No Records Found

Unfilled Prescriptions (Past 1 Month)

No Records Found (1 month prior)

CPT Code

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

Add +

Work 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

Please attach a provider Release of Information with the Signature. Click here to print the release.

Discussed referral with Member who is in agreement.

Co Treating BH Provider Other Than Self: No

Search Available EHR Patient

*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

Exhibit II.2

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 to 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

Exhibit II.1

Behavioral Health Coordination of Care Web Forms
Authorization Request

ICD Codes Select Service Priority and/or Appt Date Before entering ICD codes. ICD codes will be cleared if the Priority or Appt Date is modified. If Diagnosis is unknown, please submit V Code.

*ICD 1:

Add +

CPT Codes

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

Add +

Special Instructions/Comments

Attach Supporting Documents

Up to 5 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may not work easily from apps.

Filename | Size | Status

Add Files

Submit | Cancel

Behavioral Health Coordination of Care Web Forms
Authorization Request

BH Authorization Request Form

*denotes a required field

Member/Provider Identification

*ME-P ID:

*Are you submitting a correction to an existing authorization?

*Requesting Provider:

Member Information

Name: | Gender: | DOB: | Age:

Address: | City: | State, Zip: | Phone:

MHP ID: | CIN: | MediCare: | Medi-Cal:

LOB: | County: | Aid Code: | Group:

Requesting Provider Information

Name: | ID: | NPI #: | Phone:

Address: | City: | State, Zip: | Fax #:

Referral Date: | Provider Signature:

Referral Information

BHP strongly encourages communication between treating specialty 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 ePHI, Provider Portal.

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

*Verified Member signed the required Release of Information Form allowing BHP to release medical and behavioral health information to PCP or Referring Provider.

Click here to print the release.

*Discussed referral with Member and is in agreement.

Service Information

*Service Requested:

*Has the Member been on medication before?

*Is the Member currently on medication?

*Please Specify

*Is the Member currently in psychotherapy (talk therapy)?

*Servicing Provider (Must refer to section with in-network)

Service Priority

*Is the authorization a patient request?

*Service Priority:

(Med-Cal: Decision within 5 Business Days)
(LOB: Decision within 14 Calendar Days)

Expedited | Standard (Routine) | Request Post-Service

Appt. Date:

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.

(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 1830.205. 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:

Enclosure 4

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 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.

SAMPLE (continued)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

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

Exhibit I

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	Responsible if [illegible]	Responsible if 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

Exhibit I

Enclosure 2

DRUGS EXCLUDED FROM PLAN COVERAGE

Amantadine HCL Benztropine Mesylate Biperiden HCL Biperiden Lactate Chlorpromazine HCL Chlorprothixene Clozapine Fluphenazine Decanoate Fluphenazine Enanthate Fluphenazine HCL Haloperidol Haloperidol Decanoate Haloperidol Lactate 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	Abacavir Sulfate (Ziagen) Amprenavir (Agenerase) Delaviridine Mesylate (Rescriptor) Efavirenz (Sustiva) Indinavir Sulfate (Crixivan) Lamivudine (Epivir) Nelfinavir Mesylate (Viracept) Nevirapine (Viramune) Ritonavir (Norvir) Saquinavir (Fortovase) Saquinavir Mesylate (Invirase) Stavudine (Zerit) Zidovudine/Lamivudine (Combivir)

Enclosure 1

MEDI-CAL MANAGED CARE PLAN
SPECIALTY MENTAL HEALTH COVERAGE ALTERNATIVES

[illegible]	Plan Name	[illegible]	[illegible]
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 I

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

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.

- 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~~

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;

~~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**

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~~

- 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.

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.

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.

The medical necessity criteria are met when:

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

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

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

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

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

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

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

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.

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

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** ~~of~~ 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 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.

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.

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.

- ~~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

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.**

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**.

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

- 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.

- 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.

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:

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

(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.

- 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

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

DEPARTMENT OF HEALTH SERVICES
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March 16, 2000 REV.

MMCD Policy Letter No. 00-01 REV.

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

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

PURPOSE

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

GOALS

The goals of this letter are:

- To provide Plans with information regarding the delivery of specialty mental health services to beneficiaries, including those enrolled in a Plan, under the Medi-Cal Specialty Mental Health Services Consolidation program through local mental health plans (MHP).

- To clarify the responsibility of Plans in developing a written agreement addressing the issues of interface with the MHP, including protocols for coordinating the care of Plan members served by both parties and a mutually satisfactory process for resolving disputes, to ensure the coordination of medically necessary Medi-Cal covered physical and mental health care services.

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

Referral Form for Behavioral/Mental Health Services

Attachment D

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

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.

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:

- [illegible] NOTICE NO. 10-11 May 6, 2010;
- [illegible] NOTICE NO. 10-23 Nov. 18, 2010;
- [illegible] NOTICE NO. 11-06 April 29, 2011

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 02-04 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

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.

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.

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.

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

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.

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.

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.

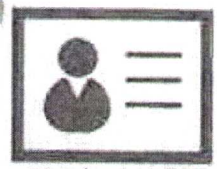
Exhibit B

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

INITIAL CONTACT

Member calls in to IEHP

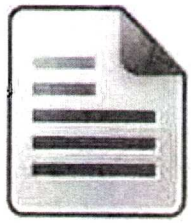
IEHP BH Screens



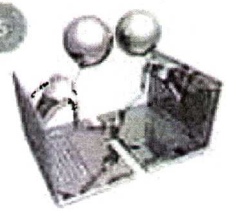
Member receives referrals to Tier 2 providers

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

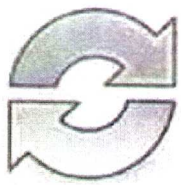
DECISION

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

	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

	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.***

ACTIVITIES DESCRIPTION GRID FOR EATING DISORDER SERVICES
INDEX

SECTION	DESCRIPTION	PAGE
1	Services Provided	1
2	Referrals/Coordination	1
3	Intensive Care Coordination	2
4	Clinical Consultation and Consultation on Medicine	3
5	Confidentiality	3

	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

	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.

	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
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

Exhibit II.2

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 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 Medications

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

Drug Name	Dosage Form	Strength (mg/ml)	Quantity

Add Medication +

Member Consent

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

Click here to print the release.

Discussed referral with Member who is in agreement.

Co Treating BH Provider Other Than Self: No

*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

File Name	Size	Status
Add Files	0 b	0%

Submit Cancel

Exhibit II.3

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:

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

Current Medication

*Is the Member currently taking mental health medication NOT listed below? 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)

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):

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider. Yes

Click here to print the release.

*Discussed referral with Member who is in agreement.

*Co Treating BH Provider Other Than Self: No

*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

Note: Different expanded options for After Care Plan

After Care Plan (Select ONE from below)

- Provide Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- Provider Referred Member to Community Based Organization for Ongoing Support
- Member Declined Appointment
  - Member Re-stabilized
  - Member Expressed No Interest in Treatment
  - Other
- Provide Referral Number to Physician's Office
- Treatment Completed

Exhibit II.3

Behavioral Health Coordination of Care Web Forms
No Further Treatment Requested

Alternative Plan (Select ONE from below)

- ( ) Provider Referred Stable Member Each 30 PCP Ongoing Psychiatric Medication Management
- ( ) Provider Referred Member to Community Resources and Self-Help Groups for Ongoing Support
- ( ) Member Discontinued Treatment (Please indicate why)
  - ( ) County Mental Health Program
  - ( ) Other (Please Specify)
- ( ) Treatment Completed

Additional Clinical Information

Attach Supporting Documents

Up to 6 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 File	0 b	0%

Submit Cancel

INLAND EMPIRE HEALTH PLAN

MMCD Letter No. 96-07
July 5, 1996

WHAT ARE EPSDT SUPPLEMENTAL SERVICES?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EPSDT SUPPLEMENTAL NURSING SERVICES

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

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

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

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

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

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

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

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: March 2, 2018

ALL PLAN LETTER 18-007
SUPERSEDES ALL PLAN LETTER 14-017

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDI-CAL MEMBERS UNDER THE AGE OF 21

PURPOSE:
This All Plan Letter (APL) clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21. This policy applies to all members under the age of 21 enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provision of Medi-Cal services, including EPSDT, and does not represent any change in policy. This APL supersedes APL 14-017.

BACKGROUND:
In 1967, Congress expanded the EPSDT benefit for children. The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in Medi-Cal and is key to ensuring that members who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age.[1] States are required to provide any Medicaid covered services listed in section 1905(a) of the SSA for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.[2] The EPSDT benefit is more robust than the Medi-Cal benefit

[1] Section 1905 of the SSA is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 CFR, Part 440, is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=9568043f8b1386fd23340e60c3e9da4f&mc=true&node=pt42.4.440&rgn=div5

package provided to adults and is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services as including the following:[3, 4]

1) Screening services provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services must include, at a minimum, a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).

2) Vision services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

3) Dental services provided at intervals which meet reasonable standards of dental practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

4) Hearing services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

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[3] 42 USC, Section 1396d, is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396d&num=0&edition=prelim

[4] The Patient Protection and Affordable Care Act (ACA) mandated the use of the current American Academy of Pediatrics "Bright Futures" periodicity schedule and guidelines when delivering the EPSDT benefit, including, but not limited to, screening services, vision services, and hearing services. MCPs must also provide all age-specific assessments and services required by the MCP contract.

5) Other necessary health care, diagnostic services, treatment, and measures, as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

The California Code of Regulations (CCR) further clarifies the parameters of California's implementation of the EPSDT program.[5] Pursuant to Title 22 of the CCR, Section 51184(a)(3), screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. Screening services must identify developmental issues as early as possible.

EPSDT in California

MCPs are required to provide and cover all medically necessary services. For members age 21 and over, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members under age 21, MCPs must provide a broader range of medically necessary services that is expanded to include standards set forth in federal law and the CCRs.

The EPSDT benefit in California is set forth under Title 22, CCR, Sections 51340, 51340.1, and 51184. It includes all medically necessary services as described under Title 22, CCR, Section 51184, and Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services" in the MCP contract with the Department of Health Care Services (DHCS).

MCPs' Contractual Requirements

MCPs are required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of 21, including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist members in gaining access to necessary medical, social, educational, and other services.

MCPs must ensure that comprehensive case management is provided to each member. MCPs must maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the MCP's provider network. If the MCP determines that case

[5] The CCR is searchable by Title and Section at: https://govt.westlaw.com/calregs/Search/Index

management services are medically necessary and not otherwise available, the MCP shall provide, or arrange and pay for, the case management services for its members who are eligible for EPSDT services (Title 22, CCR, Section 51340(k)).

For example, while services provided by the California Children's Services (CCS) program are not covered under most MCP contracts with DHCS, upon adequate diagnostic evidence that a member has a CCS-eligible condition, MCPs must refer the member to the local county CCS office for determination of eligibility. If the local CCS program does not approve eligibility, the MCP remains responsible for the provision of all medically necessary covered services for the member. If CCS denies a particular medically necessary service, MCPs may provide services through providers within the MCPs' network. If the local CCS program denies authorization for any service, the MCP remains responsible for providing the medically necessary service as determined by the MCP provider.

In addition, MCPs are also required to establish procedures for members to obtain necessary transportation services, including medical and non-medical transportation services. For additional transportation guidance, please refer to APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services.[6]

Dental services are carved-out of the MCP contract with DHCS. MCPs must cover and ensure that dental screenings for all members are included as a part of the initial health assessment. For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment. MCPs must ensure that members are referred to appropriate Medi-Cal dental providers. MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.

All members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, as early as possible. The EPSDT benefit also includes medically necessary diagnostic and treatment services for members with developmental issues, when a screening examination indicates the need for further evaluation of a child's health. The member should be appropriately referred for diagnosis and treatment without delay. MCPs are responsible for providing medically necessary Behavioral Health Treatment (BHT) services for members that meet eligibility criteria for services outlined in section 1905(a) of the SSA. For more information on MCP requirements on the provision of BHT services to eligible members, please refer to the APL 18-006, *Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.*

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[6] DHCS All Plan Letters are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

MCPs must ensure that the criteria set forth in Title 22, CCR, Section 51340.1 are met when approving the following EPSDT services: hearing services, onsite investigations to detect the source of lead contamination, and pediatric day health care services.

In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to members (*Olmstead v. L.C. ex rel. Zimring* (1999) 527 U.S. 581), and with California Government Code (GOV) Section 11135.[7]

POLICY:
Where diagnostic, treatment or other EPSDT services are provided in a home or community-based setting, the total costs incurred by the Medi-Cal program for the service must be less than what the total costs would be for the provision of "medically equivalent services" in an appropriate institutional level of care (Title 22, CCR, Section 51340(m)). "Medically equivalent services" includes services to address developmental needs that otherwise would be addressed in the home or other community setting. Pursuant to Title 22, CCR, Section 51340, speech therapy, occupational therapy, and physical therapy services are exempt from the benefit limitations set forth under Title 22, CCR, Section 51304. MCPs may not impose service limitations. In addition, MCPs are required to provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state plan unless otherwise specified in the applicable MCP contract with DHCS.

MCPs are required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary services that MCPs are responsible for providing pursuant to their contracts with DHCS.

MCPs must ensure that members under the age of 21 who are eligible for EPSDT services and their parents or guardians know what services are available and have access to the health care resources they need. MCPs have a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment (Title 42, US Code, Section 1396d(r)(1)(B)(v); Centers for Medicare & Medicaid Services, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, p. 4)).

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[7] See GOV Section 11135 at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV

Specifically, for members under the age of 21, MCPs are required to provide and cover all medically necessary services **with the following exceptions**:

A. Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal program (Policy Letter 13-002);

B. Non-medical services provided by Regional Centers (RCs) to members with developmental disabilities, including, but not limited to, respite, out-of-home placement, and supportive living. However, MCPs must monitor and coordinate all medical services with RC staff;

C. Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS);

D. Specialty mental health services listed in Title 9, CCR, Section 1810.247 for members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 17-018);

E. CCS services not included in the MCP capitated rate. The EPSDT services determined to be medically necessary for treatment or amelioration of the CCS-covered condition, including private duty nursing related to a CCS-eligible condition, must be case managed and have obtained prior authorization by the CCS program (on a FFS basis) (Title 22, CCR, Section 51013);[8]

F. Services for which prior authorization is required but are provided without obtaining prior authorization; and

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[8] For members enrolled in an MCP and who have been referred to the CCS program for case management and authorization of nursing services, the provider will submit the private duty nursing Treatment Authorization Request (TAR) to the EPSDT unit of the DHCS Integrated Systems of Care Division. The EPSDT unit will verify with the local CCS County program that the child is enrolled in the CCS program and the nursing services are related to the CCS-eligible medical condition. If the member is deemed to have a CCS-eligible medical condition, the EPSDT unit will review the TAR for medical necessity for the requested nursing services. The EPSDT unit will then refer the TAR to the local CCS program and will recommend authorization of services. If the member is not enrolled in the CCS program or the nursing services are not related to the CCS-eligible medical condition, the EPSDT unit will defer the TAR back to the provider to submit the request and or claims to the MCP pursuant to 22 CCR Sections 51003(c) and 51014.1(e).

G. Other services listed as services that are not "Covered Services" under the MCP contract with DHCS, such as Pediatric Day Health Care services.

Where another entity—such as a local education agency (LEA), RC, or local governmental health program—has overlapping responsibility for providing services to a member under the age of 21, MCPs must assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.

MCPs have the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. MCPs should not rely on a LEA program, RC, CCS, Child Health and Disability Prevention Program, local governmental health program, or other entities as the primary provider of medically necessary services. The MCP is the primary provider of such medical services except for those services that have been expressly carved out. MCPs are required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the MCP provider. For example, when school is not in session, MCPs must cover medically necessary services that were being provided by the LEA program when school was in session.

DHCS is amending Title 22 of the CCR to eliminate references to "EPSDT Supplemental Services." There is no distinction between EPSDT services and EPSDT Supplemental Services in practice, so it is unnecessary to have two separate categories of services. MCPs must ensure that all of their own policies and procedures, as well as the policies, procedures, and practices of any subplans, contracted providers, or subcontracted Independent Physician Associations, comply with these EPSDT requirements. DHCS, in concert with the Department of Managed Health Care, will monitor plans for compliance with these requirements.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

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

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

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

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

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

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

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

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

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

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

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

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

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

51304. Benefit Limitations

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

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

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

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

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

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

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

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

(f) (1) Notwithstanding subsection (e), EPSDT case management services as specified in paragraph (j) (3) may be covered for the EPSDT-eligible beneficiary when accompanied by the information described in subsection (d) of the Department determines that both of the following criteria are met:

(A) The service to which access is to be gained through case management is medically necessary for the EPSDT-eligible beneficiary. For purposes of this subsection, medical necessity is established if the service meets the criteria set forth in subsection (e) (1), (e) (2), or (e) (3).

(B) The EPSDT-eligible beneficiary has a medical or mental health condition or diagnosis.

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

(A) Whether or not the beneficiary has a complicated medical condition, including a history of multiple or complex medical or mental health diagnosis, frequent recent hospitalization, use of emergency rooms. or other indicators of medical or mental health conditions resulting in significant impairment.

(B) Whether or not the beneficiary has a history of one or more environmental risk factors, including:

(1) parent, guardian, or primary care giver mental retardation or mental illness, physical or sensory disability, substance abuse under age 18 years, prolonged absence, or

(2) other environmental stressors, which may result in neglect, abuse, lack of stable housing, or otherwise compromise the parent's guardian's, or primary caregiver's ability to assist the beneficiary in gaining access to the necessary medical, social educational, and other services.

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

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

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

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

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

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

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

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

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

51340.1 Requirements Applicable to EPSDT Supplemental Services

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

(a) Dental Services

(1) Dental services, other than orthodontic services

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

(2) Orthodontic services

Orthodontic services are covered only:

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

(b) Hearing Service

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

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

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

CHAPTER 8

Consumer Notices/ Grievances and Appeals

Introduction

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

Beneficiary Informing Materials

The RCDMH contract providers will provide beneficiaries with a copy of the informing materials upon request, when the beneficiary initially accesses services, and annually thereafter as long as they remain in treatment. The informing materials contain a description of services available, the process for obtaining the services, beneficiary rights, the right to request a change of providers, confidentiality rights, advance directive information, a list of network providers and a description of the beneficiary problem resolution process. The information provided will include both the grievance and appeals processes and will state that a Medi-Cal or RCHC beneficiary may request a State Fair Hearing after they have completed the problem resolution process. A complete list of the forms/posters is included on the Informing Materials Reorder Form (Attachment 29).

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

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

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

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's

record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

Grievance Process

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

When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log within one (1) working day and immediately fax a copy of the grievance to Outpatient QI at (951) 955-7203. Although a beneficiary is not required to complete a grievance form, it will be necessary for the provider to write pertinent information on the form to fax to Outpatient QI. Outpatient QI will also register the grievance in their grievance log within one (1) working day.

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

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

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

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

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

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

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

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

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

Notice of Denial, Termination, or Reduction of Services

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

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

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

The beneficiary/consumer no longer meets the medical necessity requirements for eligibility for a specific mental health service.

The beneficiary/consumer has obtained maximum therapeutic benefit and mental health services are no longer indicated.

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

The program does not provide the services the patient requests.

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

If the beneficiary/consumer disagrees with the action of the service provider they have a right to an Appeal.

Appeal Procedures

Non-expedited Appeal – Medi-Cal or RCHC Beneficiaries

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

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

The appeal form should indicate if the beneficiary is in any Medi-Cal or RCHC funded residential treatment program.

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

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

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

- Outpatient QI will enter the appeal into the Appeal Log within one (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary/beneficiary's representative, or documentation of the reason(s) that there has not been a final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been a final disposition of the grievance.

- A letter acknowledging the receipt of the appeal will be sent to the beneficiary within ten (10) working days. The letter will also inform a Medi-Cal or RCHC beneficiary of his/her right to request a State Fair Hearing after they have completed the problem resolution process. Outpatient QI will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

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

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

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

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

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

If the Medi-Cal or RCHC beneficiary/beneficiary's representative and/or provider are not notified of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension form the Medi-Cal or RCHC beneficiary, a Notice of Action form will be sent to the Medi-Cal or RCHC beneficiary/beneficiary's representative advising them of their right to request a Sate Fair Hearing. The Notice of Action letter will be sent on the date that the 45-calendar day period expires.

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

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

Expedited Appeal: Medi-Cal or RCHC Beneficiary

An appeal will be handled in an expedited manner when Outpatient QI determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. The Expedited Appeals block should be checked on the appeal form. When this block is checked the appeal will be processed within the Expedited Appeal guidelines.

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

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

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

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

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

- The results of the expedited appeal resolution process.
- The date that the expedited appeal decision was made.
- If the expedited appeal is not resolved wholly in favor of the Medi-Cal or RCHC beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.
- The availability of assistance to complete the form for a State Fair Hearing will be given to any Medi-Cal or RCHC beneficiary/beneficiary's representative who wishes to appeal the expedited appeal decisions.

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

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

Grievances Regarding CARES or ACT

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

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

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

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

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

State Fair Hearing

State and Federal law guarantees Medi-Cal or RCHC beneficiaries a right to a State Fair Hearing after they have completed the problem resolution process. Beneficiaries are to be notified, orally if possible, and in writing when services are being denied, terminated, or reduced. The Notice of Action (NOA) will inform Medi-Cal or RCHC beneficiaries of their right to request State a Fair Hearing within ninety (90) calendar days of the date of the notice. In addition, if the beneficiary requests a State Fair Hearing within ten (10) days of the date of the notice, the beneficiary is entitled to continue to receive services until the Fair Hearing decision is made under the Aid Paid Pending clause when:

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

The request for a State Fair Hearing is completed by the Medi-Cal or RCHC beneficiary and mailed directly to the Administrative Adjudications Division in Sacramento. Hearings are held

within thirty (30) days of the request, and involved parties are notified ten (10) days prior to the hearing. The Department will prepare a position paper concerning the issues, which must be given to the beneficiary/beneficiary's representative at least two (2) days prior to the hearing.

Enforcement

Mental health providers must abide by the decisions of the State Fair Hearing regarding treatment services provided to beneficiaries.

The Mental Health Director is responsible for assuring that the State Fair Hearing decision is followed. Failure to implement the recommendation or decision could result in disciplinary action, fines or revocation of contract as imposed by the Mental Health Director.

Confidentiality

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

Consumer Problem Resolution

RCDMH is committed to maintaining quality services for Riverside County consumers, and is mindful that there may be many factors contributing to a consumer's dissatisfaction. Complaints/Grievances about providers will be investigated by RCDMH Outpatient Quality Improvement.

Most complaints are minor and can be easily resolved on an informal level, while other situations may be more complex and may involve a written follow-up. In less frequent situations providers may be placed on a "QI Hold" while a situation is being investigated. Being placed on "hold" is dependent on the severity of the concern, pattern of past complaints, and the impact on the consumer(s). Providers will be notified in writing of the hold.

Providers will be notified via certified mail of contract termination.

Definitions

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

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

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

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

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

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

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

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

GRIEVANCE LOG

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

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

ALL PLAN LETTER 17-018
SUPERSEDES ALL PLAN LETTER 13-021

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR OUTPATIENT MENTAL HEALTH SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to explain the contractual responsibilities of Medi-Cal managed care health plans (MCPs) for the provision of medically necessary outpatient mental health services and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). MCPs must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM),that results in mild to moderate distress or impairment[1] of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services[2] to children under the age of 21. This APL also delineates MCP responsibilities for referring to, and coordinating with, county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

This letter supersedes APL 13-021 and provides updates to the responsibilities of the MCPs for providing mental health services. Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061[3] describes existing requirements regarding the provision of SMHS by MHPs, which have not changed as a result of coverage of non-specialty, outpatient mental health services by MCPs and the fee-for-service (FFS) Medi-Cal program. The requirements outlined in Information Notice 16-061 remain in effect.

[1] DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS, medical necessity is less stringent than it is for adults; therefore, children with low levels of impairment may meet medical necessity criteria SMHS (CCR, Title 9 Sections § 1830.205 and §1830.210).
[2] The term "non-specialty" in this context is used to differentiate the mental health services covered and provided by MCPs and the FFS Medi-Cal program from the SMHS covered and provided by MHPs. It is not intended to describe the providers of these services as non-specialist providers.
[3] MHSUDS Information Notices are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

BACKGROUND:

The federal Section 1915(b) Medi-Cal SMHS Waiver[4] requires Medi-Cal beneficiaries needing SMHS to access these services through MHPs. To qualify for these services, beneficiaries must meet SMHS medical necessity criteria regarding diagnosis, impairment, and expectations for intervention, as specified below. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)).

The medical necessity criteria for SMHS can be found in Title 9, California Code of Regulations (CCR), Sections (§) 1820.205 (inpatient)[5]; 1830.205 (outpatient)[6]; and 1830.210 (outpatient EPSDT)[7].

DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differs between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS medical necessity is less stringent than it is for adults, therefore children with low levels of impairment may meet medical necessity criteria for SMHS (Title 9, CCR, §1830.205 and §1830.210), whereas adults must have a significant level of impairment. To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria:

1. Have a condition that would not be responsive to physical health care based treatment; and
2. The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MCP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

Consistent with Title 9, CCR, §1830.205, an adult beneficiary must meet all of the following criteria to receive outpatient SMHS:

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[4] SHMS Waiver Information can be found at:
http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx
[5] Medical necessity criteria for inpatient specialty mental health services (Title 9, CCR, §1820.205) are not described in detail in this APL, as this APL is primarily focused on outpatient mental health services.
[6] Title 9, CCR, §1830.205
[7] Title 9, CCR, §1830.210

1. The beneficiary has one or more diagnoses covered by Title 9, CCR, §1830.205(b)(1), whether or not additional diagnoses, not included in Title 9, CCR, §1830.205(b)(1) are also present.
2. The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis:
   a. A significant impairment in an important area of life functioning; or
   b. A reasonable probability of significant deterioration in an important area of life functioning.
3. The proposed intervention is to address the impairment resulting from the covered diagnosis, with the expectation that the proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, In addition, the beneficiary's condition would not be responsive to physical health care based treatment.

Prior to January 1, 2014, adult MCP beneficiaries who had mental health conditions but did not meet the medical necessity criteria for SMHS had only limited access to outpatient mental health services, which were delivered by primary care providers (PCPs) or by referral to Medi-Cal FFS mental health providers. DHCS paid MCPs a capitated rate to provide those outpatient mental health services that were within the PCP's scope of practice (unless otherwise excluded by contract). Since January 1, 2014, DHCS adjusted MCP capitation payments to account for expanded outpatient mental health services.

DHCS requires MCPs to cover and pay for mental health services conducted by licensed mental health professionals (as specified in the Psychological Services Medi-Cal Provider Manual[8]) for MCP beneficiaries with potential mental health disorders, in accordance with Sections 29 and 30 of Senate Bill X1 1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013), which added §14132.03 and §14189 to the Welfare and Institutions Code. This requirement, which was in addition to the previously-existing requirement that PCPs offer mental health services within their scope of practice, remains in effect, along with the requirement to cover outpatient mental health services to adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (as assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools agreed upon by both the MCP and MHP) resulting from a mental health disorder (as defined in the current DSM).

[8] The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol_a07.doc

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (CMS-2333-F) that applied certain requirements from the Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110-343, enacted on October 3, 2008) to coverage offered by Medicaid Managed Care Organizations. This included the addition of Subpart K – Parity in Mental Health and Substance Use Disorder Benefits to the Code of Federal Regulations (CFR). The general parity requirement (Title 42, CFR, §438.910(b)) stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. This precludes any restrictions to a beneficiary's access to an initial mental health assessment. Therefore, MCPs shall not require prior authorization for an initial mental health assessment. DHCS recognizes that while many PCPs provide initial mental health assessments within their scope of practice, not all do. If a beneficiary's PCP cannot perform the mental health assessment because it is outside of their scope of practice, they may refer the beneficiary to the appropriate provider.

POLICY:

MCPs continue to be responsible for the delivery of non-SMHS for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current DSM. MCPs shall continue to deliver the outpatient mental health services specified in their Medi-Cal Managed Care contract and listed in Attachment 1 whether they are provided by PCPs within their scope of practice or through the MCP's provider network.

MCPs also continue to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for MCP beneficiaries who require SMHS. The eligibility and medical necessity criteria for SMHS provided by MHPs have not changed pursuant to this policy; SMHS continue to be available through MHPs.

MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, §438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider. An MCP is required to cover the cost of an initial mental health assessment

completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

If further services are needed that require authorization, MCPs are required to follow guidance developed for mental health parity, as follows:

MCPs must disclose the utilization management or utilization review policies and procedures that the MCP utilizes to DHCS, its contracting provider groups, or any delegated entity, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits included in the MCP contract.

MCP policies and procedures must ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- Service type
- Appropriate service usage
- Cost and effectiveness of service and service alternatives
- Contraindications to service and service alternatives
- Potential fraud, waste and abuse
- Patient and medical safety
- Other clinically relevant factors

The policies and procedures must be consistently applied to medical/surgical, mental health and substance use disorder benefits. The plan shall notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for MCPs include making utilization management criteria for medical necessity determinations for mental health and substance use disorder benefits available to beneficiaries, potential beneficiaries and providers upon request in accordance with Title 42, CFR §438.915(a). MCPs must also provide to beneficiaries, the reason for any denial for reimbursement or payment of services for mental health or substance use disorder benefits in accordance with Title 42, CFR, §438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.

MCP Responsibility for Outpatient Mental Health Services
Attachment 1 summarizes mental health services provided by MCPs and MHPs. MCPs must provide the services listed below when medically necessary and provided by PCPs or by licensed mental health professionals in the MCP provider network within their scope of practice:

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.

Current Procedural Terminology (CPT) codes that are covered can be found in the Psychological Services Medi-Cal Provider Manual (linked in footnote 8 above).

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

For mild to moderate mental health MCP covered services for adults, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to the county MHP for SMHS when a mental health diagnosis covered by the MHP results in significant impairment;

For beneficiaries under the age of 21, the MCP is responsible for providing medically necessary non-SMHS listed in Attachment 1 regardless of the severity of the impairment. The number of visits for mental health services is not limited as long as the MCP beneficiary meets medical necessity criteria.

At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCP's provider network. Each MCP is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the beneficiary to a mental health provider within the MCP network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with the MHP to assess the beneficiary's disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools must be identified in the MOU between the MCP and MHP, as discussed in APL 13-018.

Pursuant to the EPSDT benefit, MCPs are required to provide and cover all medically necessary services. For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. For children under the age 21, MCPs must provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01 and "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)). However for children under the age 21, MCPs are required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by a MHP.

If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because they do not meet the medical necessity criteria for SMHS, then the MCP is required to ensure the provision of outpatient mental health services as listed in the contract and Attachment 1 of this APL, or other appropriate services within the scope of the MCP's covered services.

Each MCP must ensure its network providers refer adult beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the adult MCP beneficiary has a significant impairment, but the diagnosis is uncertain, the MCP must ensure that the beneficiary is referred to the MHP for further assessment.

The MCPs must also cover outpatient laboratory tests, medications (excluding carved-out medications that are listed in the MCP's relevant Medi-Cal Provider Manual[9]), supplies, and supplements prescribed by the mental health providers in the MCP network, as well as by PCPs, to assess and treat mental health conditions. The MCP may require that mild to moderate mental health services to adults are provided through the MCP's provider network, subject to a medical necessity determination.

The MCP may contract with the MHP to provide these mental health services when the MCP covers payment for these services.

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an MCP beneficiary receiving SMHS. The MCP must coordinate care with the MHP. The MCP is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's provider network.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations, as well as other contract requirements and DHCS guidance, including applicable APLs and Duals Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachments

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[9] The provider manual for the Two Plan Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan_z01.doc
The provider manual for the Geographic Managed Care Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc
The provider manual for the County Organized Health Systems can be found at:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/.../mcpcohs_z01.doc
The provider manual for Imperial, San Benito, and Regional Models can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial_z01.doc

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY	**Mild to Moderate Impairment in Functioning** A beneficiary is covered by the MCP for services if he or she is diagnosed with a mental health disorder, as defined by the current DSM[11], resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning: • At an initial health screening, a PCP may identify the need for a thorough mental health assessment and refer a beneficiary to a licensed mental health provider within the MCP's network. The mental health provider can identify the mental health disorder and determine the level of impairment. • A beneficiary may seek and obtain a mental health assessment at any time directly from a licensed mental health provider within the MCP network without a referral from a PCP or prior authorization from the MCP. • The PCP or mental health provider should refer any beneficiary who meets medical necessity criteria	**Significant Impairment in Functioning** An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria: 1. Has an included mental health diagnosis;[12] 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function; 3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning. 4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care based treatment. *Note: For beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels*	**Emergency and Inpatient** A beneficiary is eligible for services if he or she meets the following medical necessity criteria: 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent

[10] SMHS provided by MHP
[11] Current policy is based on DSM IV and will be updated to DSM 5 in the future
[12] As specified in regulations Title 9, Section 1830.205 for adults and Section 1830.210 for those under age 21

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY (continued)	for SMHS to the MHP. • When a beneficiary's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the beneficiary may return to the MCP's network mental health provider. *Note: Conditions that the current DSM identifies as relational problems are not covered (e.g., couples counseling or family counseling.)*	*to correct or ameliorate a mental health condition or impairment.*[13]	or emergency intervention provided in the community or clinic; and; f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.
SERVICES	Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • 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 medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation	• Mental Health Services o Assessment o Plan development o Therapy o Rehabilitation o Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

[13] Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

The following psychiatric drugs are noncapitated except for HCP 170 (KP Cal, LLC):

Amantadine HCl	Olanzapine Fluoxetine HCl
Aripiprazole	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Asenapine (Saphris)	
Benztropine Mesylate	Paliperidone **(oral and injectable)**
Brexpiprazole (Rexulti)	Perphenazine
Cariprazine	Phenelzine Sulfate
Chlorpromazine HCl	Pimavanserin
Clozapine	Pimozide
Fluphenazine Decanoate	Quetiapine
Fluphenazine HCl	Risperidone
Haloperidol	Risperidone Microspheres
Haloperidol Decanoate	Selegiline (transdermal only)
Haloperidol Lactate	Thioridazine HCl
Iloperidone (Fanapt)	Thiothixene
Isocarboxazid	Thiothixene HCl
Lithium Carbonate	Tranylcypromine Sulfate
Lithium Citrate	Trifluoperazine HCl
Loxapine Succinate	Trihexyphenidyl
Lurasidone Hydrochloride	Ziprasidone
Molindone HCl	Ziprasidone Mesylate
Olanzapine	

These drugs are listed in the Medi-Cal Provider Manual in the following link:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED*)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

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[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

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[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

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[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

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[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization
MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards
MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

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[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division