RESOLUTION - ACTION REQUESTED 2019-382

MEETING: July 2, 2019

TO: The Board of Supervisors

FROM: Chevon Kothari, Health and Human Services Director

RE: Care Coordination MOU with California Health and Wellness Plan

RECOMMENDATION AND JUSTIFICATION:
Approve a Memorandum of Understanding (MOU) with California Health and Wellness Plan (CHWP) to coordinate patient physical and behavioral health care services; and authorize the Board of Supervisors Chair to Sign the MOU.

The purpose of this MOU is to describe the responsibilities of Mariposa County Behavioral Health and CHWP in the delivery of specialty mental health services to CHWP members served by both parties. It is the intention of both parties to coordinate care between providers of physical and mental health care. There will be no exchange of funds between CHWP and Mariposa County Behavioral Health under this MOU.

Mariposa County Behavioral Health is a Mental Health Plan (MHP), as defined in Title 9 California Code of Regulations (CCR), section 1810.226 and is required by the State Department of Health Care Services (DHCS) to enter into an MOU with any Medi-Cal managed care plan providing health care services to MHP Medi-Cal beneficiaries in accordance with Title 9 CCR.

BACKGROUND AND HISTORY OF BOARD ACTIONS:
The Board approved the previous agreement with California Health and Wellness Plan on July 24, 2018 by Resolution 2018-367.

Mariposa County first entered into an MOU with CHWP on July 1, 2014.

ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:
If this MOU is not approved, DHCS may sanction Mariposa County Behavioral Health pursuant to paragraph (one), subdivision (e), Section 14712 for failure to comply with the requirements of Welfare & Institution Code, Section 14715

FINANCIAL IMPACT:
There will be no exchange of funds between CHWP and Mariposa County Behavioral Health under this MOU. There will be no impact to the County General Fund.

ATTACHMENTS:
Resolution - Action Requested 2019-382

CA Health and Wellness 2020 - Wcsignature (PDF)

RESULT: ADOPTED BY CONSENT VOTE [UNANIMOUS]
MOVER: Marshall Long, District III Supervisor
SECONDER: Merlin Jones, District II Supervisor
AYES: Merlin Jones, Marshall Long, Kevin Cann, Miles Menetrey
EXCUSED: Rosemarie Smallcombe
MEMORANDUM OF UNDERSTANDING
between
CALIFORNIA HEALTH AND WELLNESS PLAN
and
COUNTY OF MARIPOSA
for
COORDINATION OF SERVICES

This MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into this __ day of __________, 2019, to be effective as of July 1, 2019 ("Effective Date") by and between the COUNTY OF MARIPOSA, a Political Subdivision of the State of California, hereinafter referred to as ("COUNTY") and CALIFORNIA HEALTH AND WELLNESS PLAN ("CHWP"), a health maintenance organization, whose address is 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833, (collectively the "Parties" and individually "Party") in order to implement certain provisions of Title 9 of the California Code of Regulations ("CCR").

WHEREAS COUNTY through its Department of Behavioral Health is a Mental Health Plan hereinafter referred to as "MHP", as defined in Title 9 CCR, section 1810.226 and is required by the State Department of Mental Health ("DMH") to enter into an MOU with any Medi-Cal managed care plan providing health care services to MHP Medi-Cal beneficiaries in accordance with Title 9 CCR; and

WHEREAS, nothing contained herein shall add to or delete from the services required by COUNTY or CHWP under each individual Party’s agreement with the State ("State") of California or the provisions of State or federal law. COUNTY and CHWP agree to perform required services under said agreements with the State, to the extent not inconsistent with laws and regulations; and

WHEREAS, the Department of Health Care Services may sanction a mental health plan pursuant to paragraph (one), subdivision (e), Section 14712 for failure to comply with the requirements of Welfare & Institution Code, Section 14715; and

WHEREAS, this MOU cannot conflict with MHP’s obligations in the State/County MHP Contract, CCR Title 9, and the State Plan for the rehabilitation and Targeted Case Management outpatient; and

WHEREAS, all references in this MOU to “members” or “Members” are limited to individuals assigned to or enrolled in CHWP health plan.

WHEREAS the purpose of this MOU is to describe the responsibilities of COUNTY through its MHP and CHWP in the delivery of specialty mental health services to members served by both Parties. It is the intention of COUNTY and CHWP to coordinate care between providers of physical care and mental health care as set forth in Attachment A, “Matrix of Parties’ Responsibilities”.

WHEREAS, COUNTY shall ensure that all CHWP members sign the program opt-in authorization form/consent. COUNTY and its subcontracted providers will manage the member-level opt-in and data sharing consents, including without limitation, data sharing revocations, and providing access to Health Net to such opt-in and data sharing consents of CHWP members.

WHEREAS, Attachment B identified as “DHCS All Plan Letter ("APL")17-018” which is attached hereto and incorporated herein, shall provide guidelines by which this MOU shall be governed. Any amendments to this APL Letter shall automatically be incorporated by reference into this MOU.
NOW, THEREFORE, in consideration of their mutual covenants and conditions, the Parties hereto agree as follows:

1. **TERM**

   This MOU shall become effective July 1, 2019 and shall automatically renew thereafter.

2. **TERMINATION**

   A. **Non-Allocation of Funds.** The terms of this MOU, and the services to be provided hereunder, are contingent on the approval of funds by the appropriating government agency. Should sufficient funds not be allocated, the services provided may be modified by mutual agreement of the Parties, or this MOU terminated at any time by COUNTY by giving CHWP sixty (60) days advance written notice.

   B. **Without Cause.** Under circumstances other than those set forth above, this MOU may be terminated by CHWP or COUNTY or Director of COUNTY’s Department of Behavioral Health, or designee, upon the giving of sixty (60) days advance written notice of termination.

   C. **For Cause.** This MOU shall terminate upon a material breach if such breach has not been cured within thirty (30) days of receipt of written notice of breach by the non-breaching party.

3. **COMPENSATION**

   The program responsibilities conducted pursuant to the terms and conditions of this MOU shall be performed without the payment of any monetary consideration by CHWP or COUNTY, one to the other.

4. **INDEPENDENT CONTRACTOR**

   In performance of the work, duties and obligations assumed by CHWP under this MOU, it is mutually understood and agreed that CHWP, including any and all of CHWP’s officers, agents, and employees will at all times be acting and performing as an independent contractor, and shall act in an independent capacity and not as an officer, agent, servant, employee, joint venture, partner, or associate of COUNTY. Furthermore, COUNTY shall have no right to control or supervise or direct the manner or method by which CHWP shall perform its work and function. However, COUNTY shall retain the right to administer this MOU so as to verify that CHWP is performing its obligations in accordance with the terms and conditions thereof. CHWP and COUNTY shall comply with all applicable provisions of law and the rules and regulations, if any, of governmental authorities having jurisdiction over matters which are directly or indirectly the subject of this MOU.

   Because of its status as an independent contractor, CHWP shall have absolutely no right to employment rights and benefits available to COUNTY employees. CHWP shall be solely liable and responsible for providing to, or on behalf of, its employees all legally-required employee benefits. In addition, CHWP shall be solely responsible and save COUNTY harmless from all matters relating to payment of CHWP’s employees, including compliance with Social Security, withholding, and all other regulations governing such matters. It is acknowledged that during the term of this MOU, CHWP may be providing services to others unrelated to the COUNTY or to this MOU.

5. **HOLD-HARMLESS**

   Each of the Parties hereto shall be solely liable for negligent or wrongful acts or omissions of its officers, agents and employees occurring in the performance of this MOU, and if either Party becomes liable for damages caused by its officers, agents or employees, it shall pay such damages without contribution by the other Party. Each Party hereto agrees to indemnify, defend (if requested by the other Party) and save harmless the other Party, its officers, agents and employees from any and all costs and expenses, including attorney fees and court
costs, claims, losses, damages and liabilities proximately caused by the Party, including its officers, agents and employees, solely negligent or wrongful acts or omissions. In addition, either Party agrees to indemnify the other Party for Federal, State and/or local audit exceptions resulting from noncompliance herein on the part of the Party.

6. **DISCLOSURE OF SELF-DEALING TRANSACTIONS**

Members of CHWP Board of Directors shall disclose any self-dealing transactions that they are a party to CHWP while CHWP is providing goods or performing services under this MOU. A self-dealing transaction shall mean a transaction to which CHWP is a party and in which one or more of its directors has a material financial interest. Members of the Board of Directors shall disclose any self-dealing transactions to which they are a party.

7. **CONFIDENTIALITY**

All responsibilities performed by the Parties under this MOU shall be in strict conformance with all applicable Federal, State and/or local laws and regulations relating to confidentiality. CHWP and COUNTY each agree to keep the Confidential Information strictly confidential. CHWP and COUNTY agree that Confidential Information shall be used only for the purposes contemplated herein, and not for any other purpose. CHWP and COUNTY agree that nothing in this MOU shall be construed as a limitation of (i) disclosures to counsel of a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining to this MOU; (ii) disclosures required to be made to a regulatory agency; (iii) disclosures to internal or independent auditors of a party for audit purposes pertaining to this MOU; or (iv) disclosures to employees or consultants of a party who have a need to know for the purpose of carrying out the obligations of a party under this MOU, provided that in either case the counsel or consultant (in subsection (i) or (iv)) agrees in writing to comply with the provisions of this Section. The parties shall confer prior to disclosing any Confidential Information pursuant to the California Public Records Act or the Ralph M. Brown Act. Each party is responsible for its own compliance obligations. In brief, County and CHWP will comply with all applicable laws pertaining to the use and disclosure of Protected Health Information (PHI) including but not limited to:

- HIPAA / 45 C.F.R. Parts 160 and 164
- LPS / W & I Code Sections 5328-5328.15
- 45 C.F.R. Part 2 (Substance Use Disorders – SUD)
- HITECH Act (42. U.S.C. Section 17921 et. seq.
- CMIA (Ca Civil Code 56 through 56.37)
- Title 9, CCR, Section 1810.370(a)(3)

The terms of this Section 7 shall survive termination of this MOU.

8. **NON-DISCRIMINATION**

During the performance of this MOU, CHWP shall not unlawfully discriminate against any employee or applicant for employment, or recipient of services, because of race, religion, color, national origin, ancestry, physical disability, medical condition, sexual orientation, marital status, age, or gender, pursuant to all applicable State and Federal statutes and regulations.
9. AUDITS AND INSEPCIONS

Each Party shall, at any time upon reasonable notice during business hours, and as often as may be deemed reasonably necessary, make available for examination by the other Party, State, local, or federal authorities all of its records and data with respect to the matters covered by this MOU as may be required under State or federal law or regulation or a Party’s contract with a State agency.

10. NOTICES

The persons having authority to give and receive notices under this MOU and their addresses include the following:

**HEALTH PLAN**
- California Health & Wellness Plan
  - 1740 Creekside Oaks Dr., Suite 200
  - Sacramento, CA 95833

**COUNTY:**
- County of Mariposa
  - P.O. Box 99
  - Mariposa, CA 95338

Or to such other address as such Party may designate in writing.

Any and all notices between COUNTY and CHWP provided for or permitted under this MOU or by law, shall be in writing and shall be deemed duly served when personally delivered to one of the Parties, or in lieu of such personal service, when deposited in the United States Mail, postage prepaid, addressed to such Party.

11. GOVERNING LAW

The Parties agree that for the purposes of venue, performance under this MOU is to be in Mariposa County, California.

This MOU shall be governed by and construed and enforced in accordance with the laws of the State of California, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall be governed.

12. SEVERABILITY

If any provision of this MOU is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this MOU shall remain in full force and effect.

13. WAIVER OF OBLIGATIONS: The waiver of any obligations or breach of this MOU by either party shall not constitute a continuing waiver of any obligation or subsequent breach of either the same or any other provision(s) of this MOU. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.
14. ENTIRE AGREEMENT

This MOU including all Exhibits and Attachments attached hereto constitutes the entire agreement between CHWP and COUNTY with respect to the subject matter hereof and supersedes all previous agreement negotiations, proposals, commitments, writings, advertisements, publications and understandings of any nature whatsoever unless expressly included in this MOU.

15. COUNTERPARTS:

This MOU may be executed in counterparts and by facsimiles or PDF signature, all of which taken together constitute a single agreement between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.

16. AMENDMENTS.

This MOU may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or federal laws or regulations, requirements of regulatory agencies, or requirements of accreditation agencies, including without limitation, changes required to comply with DHCS and/or CMS shall not require the consent of COUNTY or CHWP and shall be effective immediately on the effective date of the requirements.

17. ASSIGNMENT.

Neither this MOU, nor any of a party’s rights or obligations hereunder is assignable by either party without the prior written consent of the other part which consent shall not be unreasonably withheld. CHWP expressly reserves the rights assign, delegate or transfer any or all of its rights, obligations or privileges under this MOU to an entity controlling, controlled by, or under common control with CHWP.

18. NO THIRD PARTY BENEFICIARIES.

Nothing in this MOU shall confer upon any person other than the parties any rights, remedies, obligations, or liabilities whatsoever.

18. INSURANCE

General Provisions for all Insurance Coverage: Without limiting either party's indemnification of the other, and during the pendency of this MOU, each party shall provide and maintain at its own expense insurance coverage, which may include self-insurance, sufficient for liabilities, which may arise from or relate to this MOU

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THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES
IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the date set forth beneath their respective signatures.

California Health and Wellness Plan

Signature: [Signature]
Print Name: Abbie A. Totten
Title: Medi-Cal Program Officer
Date: [Date]
ECM #: 288890

County of Mariposa

(Legibly Print Name of Provider)
Signature: [Signature]
Print Name: Miles Menetrey
Title: Board Chair
Date: [Date]

To be completed by California Health and Wellness Plan only:

Effective Date of Agreement:

Included in Agreement | Attachment/Exhibit
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X | Attachment A: Matrix of Parties’ Responsibilities
X | Attachment B: DHCS All Plan Letter 17-018 (Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services)
 | Attachment C: SUD MOU Addendum
X | Attachment D: APL 17-010 (Non-Emergency Medical and Non-Medical Transportation Services)

APPROVED AS TO FORM:

[Signature]
STEVEN W. DAHLEM
COUNTY COUNSEL

CHWP MOU BH 02.21.19
ATTACHMENT A
TO
MEMORANDUM OF UNDERSTANDING

MATRIX PARTIES’ OF RESPONSIBILITIES
# ATTACHMENT A

TO

MEMORANDUM OF UNDERSTANDING

MATRIX OF PARTIES’ RESPONSIBILITIES

<table>
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<tr>
<th>CATEGORY</th>
<th>MENTAL HEALTH PLAN (MHP)</th>
<th>CHWP</th>
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| 1. Basic Requirements | 1. MHP agrees to address policies and procedures with the CHWP that cover:  
- management of the members care, including – but not limited to the following:  
- screening assessment and referrals  
- medical necessity determination  
- care coordination and  
- exchange of medical information. | 1. CHWP agrees to address policies and procedures with the MHP that cover:  
- management of the members care,  
- including – but not limited to the following:  
- screening assessment and referrals  
- medical necessity determination  
- care coordination and  
- exchange of medical information. |
| 2. Mental Health Covered Services | 1. MHP is responsible for providing CHWP members with outpatient mental health benefits for members with significant impairment in functions that meet the medical necessity criteria. See Attachment B: DHCS APL 17-018 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services  
2. Conditions that the Diagnostic and Statistical Manual (DSM) identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by the MHP or by CHWP.  
3. All services must be provided in a culturally and linguistically appropriate manner | 1. CHWP is obligated to cover and pay for mental health assessments of CHWP members with potential mental health disorders rendered by CHWP’s network providers for services that are Plan responsibility. This new requirement is in addition to the existing requirement that PCPs offer mental health services within their scope of practice.  
2. CHWP is responsible for providing members with outpatient mental health benefits for 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 (DSM) that is also covered according to State regulations and consistent with DHCS APL 17-018 (Attachment B) and any revisions thereto.  
3. CHWP will be responsible for providing these services when medically necessary and provided by PCPs or licensed mental health professionals in CHWP’s provider network within the scope of their practice. See Attachment B: Attachment 1, Mental Health Services Description Chart for Medi-Cal Managed Care Members.  
4. Conditions that the DSM |
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<td>All services must be provided in a culturally and linguistically appropriate manner.</td>
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<td>3. Oversight Responsibilities</td>
<td>a. MHP’s administrative staff is the liaison that will be responsible for notifying its network providers and relevant staff of their roles and responsibilities in the management of this MOU.</td>
<td>a. CHWP’s affiliate behavioral health company, Cenpatico Behavioral Health (“Cenpatico”) has direct contracts with mental health professionals (LMHP) network and will be responsible for notifying their LMHPs and relevant staff of their roles and responsibilities.</td>
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<td>b. MHP will have staff participate on an oversight team comprised of representatives from both CHWP and the MHP who will be responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of this MOU.</td>
<td>b. CHWP has a Public Programs administrator/liaison that will participate on an oversight team comprised of representatives from both MHP and CHWP who will be responsible for program oversight, quality improvement, problem and dispute resolution as well as management of this MOU.</td>
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<td>c. MHP will also have staff participate on a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. The MHP and CHWP may determine the composition of the multidisciplinary teams.</td>
<td>c. CHWP will also have staff participate on a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. CHWP and MHP may determine the composition of the multidisciplinary teams.</td>
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<td>d. The MHP and CHWP oversight teams and multidisciplinary teams may be the same teams.</td>
<td>d. CHWP and the MHP oversight teams and multidisciplinary teams may be the same teams.</td>
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<td>e. MHP liaison will provide CHWP with an updated list of approved MHP providers, specialists and mental health care centers in the county. This information is also available on the MHP’s managed care website.</td>
<td>e. CHWP liaison will provide MHP with an updated list of its LMHPs and specialists.</td>
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<td>4. Screening, Assessment and Referral</td>
<td>a. MHP accepts referrals from CHWP staff, providers and members’ self-referrals for determination of medical necessity for specialty mental health services. Medical necessity for specialty mental health services is defined at Title 9, CCR, Sections 1820.205*, 1830.205* and 1830.210*.</td>
<td>1. CHWP is responsible for the screening, assessment and referrals, including agreed upon screening and assessment tools for use in determining if CHWP or the MHP will provide mental health services.</td>
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<td>b. If it is determined by CHWP’s LMHP that the member may meet specialty mental health services medical necessity criteria, the</td>
<td>2. CHWP accepts referrals from MHP staff, providers, and members’ self-referral for assessment, makes a determination of medical necessity for outpatient services, and provides referrals within CHWP’s &quot;s LMHP</td>
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<td>CHWP LMHP refers the member to the MHP for further assessment and treatment.</td>
<td>network. Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.</td>
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<td>c. MHP providers will refer CHWP members to their identified PCP for medical and non-specialty mental health conditions that would be responsive to appropriate physical health care.</td>
<td>When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, “medical necessity” is expanded to include the standards set forth in Title 22 CCR Sections 51340* and 51340.1*.</td>
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<td>3. CHWP PCP’s will refer CHWP members to a CHWP LMHP for:</td>
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<td>i. An assessment to confirm or arrive at a diagnosis and treatment (except in emergency situations or in cases when the beneficiary clearly has a significant impairment that the member can be referred directly to the MHP).</td>
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<td>ii. If it is determined by the CHWP LMHP that the member may meet the Specialty Mental Health Services (SMHS) medical necessity criteria, the CHWP LMHP refers the member to the MHP for further assessment and treatment.</td>
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<td>4. Primary care mental health treatment includes:</td>
<td>When a CHWP member’s condition improves under SMHS and the CHWP LMHP and MHP coordinate care, the CHWP member may return to the CHWP LMHP.</td>
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<td>a. Basic education, assessment, counseling and referral and linkage to other services for all CHWP members</td>
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<td>b. Medication and treatment for</td>
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<td>i. Mental health conditions that would be responsive to physical healthcare-based treatment</td>
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<td>ii. Mental health disorders</td>
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| 5. Care Coordination | 1. When medical necessity criteria are met and services are approved by the MHP, the MHP and contracted providers will provide hospital based specialty mental health ancillary services, which include, but are not limited to Electroconvulsive Therapy (ECT) and magnetic resonance imaging (MRI) that are received by an CHWP member admitted to a psychiatric inpatient hospital other than routine services. Per Title 9, CCR, Article 3, Section 1810.350*. | 1. CHWP must cover and pay for medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Section 51311*. CHWP will cover related services for Electroconvulsive Therapy (ECT) such as anesthesiologist services provided on an outpatient basis. Per MMCD Policy Letter No. 00-01 REV.  
2. CHWP will cover and pay for all medically necessary professional services to meet the physical health care needs of the members who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital or Psychiatric Health Facility (PHF). These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultation. Per MMCD Policy Letter No. 00-01 REV.  
3. CHWP is not required to cover room and board charges or mental health services associated with a CHWP member's admission to a hospital or inpatient psychiatric facility for psychiatric inpatient services. Per MMCD Policy Letter No. 00-01 REV. |
| 5a. Laboratory, Radiological and Radioisotope Services | 1. For any member needing laboratory, radiological, or radioisotope services when necessary for the diagnosis, treatment or monitoring of a mental health condition MHP will utilize the list of CHWP contract providers. | 1. CHWP will cover and pay for medically necessary laboratory, radiological and radioisotope services when ordered by the MHP for the diagnosis, treatment or monitoring of a mental health condition (and side effects resulting from medications prescribed to treat the mental health diagnosis) as described in Title 22, CCR Section 51311* and MMCD Policy Letter No. 00-01 REV.  
2. CHWP will coordinate and assist the MHP in the delivery of |
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<td>1. CHWP will cover and pay for prior authorized home health agency services as described in Title 22, CCR, Section 51337* prescribed by a CHWP provider when medically necessary to meet the needs of homebound CHWP members. CHWP is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program. 2. CHWP will refer members who may be at risk of institutional placement to the Home and Community Based Services (HCBS) Waiver Program if appropriate.</td>
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<td>5.b. Home Health Agency Services</td>
<td>1. MHP shall cover and pay for medication support services, case management, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247*, which are prescribed by a psychiatrist and are provided to a CHWP member who is homebound. MHP will collaborate with CHWP on any specialty mental health services being provided to a CHWP member.</td>
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<td>5.c. Pharmaceutical Services and Prescribed Drugs</td>
<td>1. The MHP list of contracted network providers is available online. 2. MHP providers will prescribe and monitor the effects and side effects of psychotropic medications for CHWP members under their treatment 3. MHP will coordinate with CHWP representatives to ensure that psychotropic drugs prescribed by MHP providers are included in the CHWP formulary and/or available for dispensing by CHWP network pharmacies unless otherwise stipulated by state regulation. 4. MHP will inform MHP providers regarding process and procedure for obtaining prescribed medications for CHWP members 5. MHP providers will utilize CHWP contracted laboratories for laboratory tests needed in connection with administration and management of psychotropic medications. 6. MHP will assist CHWP in the utilization review of psychotropic drugs prescribed by out-of-network psychiatrists. 7. MHP will share with CHWP a list</td>
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<td>of non-psychiatrist MHP providers contracted to provide mental health services in areas where access to psychiatrists is limited on a quarterly basis.</td>
<td>Excluded from CHWP Coverage <a href="http://files.medicall.ca.gov/pubs/docs/manuals.html">link</a>. CHWP will apply utilization review procedures when prescriptions are written by out-of-network psychiatrists for the treatment of psychiatric conditions a. Covered psychotropic drugs written by out-of-network psychiatrists will be filled by CHWP network pharmacies b. CHWP will provide members with the same drug accessibility written by out-of-network psychiatrists as in-network providers c. CHWP will not cover and pay for mental health drugs written by out-of-network 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. Per MMCD Policy Letter No. 00-01 REV. 3. CHWP PCPs will monitor the effects and side effects of psychotropic medications prescribed for those members whose psychiatric conditions are under their treatment. 4. Reimbursement to pharmacies for new psychotropic drugs classified as antipsychotics and approved by the FDA will be made through the MHP whether these drugs are provided by a pharmacy contracting with CHWP or by an MHP pharmacy. Per MMCD Policy Letter No. 00-01 REV.</td>
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5.d. Service Authorizations

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<td>1. For any member needing prescribed drugs and laboratory services when necessary for the treatment or monitoring of a mental health condition, MHP will utilize the list of CHWP contracted providers found on their website.</td>
<td>1. CHWP will authorize medical assessment and/or treatment services by CHWP LMHPs who are credentialed and contracted with CHWP for covered medically necessary services.</td>
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<td>2. MHP will authorize treatment services by MHP providers who are credentialed and contracted with MHP for services that meet SMHS medical necessity criteria.</td>
<td>2. CHWP will inform PCPs that they may refer members to the MHP for specialty mental health services.</td>
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<td>3. CHWP contracted providers can be found on the website.</td>
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<td>5.e. Nursing and Residential Facility Services</td>
<td>1. MHP will arrange and coordinate payment for nursing facility services, i.e., augmented Board and Care (ABC), Skilled Nursing Facility (SNF), Institution for Mental Disease (IMD), etc., for members who meet medical necessity criteria and who require a special treatment program [Title 22, California Code of Regulations (CCR), Section 51335(k)*] 2. MHP’s provide medically necessary specialty mental health services, typically visits by psychiatrists and psychologists.</td>
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<td>5.f. Developmentally Disabled Services</td>
<td>1. MHP will refer members with developmental disabilities to the Local Regional Center for non-medical services such as respite, out-of-home placement, supportive living, etc., if such services are needed. 2. MHP has a current list of names, addresses and telephone numbers of local providers, provider organizations, and agencies that is available to an CHWP member when that member has been determined to be ineligible for MHP covered services because the member’s diagnosis is not included in CCR, Title 9 1830.205(b)(1)*.</td>
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<td>6. Exchange of Protected Health Information</td>
<td>1. MHP will comply with all applicable laws pertaining to use and disclosure of PHI including but not limited to:  • HIPAA / 45 C.F.R. Parts 160 and 164  • LPS / W &amp; I Code Sections 5328- 5328.15  • 45 C.F.R. Part 2  • HITECH Act (42. U.S.C. Section 17921 et. seq.  • CMIA (Ca Civil Code 56 through 56.37)  • Title 9, CCR, Section 1810.370(a)(3)* 2. MHP will train all members of its workforce on policies and procedures regarding Protected Health Information (PHI) as necessary and appropriate for them to carry out their functions within the covered entity. 3. Only encrypted PHI as specified in the HIPAA Security Rule will be</td>
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<td>disclosed via email. Unsecured PHI will not be disclosed via email.</td>
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<td>4. MHP will notify the State of verified breaches (as defined by the HITCHE Act as posing a significant risk of financial, reputational or other harm to the client) and corrective actions planned or taken to mitigate the harm involving members within the required timelines.</td>
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<td>7. Reporting and Quality Improvement Requirements</td>
<td>1. MHP in conjunction with CHWP will hold regular meetings to review the referral and care coordination process and to monitor member engagement and utilization.</td>
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<td>2. No less than semi-annually, MHP and CHWP will review the referral and care coordination process to improve quality of care; and at least semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. Reports summarizing findings of the review must address the systemic strengths and barriers to effective collaboration between MHP and CHWP.</td>
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<td>3. MHP and CHWP will develop reports that track cross-system referrals, beneficiary engagement, and service utilization to be determined in collaboration with DHCS, including, but not limited to, the number of disputes between MHP and CHWP, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access and dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by members receiving such services from MHP and CHWP, as well as quality strategies to address duplication of services.</td>
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<td>4. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.</td>
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<td>8. Dispute Resolution</td>
<td>1. MHP Liaison will participate in an annual review, update and/or</td>
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CHWP MOU BH 02.21.19
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<td>renegotiations with CHWP on this agreement as is mutually agreed.</td>
<td>renegotiations of this agreement with the MHP, as is mutually agreed.</td>
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<td>2. When the MHP has a dispute with CHWP that cannot be resolved to the satisfaction of the MHP concerning the obligations of the MHP or CHWP under their respective contracts with the DHCS, State Medi-Cal laws and regulations, or with this MOU as described in Section 1810.370*, the MHP may submit a request for resolution to the Department.</td>
<td>2. When CHWP has a dispute with the MHP that cannot be resolved to the satisfaction of CHWP concerning the obligations of the MHP or CHWP under their respective contracts with the DHCS, State Medi-Cal laws and regulations, or with this MOU as described in Section 1810.370*, CHWP may submit a request for resolution to the Department.</td>
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<td>3. Either the MHP or CHWP shall submit a request for resolution to either Departments within 15 calendar days of the completion of the dispute resolution process between the Parties. The request for resolution shall contain the following information:</td>
<td>3. Either the MHP or CHWP shall submit a request for resolution to either Departments within 15 calendar days of the completion of the dispute resolution process between the Parties. The request for resolution shall contain the following information:</td>
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<td>(a) A summary of the issue and a statement of the desired remedy, including any disputed services that have been or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service.</td>
<td>(a) A summary of the issue and a statement of the desired remedy, including any disputed services that have been or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service.</td>
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<td>(b) History of attempts to resolve the issue.</td>
<td>(b) History of attempts to resolve the issue.</td>
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<td>(c) Justification for the desired remedy.</td>
<td>(c) Justification for the desired remedy.</td>
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<td>(d) Documentation regarding the issue.</td>
<td>(d) Documentation regarding the issue.</td>
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<td>(e) Upon receipt of a request for resolution, the department receiving the request will notify the department and the other Party within seven calendar days. The notice to the other Party shall include a copy of the request and will ask for a statement of the Party's position on the dispute, any relevant documentation supporting its position, and any dispute of the rate of payment for services included by the other Party in its request.</td>
<td>(e) Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other Party within seven calendar days. The notice to the other Party shall include a copy of the request and will ask for a statement of the Party's position on the dispute, any relevant documentation supporting its position, and any dispute of the rate of payment for services included by the other Party in its request.</td>
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<td>(f) The other Party shall submit the requested documentation within 21 calendar days from notification of the Party from whom documentation is requested.</td>
<td>(f) The other Party shall submit the requested documentation within 21 calendar days from notification of the Party from whom documentation is requested.</td>
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<td>being requested by the Party that received the initial request for resolution or the departments shall decide the dispute based solely on the documentation filed by the initiating Party.</td>
<td>whom documentation is being requested by the Party that received the initial request for resolution or the departments shall decide the dispute based solely on the documentation filed by the initiating Party.</td>
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<td>8.a. Departments’ Responsibility for Review of Disputes</td>
<td>1. The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees. 2. The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and CHWP. 3. The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and CHWP an opportunity to present oral argument.</td>
<td>1. The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees. 2. The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and CHWP. 3. The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and CHWP an opportunity to present oral argument.</td>
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<td>8.b. Provision of Medically Necessary Services Pending Resolution of Dispute</td>
<td>1. A dispute between an MHP and CHWP shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries. Until the dispute is resolved, the following shall apply: (a) The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or (b) When the dispute concerns the MHP's contention that CHWP is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.</td>
<td>1. A dispute between an MHP and CHWP shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries. Until the dispute is resolved, the following shall apply: (a) The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or (b) When the dispute concerns CHWP's contention that the MHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, CHWP shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved.</td>
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| 9. Emergency and After-Hours | 1. MHP will have a toll free 24 hours a day, seven days a week line available to assist members and providers after hours as well as to coordinate urgent and emergent services with Emergency Room personnel during a crisis.  
2. MHP shall cover and pay for the professional services of a mental health specialist provided in an emergency room to an CHWP member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met. Per MMCD Policy Letter No. 00-01 REV.  
3. The MHP is responsible for the facility charges resulting from the emergency services and care of an CHWP member whose condition meets MHP medical necessity criteria when such services and care do result in the admission for 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. Per MMCD Policy Letter No. 00-01 REV.  
4. 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. Per MMCD Policy Letter No 00-01 REV. | The MHP shall identify and provide CHWP with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the CHWP provider responsible for the beneficiary's care.  
1. All CHWP members have access to quality, comprehensive behavioral health care first response services twenty-four (24) hours a day, seven (7) days a week by CHWP providers. CHWP’s network LMHPs have agreed to provide availability for emergency services twenty four (24) hours a day, seven (7) days a week and to arrange for coverage by another provider, in the event of provider’s illness, vacation or other absence from his or her practice.  
As part of the coverage, LMHPs will coordinate urgent and emergent services with the County Mental Health Program or emergency room personnel during a crisis.  
In general, the LMHP must be available to CHWP members twenty-four (24) hours a day, seven (7) days a week by telephone or have an arrangement with an on-call provider to cover when s/he is not available.  
2. CHWP 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.  
3. CHWP shall cover and pay for the facility charges resulting from the emergency services and care of an CHWP 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 |
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<td>10. Member and Provider Education</td>
<td>MHP and CHWP, will coordinate and determine the training requirements for member and provider access to MHP and CHWP covered mental health services.</td>
<td>CHWP and the MHP, if necessary, will coordinate and determine the training requirements for member and provider access to MHP and CHWP covered mental health services.</td>
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| 11. Grievances and Appeals | 1. MHP will share with CHWP the established process for members and providers to register grievances/complaints regarding any aspect of the mental health care services.  
2. MHP will ensure that the CHWP members and providers are given an opportunity for reconsideration and appeal for denied, modified or delayed services.  
3. MHP will ensure that the CHWP members receive specialty mental health services and prescription drugs while the dispute is being resolved. | 1. CHWP has in place a written process for the submittal, processing and resolution of all member and provider grievances and complaints which is inclusive of any aspect of the health care services or provision of services.  
2. CHWP liaison will coordinate and share the established complaint and grievance process for its CHWP MHP members with the MHP.  
3. CHWP will ensure that members and providers are given an opportunity for reconsideration and an appeal for denied, modified or delayed services  
4. CHWP will ensure that medically necessary services continue to be provided to members while the dispute is being resolved. |
| 12. Emergency and Non-Emergency Medical Transportation | 1. Medical transportation services as described in Title 22, Section 51323 are not the responsibility of the MHP except when the purpose of the medical transportation service is to transport a beneficiary from a psychiatric inpatient hospital to another psychiatric hospital. | 1. CHWP will arrange and pay for transportation of members needing medical transportation from:  
a. The emergency room for medical evaluation.  
b. A psychiatric inpatient hospital to a medical inpatient hospital required to... |
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<td>inpatient 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.</td>
<td>address the member’s change in medical condition</td>
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<td>c. A medical inpatient hospital to a psychiatric inpatient hospital required to address the member’s change in psychiatric condition</td>
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<td>2. CHWP will cover and pay for all medically necessary emergency transportation (per CCR Title 22, 51323*). Ambulance services are covered when the member’s medical condition contraindicates the use of other forms of medical transportation.</td>
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<td>3. Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient as per CCR Title 22, 51323*.</td>
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<td>4. Ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary’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. Ambulance services are covered when the patient’s medical condition contraindicates the use of other forms of medical transportation</td>
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<td>5. CHWP will cover all nonemergency medical transportation, necessary to obtain program covered services</td>
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<td>a. When the service needed is of such an urgent nature that written authorization could not have been reasonably submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization.</td>
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<td>b. Transportation shall be authorized only to the nearest facility capable of meeting the patient’s medical needs.</td>
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<td>6. CHWP will cover and pay for</td>
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| 13. Consultation | 1. MHP encourages the use of the consultation by MHP providers with CHWP PCP providers around specialty mental health issues including consultation around medication issues, in accordance with HIPAA federal and state regulations regarding confidentiality. Per HIPAA Privacy Rule 45 C.F.R. Part 164.  
2. For those CHWP members who are included in MHP services, MHP will provide clinical consultation and training to the CHWP PCPs, other Licensed Mental Health Professionals and/or CHWP staff on the following topics  
   a. Recommended physical healthcare-based treatment for diagnosed conditions  
   b. Complex diagnostic assessment of mental disorders (e.g., multiple co-occurring diagnosis, atypical symptom patterns)  
   c. Treatment of stabilized but serious and debilitating mental disorders  
   d. Complex psychotropic medications practices (medication interactions, polypharmacy, use of novel psychotropic medication)  
   e. Treatment of complicated sub-syndrome psychiatric symptoms  
   f. Treatment of psychiatric symptoms precipitated by medications used to treat medical conditions  
   g. Treatment of outpatient mental health services that are within the CHWP PCP’s scope of practice. | 1. PCP providers will be available to consult with MHP and CHWP providers about CHWP members that they both treat, in accordance with HIPAA federal and state regulations regarding confidentiality. Per HIPAA Privacy Rule 45 C.F.R. Part 164.  
2. For those CHWP members who meet MHP medical necessity criteria and whose psychiatric symptoms will be treated by an MHP provider, CHWP and/or PCP will provide consultation to MHP providers and/or MHP staff on the following topics:  
   a. Acquiring access to covered CHWP medical services  
   b. Treatment of physical symptoms precipitated by medications used to treat mental disorders  
   c. Treatment of complicated sub-syndrome medical symptoms  
   d. Complex medication interactions with medications prescribed by PCP not commonly used in psychiatric specialty practice. |
APPROVED AS TO FORM:

STEVEN W. DAHLEM
COUNTY COUNSEL
ATTACHMENT B
TO
MEMORANDUM OF UNDERSTANDING

DHCS ALL PLAN LETTER 17-018

Medi-Cal Managed Care Plan Responsibilities For Outpatient Mental Health Services
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\textsuperscript{1} of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services\textsuperscript{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\textsuperscript{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 16061 remain in effect.

\textsuperscript{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 § 1839.205 and §1839.210).

\textsuperscript{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.

\textsuperscript{3} MHSUDS Information Notices are available at: http://www.dhcs.ca.gov/formsjampubs/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:

\(^{4}\)SMHS Waiver information can be found at: http://www.dhcs.ca.gov/services/MHP/Pages/1915b_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) 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).

The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoc/publications-masters-mtp/part2/psychel_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®), 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

*The provider manual for the Two Plan Model can be found at:
http://files.medi-cal.ca.gov/pubsdocc/publications/masters-mtp/part1/mcpwoplan_z01.doc
The provider manual for the Geographic Managed Care Model can be found at:
http://files.medi-cal.ca.gov/pubsdocc/publications/masters-mtp/part1/mcpmgac_z01.doc
The provider manual for the County Organized Health Systems can be found at:
https://files.medi-cal.ca.gov/pubsdocc/publications/masters-mtp/.../mcppohs_z01.doc
The provider manual for Imperial, San Benito, and Regional Models can be found at:
http://files.medi-cal.ca.gov/pubsdocc/publications/masters-mtp/part1/mcpimperial_z01.doc*
# Attachment 1

## Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>MCP</th>
<th>MHP&lt;sup&gt;10&lt;/sup&gt; OUTPATIENT</th>
<th>MHP INPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELIGIBILITY</td>
<td>Mild to Moderate Impairment in Functioning</td>
<td>Significant Impairment in Functioning</td>
<td>Emergency and Inpatient</td>
</tr>
<tr>
<td>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&lt;sup&gt;11&lt;/sup&gt;, resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning:</td>
<td>An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria:</td>
<td>A beneficiary is eligible for services if he or she meets the following medical necessity criteria:</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td>1. Has an included mental health diagnosis;</td>
<td>1. An included diagnosis;</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td>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;</td>
<td>2. Cannot be safely treated at a lower level of care;</td>
<td></td>
</tr>
<tr>
<td>- The PCP or mental health provider should refer any beneficiary who meets medical necessity criteria.</td>
<td>3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning.</td>
<td>3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and</td>
<td>a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. The condition would not be responsive to physical health care based treatment.</td>
<td>b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: For beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels</td>
<td>c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent</td>
<td></td>
</tr>
</tbody>
</table>

---

<sup>*SMHS provided by MHP</sup>

<sup><sup>*Current policy is based on DSM IV and will be updated to DSM 5 in the future</sup></sup>

<sup><sup>*As specified in regulations Title 9, Section 1830.205 for adults and Section 1830.210 for those under age 21</sup></sup>
<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>MCP</th>
<th>MHP&lt;sup&gt;10&lt;/sup&gt; OUTPATIENT</th>
<th>MHP INPATIENT</th>
</tr>
</thead>
</table>
| 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.<sup>13</sup> | 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  
  - Assessment  
  - Plan development  
  - Therapy  
  - Rehabilitation  
  - Collateral | Acute psychiatric inpatient hospital services  
  - Psychiatric Health Facility Services  
  - Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital |

<sup>13</sup>Title 9, COP, §1830.210
Attachment 2

Drugs Excluded from MCP Coverage

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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amantadine HCl</td>
<td>Olanzapine Fluoxetine HCl</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Olanzapine</td>
</tr>
<tr>
<td>Asenapine (Saphris)</td>
<td>Pamoate</td>
</tr>
<tr>
<td>Monohydrate (Zyprexa Relprevy)</td>
<td></td>
</tr>
<tr>
<td>Benztrapine Mesylate</td>
<td>Paliperidone <strong>(oral and injectable)</strong></td>
</tr>
<tr>
<td>Brexpiprazole (Rexulti)</td>
<td>Perphenazine</td>
</tr>
<tr>
<td>Cariprazine</td>
<td>Phenelzine Sulfate</td>
</tr>
<tr>
<td>Chlorpromazine Hydrochloride</td>
<td>Pimavanserin</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Pimozide</td>
</tr>
<tr>
<td>Fluphenazine Decanoate</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Fluphenazine Hydrochloride</td>
<td>Risperidone</td>
</tr>
<tr>
<td>Haloperidol Hydrochloride</td>
<td>Risperidone Microspheres</td>
</tr>
<tr>
<td>Haloperidol Decanoate</td>
<td>Selegiline (transdermal only)</td>
</tr>
<tr>
<td>Haloperidol Lactate</td>
<td>Thioridazine HCl</td>
</tr>
<tr>
<td>Iloperidone (Fanapt)</td>
<td>Thiothixene</td>
</tr>
<tr>
<td>Isocarboxazid</td>
<td>Thiothixene HCl</td>
</tr>
<tr>
<td>Lithium Carbonate</td>
<td>Tranylcypromine Sulfate</td>
</tr>
<tr>
<td>Lithium Citrate</td>
<td>Trifluoperazine Hydrochloride</td>
</tr>
<tr>
<td>Loxapine Succinate</td>
<td>Trihexyphenidyl</td>
</tr>
<tr>
<td>Lurasidone Hydrochloride</td>
<td>Ziprasidone</td>
</tr>
<tr>
<td>Molindone HCl</td>
<td>Ziprasidone Mesylate</td>
</tr>
<tr>
<td>Olanzapine</td>
<td></td>
</tr>
</tbody>
</table>

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](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc)
# ATTACHMENT C

## SUBSTANCE USE DISORDER MATRIX OF RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Oversight Responsibility</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Serve as the entity that will be responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the addendum to the existing MOU</td>
<td>CH&amp;W</td>
</tr>
<tr>
<td>2. Formulate a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. Determine the final composition of the multidisciplinary teams to conduct this oversight function</td>
<td>County</td>
</tr>
<tr>
<td>3. Designate as appropriate and when possible the same staff to conduct tasks associated within the oversight and multidisciplinary clinical teams.</td>
<td>County</td>
</tr>
<tr>
<td>4. Work with the COUNTY to ensure that oversight is coordinated and comprehensive and that the Member’s healthcare is at the center of all oversight. Specific processes and procedures will be developed cooperatively with COUNTY, as will any actions required to identify and resolve any issues or problems that arise.</td>
<td>County</td>
</tr>
</tbody>
</table>

## Screening, Assessment and Referral

<table>
<thead>
<tr>
<th>Determination of Medical Necessity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Follow the medical necessity criteria outlined in Title 22, California Code of Regulations (CCR) for Drug Medi-Cal services (DMC). DMC services shall be available as a benefit for individuals who meet the medical necessity criteria and reside in a county that provides DMC services.</td>
</tr>
<tr>
<td>b. Determine medical necessity as it relates to covered health care benefits, as outlined in 22 CCR51303(a).</td>
</tr>
<tr>
<td>c. Continue to cover and ensure the provision of primary care and other services unrelated to SUD treatment</td>
</tr>
</tbody>
</table>

## Assessment Process:

| Develop and agree to written policies and procedures regarding agreed-upon screening, assessment and referral processes. | CH&W |
| Have available to the community and to their providers the current version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC Adult & Adolescent) crosswalk that identifies the criteria utilized to assist with determining the appropriate treatment level of care to ensure providers are aware of SUD levels of care for referral purposes. | County |
| CH&W providers will ensure; substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services for Members is available. | County |
| Identify individuals requiring alcohol and or substance abuse treatment services | County |

## Referrals

| Develop and agree to written policies and procedures regarding referral processes and tracking of referrals, including the following: | CH&W |
| County | County |
### Roles and Responsibilities

<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Accept referrals from CH&amp;W staff, providers and Members’ self-referral for determination of medical necessity for alcohol and other drug services (including outpatient heroin detoxification providers, for appropriate services).</td>
<td>CH&amp;W County</td>
</tr>
<tr>
<td>ii. Accept referrals from COUNTY staff, providers and Members’ self-referral for physical health services.</td>
<td>County</td>
</tr>
</tbody>
</table>

### Care Coordination

| 1. Develop and agree to policies and procedures for coordinating health care for Members enrolled with CH&W and receiving alcohol and other drug services through COUNTY. | CH&W County       |
| 2. Identify point of contact from each party to serve as a liaison and initiate, provide, and maintain the coordination of care as mutually agreed upon in the CAH&W and COUNTY protocols | CH&W County       |
| 3. Coordination of care for alcohol and other drug treatment provided by COUNTY shall occur in accordance with all applicable federal, state and local regulations. | County            |
| 4. Promote availability of clinical consultation for shared clients receiving physical health, mental health and/or SUD services, including consultation on medications when appropriate. | County            |
| 5. Outline delineation of case management responsibilities. | County            |
| 6. Hold regular meetings to review referral, care coordination, and information exchange protocols and processes will occur with COUNTY and CH&W representatives | CH&W County       |
| 7. Assist members in locating available treatment service sites. To the extent that treatment slots are not available within CH&W service area, CH&W shall pursue placement outside of the area. | County            |
| 8. Coordinate services between the primary care providers and the treatment programs | County            |

### Information Exchange

<p>| 1. Agree that use or disclosure of Member information qualifying as “protected health information” (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), shall be made in accordance with the requirements and any regulations promulgated thereunder (collectively, the HIPAA Rules). Agree that the use or disclosure of Member information qualifying as &quot;Patient Identifying Information&quot; (PII) as that term is defined in section 2.11 of 42 CFR Part 2, shall be made in accordance with the requirements and any regulations promulgated under 42 CFR Part 2 as well as California state law, HIPAA, and/or HITECH. | County            |
| 2. PII shared under this Addendum shall be the minimally necessary PII needed to carry out the purposes of this Addendum and will be shared only for purposes permitted under 42 CFR Part 2. | County            |</p>
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Where applicable, any Member information that constitutes “medical information,” as that term is defined under the California Confidential Medical Information Act (CMIA), is disclosed in accordance with the requirements of that law; and if the disclosure of Member information would include information and records obtained in the course of providing mental health services from a facility subject to the additional privacy protections under the Lanterman-Petris-Short Act (Lanterman Act) or if it would be information originating from a federally assisted drug abuse program subject to the additional privacy protections provided by 42 C.F.R. Part 2 that identifies a patient as having or having had a SUD, the party making the disclosure will obtain the appropriate authorization(s) or consent(s) required by the Lanterman Act and/or 42 C.F.R. Part 2 from the Member prior to making the disclosure.</td>
<td>□</td>
</tr>
<tr>
<td>4. Develop and agree to information sharing policies and procedures and agreed upon roles and responsibilities for timely sharing of PHI for the purposes of medical and behavioral health care coordination pursuant to Title 22, Title 9, CCR, Section 1810.370(a)(3), the above referenced regulations, and other pertinent state and federal laws governing the confidentiality of mental health, alcohol and drug treatment information.</td>
<td>□</td>
</tr>
<tr>
<td>5. Each party is responsible for its own compliance obligations under the above referenced regulations.</td>
<td>□</td>
</tr>
<tr>
<td>Reporting and Quality Improvement Requirements</td>
<td>□</td>
</tr>
<tr>
<td>1. Have policies and procedures to address quality improvement requirements and reports.</td>
<td>□</td>
</tr>
<tr>
<td>2. Hold regular meetings, as agreed upon by each entity to review the referral and care coordination process and monitor Member engagement and utilization.</td>
<td>□</td>
</tr>
<tr>
<td>Dispute Resolution Process</td>
<td>□</td>
</tr>
<tr>
<td>1. Agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Medi-Cal Managed Care Plans and the State Department of Health Care Services (DHCS) and Centers for Medicare &amp; Medicaid Services (CMS). A dispute will not delay Member access to medically necessary services.</td>
<td>□</td>
</tr>
<tr>
<td>Telephone Access</td>
<td>□</td>
</tr>
<tr>
<td>1. Ensure that members will be able to assess services for urgent or emergency services 24 hours per day, 7 days a week</td>
<td>□</td>
</tr>
<tr>
<td>2. There will be a “no wrong door” to service access approach. There will be multiple entry paths for beneficiaries to access alcohol and other drug services. Referrals may come from primary care physicians, providers, CH&amp;W staff, County Departments, and self-referral.</td>
<td>□</td>
</tr>
<tr>
<td>Provider and Member Education</td>
<td>□</td>
</tr>
<tr>
<td>1. Determine the requirements for coordination of Member and provider information about access to CH&amp;W and COUNTY covered services to increase navigation support for beneficiaries and their caregivers.</td>
<td>□</td>
</tr>
<tr>
<td>Point of Contact for MOU</td>
<td>□</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>CH&amp;W</td>
</tr>
<tr>
<td>1. Designate a liaison as the point of contact for the MOU Addendum</td>
<td>✓</td>
</tr>
</tbody>
</table>
ATTACHMENT D
TO
MEMORANDUM OF UNDERSTANDING

DHCS ALL PLAN LETTER 17-010

Non-Emergency Medical and Non-Medical Transportation Services
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
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 1250².

MCPs must ensure that the medical professional’s decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS³. 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 services⁴. 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 crutches⁵. 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.

---

¹ 22 CCR Section 51323 (b)(2)(C)
² Exhibit A, Attachment 1 (Organization and Administration of the Plan)
³ 22 CCR Section 51323 (a)
⁴ 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\(^\text{12}\).

Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance\(^\text{13}\).

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)\(^\text{14}\):

- 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\(^\text{15}\):

- 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).

\(^{12}\) 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. 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. 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:
• Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), as well as mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

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:
  o Medically necessary covered services.
  o Members picking up drug prescriptions that cannot be mailed directly to the member.
  o 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:
  o Has no valid driver’s license.
  o Has no working vehicle available in the household.
  o Is unable to travel or wait for medical or dental services alone.
  o 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)\textsuperscript{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

\textsuperscript{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 manner. 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.

\(^{22}\) VEH Section 12500, 4000, and 16020

\(^{23}\) IRS Standard Mileage Rate for Business and Medical Purposes

\(^{24}\) 28 CCR Section 1300.51(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