DEPARTMENT OF MENTAL HEALTH

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ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

56 April 30, 2019

CELIA ZAVALA
EXECUTIVE OFFICER

April 30, 2019

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL TO EXECUTE MEMORANDA OF UNDERSTANDING FOR COORDINATION OF EXPANDED MEDI-CAL MENTAL HEALTH SERVICES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval to execute Memoranda of Understanding with the following Managed Care Health Plans: Health Net Community Solutions, Inc. and L.A. Care Health Plan for coordination of specialty and non-specialty mental health services available to Medi-Cal beneficiaries.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and authorize the Director of Mental Health (Director), or his designee, to sign and execute new Memoranda of Understanding (MOUs) substantially similar to Attachments I and II, with Health Net Community Solutions, Inc. and L.A. Care Health Plan for the coordination of specialty and non-specialty mental health services to Medi-Cal beneficiaries in Los Angeles County (County). The term of the MOUs will be effective July 1, 2019 through June 30, 2024. These MOUs do not have a total contract amount and will only be reimbursed on case-by-case basis for the approved psychiatric professional services associated with Electroconvulsive Treatment (ECT). The Department of Mental Health (DMH) will budget a total estimated amount of $240,000 per fiscal year (FY) for the duration of the term of the MOUs to pay for such approved ECT services.

2. Delegate authority to the Director, or his designee, to prepare, sign and execute future required, substantially similar MOUs with other Managed Care Health Plans (Health Plans) identified by California Department of Health Care Services (CDHCS) and Centers for Medicare or Medicaid services to participate in the expansion of specialty and non-specialty mental health services available to Medi-Cal beneficiaries within the County, subject to review and approval as to form by

County Counsel and written notification to your Board and the Chief Executive Officer (CEO).

3. Delegate authority to the Director, or his designee, to prepare, sign and execute future amendments to the MOUs described in Recommendations 1 and 2, provided that: any such amendment is necessary to: improve care coordination; improve operational processes; meet State and/or federal requirements related to the coordination of medically necessary mental health services to Medi-Cal beneficiaries; or make non-substantive changes to the MOU language so long as sufficient funds are available for ECT services and the amendments are subject to review and approval as to form by County Counsel with a written notice to your Board and the CEO.

4. Delegate authority to the Director, or his designee to increase the County's total payments to the Health Plans for ECT under the MOU not to exceed an increase of 10 percent per fiscal year from the Board-approved budgeted amount in Recommendation 1.

5. Delegate authority to the Director, or his designee, to terminate any of the MOUs described in Recommendation 1 and 2 in accordance with the MOUs termination provisions, including Termination without Cause, subject to review and approval as to form by County Counsel with notice to your Board and the CEO.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of Recommendation 1 will allow DMH to execute new MOUs with the Health Plans, for a term effective July 1, 2019 through June 30, 2024. The MOUs will establish the mutual understandings, commitments, and protocols for the coordination and management of specialty and non-specialty mental health services to beneficiaries by DMH and the Health Plans, including services provided through the delegated health plans (e.g., Kaiser, Blue Shield of California Promise, Anthem Blue Cross, and others). Additionally, the new MOUs will allow for the payment of approved ECT services on an as needed basis, up to an estimated total of $240,000 per fiscal year for the approved psychiatric professional services associated with ECT. ECT is a planned induction of a seizure through electrical means for therapeutic purposes to end or reduce depression, agitation and disturbing thoughts (Title 9 California Code of Regulations (9CCR) 835(a)). If the member has been assessed by DMH to meet the criteria for ECT treatment to address their included diagnosis, other less invasive treatments being found to be ineffective, then DMH may co-ordinate ECT services with the Health Plans. DMH will be responsible for payment of the psychiatric professional services only. Health Plans will be responsible for payment of facility fees and anesthesia services.

Approval of Recommendation 2 will allow DMH to execute future MOUs with other Health Plans identified by CDHCS.

Approval of Recommendations 3 will allow DMH to execute future amendments, to the MOUs in Recommendations 1 and 2, including increasing the total estimated budgeted amount for up to 10 percent per fiscal year to provide additional ECT services, as needed.

Approval of Recommendation 4 will allow DMH to terminate the MOUs in Recommendations 1 and 2, in accordance with the MOU termination provisions.

Implementation of Strategic Plan Goals

The recommended actions are consistent with County's Strategic Plan Goal I, Make Investments That Transform Lives, and Strategic Plan Goal II, Foster Vibrant and Resilient Communities.

FISCAL IMPACT/FINANCING

Under these MOUs, there is no fiscal impact for the coordination of specialty and non-specialty mental health services to Medi-Cal beneficiaries in the County. With regards to ECT services, the Managed Care Plans are responsible for payment of facility fees and anesthesia services. However, DMH will be responsible for the approved psychiatric professional services only for up to an estimated amount of $240,000 per fiscal year for the duration of the MOUs. For FY 2019-20, the estimated funding of $240,000, fully funded by 2011 Realignment-Managed Care funds is included in DMH's FY 2019-20 CEO Recommended Budget.

Funding for future years will be requested through DMH's annual budget request process.

There is no net County cost impact associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On January 1, 2014, in addition to primary care, the Health Plans became responsible for the delivery of certain mental health services to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), that are outside of the primary care physician's scope of practice. The Coordinated Care Initiative, enacted through Senate Bill 1008, also required the Health Plans to provide initial mental health assessments to determine if clients should receive non-specialty mental health services from the Health Plans and/or their provider groups and plans, or if the client should be referred to DMH for specialty mental health services. The federal Section 1915(b) Medi-Cal Specialty Mental Health Services Waiver requires Medi-Cal beneficiaries needing specialty mental health services to access these services through DMH, the County's Mental Health Plan.

As the Mental Health Plan, DMH is statutorily required to enter into an MOU with any Health Plan that provides Medi-Cal eligible services to the same Medi-Cal recipients served by DMH. Your Board authorized the MOUs with Health Net Community Solutions, Inc. and L.A. Care Health Plan, effective January 1, 2014 through December 31, 2018, with a subsequent authority to extend the term of the MOUs through June 30, 2019, for the coordination of the expansion of integrated services provided to shared Medi-Cal beneficiaries throughout the County and establishment of protocols and methods for the transfer of client information. The current MOUs with Health Net Community Solutions, Inc. and L.A. Care Health Plan will terminate on June 30, 2019.

Through this Board letter, DMH will enter into new MOUs with Health Net Community Solutions, Inc. and L.A. Care Health Plan. Attached MOUs (Attachments I and II) have been reviewed as to form by County Counsel.

DMH and the Health Plans are required to hold regularly scheduled meetings to ensure effective collaboration. Additionally, DMH program administration staff will administer and monitor adherence to the MOUs' provisions and performance outcomes at least semi-annually to ensure that quality of services is being provided in accordance with the terms and conditions of the MOUs.

Health Net Community Solutions' corporate office is located at 11971 Foundation Place, Rancho Cordova, CA 95670, which is located outside of County.

L.A. Care Health Plan's corporate office is located at 1055 West 7th Street, Los Angeles, CA 90017,

which is located in Supervisorial District 1.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the proposed actions will allow DMH and the Health Plans to coordinate Medi-Cal benefits into the system of care to improve health outcomes, improve beneficiary satisfaction, and reduce health care cost.

Respectfully submitted,

JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:GP:ES:SK:RLR:dg

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Chairperson, Mental Health Commission

Managed Behavioral Health Administrative Services

Memorandum of Understanding (MOU) Agreement

Between

Health Net Community Solutions, Inc.

and

Los Angeles County Department of Mental Health

This Managed Behavioral Health Administrative Services Memorandum of Understanding ("MOU") is entered into by and among **Health Net Community Solutions Inc, ("Health Net" or "HN")** with its principal office at 11971 Foundation Place, Rancho Cordova, CA 95670, and the **Los Angeles County Department of Mental Health ("DMH"),** operating as the Los Angeles County Local Mental Health Plan, with its principal office located at 550 South Vermont Ave, Los Angeles, California 90020, effective as of the 1st day of July, 2019 (the "Effective Date") through and including the 30th day of June 2024 for a term of five (5) fiscal years. Health Net and DMH are sometimes referred to herein as "Party" or "Parties."

Whereas, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provisions of specified Medi-Cal benefits; and

Whereas, Health Net, a licensed California health care service plan under the Knox Keene Act holds a contract with the California Department of Health Care Services ("DHCS"); and

Whereas, DMH is designated by the Los Angeles County Board of Supervisors, and as such, is a duly constituted local government agency, created pursuant to Welfare and Institutions Code Sections 14087.38(b) and 14087.9605, and Los Angeles County Ordinance; and

Whereas, Health Net is required under its contract with DHCS (the "MCP Contract") to provide physical health services and non-specialty mental health services to Medi-Cal members through a network of contracted providers; and,

Whereas, DMH and Health Net agree on the importance of health care services in the amelioration and/or management of mental health problems, and the importance of mental health services to the well-being of the individual and that coordination, collaboration, consultation and communication are of significant importance in the treatment and management of mental health and physical health conditions of Members.

NOW THEREFORE, the parties hereto agree as follows:

PURPOSE

The purpose of this MOU is to coordinate Medi-Cal mental health services between Health Net and DMH. The responsibilities set forth in this MOU are in addition to the responsibilities for specialty mental health services provided by the Mental Health Plan ("MHP") as outlined in Title 9, Chapter 11 — Medi-Cal Specialty Mental Health Services Regulations and Exhibits 11 and 12 of the current Medi-Cal Managed Care Health Plan ("MCP") contract for Medi-Cal Managed Care services between the California Department of Health Care Services ("DHCS") and Health Net.

The following outpatient mental health benefits became available through MCPs for Medi-Cal 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 and covered according to State regulations:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, medications, supplies, and supplements (excluding medications as described in the DHCS Medi-Cal Managed Care All Plan Letter ("APL"), (Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services).

The State requires that Health Net execute an MOU with DMH for the purpose of coordinating care between specialty and non-specialty mental health systems of care for shared Members of Los Angeles County.

Further, this MOU sets forth the Parties' mutual understandings, commitments, and protocols with respect to how specialty and non-specialty mental health services funded by Medi-Cal will be coordinated and managed by DMH and Health Net for Members, including those Members receiving Medi-Cal services through Health Net delegated provider groups and health plans. The MOU addresses the following areas: 1) Covered services and population, 2) Oversight of responsibilities of Health Net and DMH, 3) Screening, assessment, and referral, 4) Care coordination, 5) Pharmacy and laboratory services, 6) Gray area services, 7) Protocols governing the exchange of information, 8) Reporting and quality improvement requirements, 9) Dispute resolution, 10) After-hours policies and procedures, 11) Member and provider education, 12) Term of MOU, 13) Indemnification, 14) Insurance, 15) Termination and 16) Miscellaneous terms.

DEFINITIONS — The following Definitions shall apply to this MOU:

"California Department of Health Care Services (DHCS)" means the single State department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children Services, Genetically Handicapped Persons Program, Child Health and Disabilities Prevention, and other health related programs. DHCS provides State oversight of the MCPs and the MHPs in all California counties, including Health Net as an MCP and DMH as the MHP for Los Angeles County.

"CMS"- Center for Medicare and Medicaid Services is a federally run agency responsible for administering Medicare, Medicaid and the State Children's Insurance Plan.

"Determination of Specialty Mental Health Criteria" means the process for identifying the presence of criteria for provision of specialty mental health services as described in Title 9, California Code of Regulations (CCR) Sections 1820.205, 1830.205, 1830.210. Criteria for Medi-Cal specialty mental health services include:

- One or more of the disorders identified in the current Diagnostic and Statistical Manual of Mental Disorders excepting those specifically excluded by applicable statute and regulation.
- Significant impairment in an important area of life functioning as a result of the included mental disorder or probability of significant deterioration of an important area of life functioning.

- Services must address the impairment, be expected to significantly diminish the impairment, and the condition would not be responsive to physical health care based treatment.
- Services must be best delivered in a specialty mental health setting.

"DPH/SAPC" -Department of Public Health/Substance Abuse Prevention and Control are the Los Angeles County departments responsible for the prevention and treatment of substance use disorder, among other responsibilities.

"HIPAA" - Health Insurance Portability and Accountability Act of 1996, a federal law, Public Law 104-191 and its implementing regulations, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which provide federal rights and protections for individually identifiable health information held by covered entities, as defined therein.

"Health Homes" - Pursuant to the Affordable Care Act Section 2703, Health Homes Program is Medicaid coordinated care for the full range of physical and behavioral health services and community-based long-term services and supports needed by members with chronic conditions.

"MCP"- Managed Care Plans are systems of care organized to assist beneficiaries with choices of doctors, pharmacies, clinics and specialists.

"Medi-Cal CMT"-A multidisciplinary behavioral health Care Management Team that provides care management, care coordination and dispute resolution for Medi-Cal services. The Medi-Cal CMT is composed of representatives from DMH, DPH SAPC, MHN, and as appropriate, delegated Health Plans.

"Medi-Cal PAT"- A Program Administration Team composed of staff from Health Net, DPH SAPC, MHN, and DMH that provides program oversight of the Medi-Cal CMT.

"Medically Necessary" or **"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.

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. Medical Necessity for specialty mental health services is defined at Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210.1

"Member"- means an eligible Medi-Cal beneficiary who has enrolled in Health Net.

"MHN SERVICES, LLC" ('MHN') - Health Net's behavioral health entity, managing behavioral health clinical services.

"MHP"- Mental Health Plan is the portion of Medi-Cal services defined as "specialty mental health services."

"Provider Communication Form" – This form (MH 707) is for the use by providers to communicate about Member services and care (See Attachment 4). Specifically, the form can be used for the following reasons:

- Information Exchange for Coordination of Care- To facilitate exchange of information between providers regarding a shared Member for coordination of care.

- Transfer of care- To request confirmation of the transfer of responsibility for Member care from one treating mental health provider to another when the current mental health provider is discontinuing services.
- Referral for Services- To request services for a Member not provided by the provider/agency.
- Care Consultation- To request the clinical expertise or opinion of another provider regarding treatment of a Member currently under the care of the requesting provider.
- Discharge from Care- To notify another treating provider when the current treating provider has discontinued Member's services. For information only, does not indicate a transfer of responsibility for Member care or require feedback or follow-up unless desired by recipient.

"Quality Improvement"- means the result of systematic approach to the analysis of practice performance and efforts to improve performance especially in the area of care coordination.

"Quality of Care"- means the degree to which a health care delivery system increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health se vices that are consistent with current professional knowledge in at least one of the six domains of quality, as specified by the Institute of Medicine. The six domains are as follows: efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

"Required By Law"-, for the purposes of the MOU requirements outlined in this document, means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

"Screening Form"- The Behavioral Health Screening Form (MH 731) is utilized to triage level of care by applying the designed algorithm. The algorithm establishes the symptoms/impairments: necessary to initiate a referral for a priority appointment at a DMH directly operated or contracted clinic. The screening form is transmitted to the DMH Appointment Line, and a follow up phone call will provide the appointment information. In addition, the Screening Form establishes the referral pathway for substance abuse services

"Specialty Mental Health Services"- means the following mental health services covered by DMH:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation, and collateral).
  - Medication support services.
  - Day treatment intensive services.
  - Day rehabilitation services.
  - Crisis intervention services.
  - Crisis stabilization services.
  - Targeted case management services.
  - Therapeutic behavioral services.

  Residential services:
  - Adult residential treatment services.
  - Crisis residential treatment services.

  Inpatient services:
  - Acute psychiatric inpatient hospital services.
  - Psychiatric inpatient hospital professional services.

- Psychiatric health facility services.

"Timely"- for the purposes of the MOU requirements outlined in this document, means a reasonable time period from the date of request for services to the date when the Member receives Medically Necessary mental health services. Timeliness also applies to the provision of information that may positively impact the course of treatment, would not negatively impact the Member's condition or delay the provision of services. All timeliness standards must be consistent with Knox-Keene access standards and the contract requirements for Health Net and DMH.

"Whole Person Care"- A program that coordinates Behavioral Health, Social Services and Physical Heath for Medical beneficiaries that have repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement with two or more chronic conditions: with mental health and/or substance abuse disorders; who are currently experiencing homelessness; and/or who are at risk of homelessness including individuals who will experience homelessness upon release from institutions (e.g. hospital, skilled nursing facility, rehabilitation facility, jail/prison etc.).

1. COVERED SERVICES AND POPULATION

A. Health Net shall be responsible for providing Members all Medically Necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medi-Cal as developed by the DHCS (Attachment 1). DMH shall be responsible for providing Members all Medically Necessary Specialty Mental Health Services, as defined in Title 9, Chapter 11. (Attachment 2)

2. OVERSIGHT RESPONSIBILITIES OF HEALTH NET AND DMH

A. Health Net shall be responsible for administrative services related to health care management and for their subcontracted provider network services.

B. A Health Net and DMH Medi-Cal oversight team (Medi-Cal PAT) composed of senior representatives of Health Net and DMH shall have responsibilities for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.

C. Health Net and DMH multidisciplinary team (Medi-Cal CMT) shall have oversight responsibility for provision of screening, assessment, referrals, care management, care coordination and authorization of new Medi-Cal mental health services to eligible Members when appropriate.

D. Health Net and DMH oversight team (Medi-Cal PAT) is distinct from the multidisciplinary team (Medi-Cal CMT), but membership in the teams may overlap.

3. SCREENING, ASSESSMENT AND REFERRAL

There will be multiple entry paths for Members to access mental health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling MHN's toll free behavioral health number that will be available 24 hours, 7 days a week for screening, and referral.

A. HN/MHN and DMH shall use an agreed upon tool for screening and functionally determining level of care for priority appointments (Form MH 731).

B. DMH shall accept HN/MHN staff, providers, and Members' referrals for determination of Medical Necessity for Specialty Mental Health Services.

C. Health Net's primary care provider shall refer the Member to MHN for initial assessment and treatment.

D. If it is determined by the MHN behavioral health provider that the Member may meet Specialty Mental Health Services Medical Necessity criteria, the MHN provider shall refer the Member to DMH for further assessment and treatment.

   a. DMH shall refer Members to MHN when the service needed does not meet the Specialty Mental Health Services Medical Necessity criteria.

   b. For Members in need of transition in level of care, the process will encompass a mutually agreed upon transition of Clinical Transfer/Care Coordination form (Form MH 707).

c. Each Party to this MOU will develop written policies and procedures for these purposes.

4. CARE COORDINATION

Health Net/MHN and DMH shall have written policies and procedures that address, but are not limited to, the following:

A. A process for assignment of an Interdisciplinary Team (Medi-Cal CMT) to coordinate a Member's care when necessary, as determined by mutually agreed upon protocols.

B. Coordination of ongoing care for Members in transition and programs such as Whole Person Care and the Health Homes Program as developed and directed by DHCS. Health Net and DMH will develop and agree to written policies and procedures for coordinating care for beneficiaries enrolled in the Health Net Health Homes Program and receiving Medi-Cal specialty mental health services through DMH.

C. Continuity of Care including shared treatment plans for Members receiving both MHN and DMH mental health services, as legally permitted.

D. Timely information exchange during referral, active treatment and inpatient phases, including: Member demographic information; diagnosis; treatment plan; medications prescribed; laboratory results; referrals/discharges to/from inpatient and crisis services; and known changes in condition that may adversely impact the Member's health and welfare.

E. Identification of mental health clients that need physical health care services and referral of those clients to the Primary Care Physician (PCP) assigned to that Member.

5. PHARMACY AND LABORATORY SERVICES

A. The Los Angeles County Department of Mental Health (DMH) contracts with a Pharmacy Benefits Management (PBM) application to adjudicate claims and manage the pharmacy network for uninsured members. For clients with Medi-Cal, DMH providers will use the Medi-Cal or Health Plan (MCP) formulary and send clients to a local retail pharmacy of the members choosing to access obtain behavioral health medications. Retail pharmacies may send claims directly to the State or the Medi-Cal Managed Care Health Plan (MCP) for payment based on their coverage provisions.

B. The MCP should be made aware that DMH has a “chargeback” process, whereby DMH reviews medication claims processed over the previous month and determines if another payor has financial responsibility for that claim (i.e. State, MCP, etc.) and DMH then contacts the pharmacy to validate whether the claim was incorrectly billed to and paid for by DMH. If appropriate, the pharmacy will reverse the claim and rebill the appropriate payor. This process can take place up to 60 days after the medication was dispensed.

C. The Managed Care Plans should honor the State’s timeline of 120 days for claims adjudication.

D. DMH contracts with a Laboratory Service Provider (LSP) for laboratory services for DMH clients. Due to the volume of clients and the client population, DMH offers onsite phlebotomy services and clients may also go to draw stations of the LSP, as needed. DMH only maintains financial responsibility and therefore will only pay the LSP for clients who are uninsured. The LSP must enter into an agreement with the MCP so that the LSP can bill the Mental Health Plan (MHP) when appropriate.

   a. The MCP agrees to use the DMH laboratory service list as the available list of labs that DMH providers can order for MHP covered Members of Health Net.

   b. The MCP will not require any preauthorization for labs ordered by DMH providers for MHP covered clients.

6. GRAY AREA SERVICES

LACDMH is responsible for specialty mental health services for covered diagnoses. However, a covered diagnosis may be present at the same time as a Member has a diagnosis related to fixed neurological deficits with behavioral manifestations. If there is a co-occurring mental health diagnosis, then specialty mental health

services may be authorized by DMH to treat the symptoms related to the covered diagnosis only. Gray area cases will be addressed within the Medi-Cal Care Management Team (CMT) meeting format.

A. Eating Disorders: Once a Member has been assessed by DMH to meet Medical Necessity criteria for the SMI range of severity, when diagnosed with an included eating disorder, then outpatient treatment may be available at a DMH directly operated or contracted clinic. If the DMH assessment results in a need for inpatient or intermediate levels of care, then DMH may coordinate with Health Net to provide inpatient or intermediate levels of services in a timely manner. DMH will be responsible for payment for services related to the treatment of the covered diagnosis.

B. Electroconvulsive Treatment (ECT): If the member has been assessed by DMH to meet the criteria for ECT treatment to address their included diagnosis, other less invasive treatments being found to be ineffective, then DMH may co-ordinate Electroconvulsive Treatment services with Health Net. DMH will be responsible for payment of the psychiatric professional services only. Health Net will be responsible for payment of facility fees and anesthesia services.
DMH will annually budget in the amount of $240,000 per County's fiscal year starting with the fiscal year 2019-20 for the approved psychiatric professional services associated with ECT. Throughout each County fiscal year while this MOU is in effect, MH will routinely monitor the cost of psychiatric professional services associated with ECT and may increase the budget, if necessary, through pre-approved delegated authority or action of its Board of Supervisors for the purposes of ensuring that Members who require psychiatric professional services associated with ECT are provided access to such care without interruption or delay. The MCP will not be responsible in any way whatsoever for DMH's cost of psychiatric professional services provided for ECT.

C. Traumatic Brain Injury (TBI): While Traumatic Brain Injury and its manifestations are not an DMH included diagnosis, if a Member is assessed by DMH as having a co-occurring covered diagnosis that meets the criteria then specialty mental health services may be authorized. Non-specialty mental health services will be covered by the MCP.

D. Dementia: While Dementia and its manifestations are not an DMH included diagnosis, if a Member is assessed by DMH as having a co-occurring covered diagnosis that meets the criteria then specialty mental health services may be authorized. Non- specialty mental health services will be covered by the MCP.

E. Medical Inpatient Hospitalization Requiring Transfer to Psychiatric Beds:
Members initially hospitalized on a medical floor for treatment of a medical condition who have co-occurring psychiatric symptoms and meet criteria for involuntary detention cannot be transferred to an acute psychiatric hospital until medically cleared, other than occasions when their combined treatment needs can be met at LAC-USC.

The DMH Psychiatric Mobile Response Team will not assess members who are admitted on the medical floor except if they are under the care of the Department of Child and Family services or probation. In other cases, the hospital should contact Fee – For -Service hospitals to access a bed and then arrange for a Psychiatric Emergency Team to transfer the patient so that an evaluation can be conducted. In the future it is anticipated that DMH will implement a hospital bed allocation system available via the DMH ACCESS line. Processes and procedures related to this system will be developed when the system becomes operational. The Intensive Care Division at DMH is the key point of contact for questions related to inpatient admissions or transfers between levels of care.

In all cases specialty mental health services, whether inpatient or outpatient, will be initiated/will require with an assessment by DMH. Each Member and their needs are different and it may require coordination between Health Net and DMH to determine how best to meet their needs.

7. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

Health Net/MHN and DMH shall have a mutually agreed upon process detailing the exchange of information that addresses, but is not limited to, the following:

A. The parties understand and agree that each party has obligations under HIPAA with respect to the confidentiality, privacy, and security of patients' health information, and that each must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including, when required, the use of appropriate authorizations.

B. Each party acknowledges that it may have additional obligations under other State or federal laws that may impose on that party additional restrictions with respecting to the sharing of information, including but not limited to the Confidentiality of Medical Information Act, Welfare and Institutions Code Section 5328 et seq. and 42 Code of Federal Regulations Part 2.

C. Attachment 3 sets forth the understanding of the parties regarding the exchange of data to coordinate care for Members, including protocols governing the secure and legally permissible exchange of information, to ensure coordination of physical health, mental health, and substance abuse services.

   a. Health Net/MHN shall provide to DMH the information described in the attached Protocol for the Sharing of Enrollee/Client Information Protocol (Attachment 3). The parties agree for purposes of this MOU that this information shall be treated as Protected Health Information (PHI).
   b. Health Net/MHN and DMH have reviewed the attached Protocol and have jointly determined that the PHI described in section 1 meets the minimum necessary standard.
   c. Health Net/MHN shall transmit the PHI described in Attachment 3in the manner described in the attached Protocol.
   d. Health Net/MHN is responsible for ensuring that the manner in which the information described in Attachment 3 is transmitted to DMH complies with HIPAA.
   e. DMH shall use the PHI described in section 1 solely for purposes of determining which Health Net/MHN enrollees are also DMH clients and thereafter for purposes of coordinating care.
   f. DMH shall transmit to Health Net/MHN the PHI of matched individuals, i.e., Health Net/MHN enrollees who are also DMH clients, in the manner described in the attached Protocol and complies with the HIPAA Security Rule and the HITECH Act (42.U.S.C. Section 17921 et. Seq.) for secured data transfers.
   g. DMH is responsible for ensuring that the manner in which the information described in Attachment 3 is transmitted to Health Net/MHN complies with HIPAA.
   h. Signed authorizations to Release Information
      i. HIPAA permits a covered entity to use PHI for its own treatment or health care operations, including coordination of care, to disclose PHI for treatment activities of another health care provider, and to disclose PHI to another covered entity for certain health care operations activities (such as coordination of care) of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested. DMH hereby represents and warrants to Health Net that DMH is a Covered Entity, as defined by HIPAA.

      ii. Signed authorizations to release information will be required for all exchanges of PHI to the extent that HIPAA permits the exchange only with the subject individual's consent. Form, content and recording of authorizations to release information will be managed in accordance with applicable regulations.

8. REPORTING AND QUALITY IMPROVEMENT REQUIREMENTS

The Health Net and DMH oversight committee (Medi-Cal PAT) shall address quality improvement requirements for mental health services including, but not limited to:

A. Regular meetings, as agreed upon by Health Net and DMH, to review the referral and care coordination process.

B. No less than semi-annual calendar year reviews of referral and care coordination processes to improve quality of care.

C. Performance measures and quality improvement initiatives to be determined required by regulatory and accredited governing bodies.

9. DISPUTE RESOLUTION

Health Net and DMH will follow a mutually agreed upon review process to facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether Health Net/MHN or DMH should provide mental health services.

A. Dispute Resolution Related to Reimbursement for Services
   a. The Medi-Cal Members shall continue to receive clinically appropriate care, including prescriptions, until the dispute is resolved.
   b. First level disputes will be addressed by Medi-Cal CMT. Disputes may include disagreements regarding authorization for reimbursement of Medi-Cal services, care management, and care coordination issues.
   c. Second level disputes will be addressed by the Medi-Cal Program Administration Team (PAT) within regulatory timeframes and a decision will be made and reported back to the Medi-Cal Care Management Team (Medi-Cal CMT).
   d. Third level disputes will be addressed by executive management staff from each of the organizations. The executive management staff will review the dispute and report back to the Medi-Cal PAT within regulatory timeframes from the date the dispute was received.
   e. If a decision cannot be made at the executive management level, Health Net, DMH and DPH agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505.

B. Dispute Resolution Related to Issues other than Reimbursement for Services, The dispute resolution process between Health Net and DMH related to provider relations and contracting is as follows:

   a. First level disputes will be addressed by executive management staff from each of the Parties.
   b. Second level disputes will be addressed by executive management staff from each of the organizations. The executive management staff will review the dispute and report back to the Medi-Cal PAT within regulatory timeframes from the date the dispute was received.
   c. If a decision cannot be made at the executive management level, Health Net, DMH and DPH agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505.
   d. The Medi-Cal Members shall continue to receive clinically appropriate care, including prescriptions, until the dispute is resolved.

10. AFTER HOURS POLICIES AND PROCEDURES

Each party ensures the following:

A. Member access afterhours.
   a. Health Net and its behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:
      (i) Provide a toll free number connecting Members to clinical staff coverage 24 hours/day, 7 days/week, 365 days/year to respond to all member and provider calls, including, emergent, urgent and routine calls.
      (ii) DMH shall instruct Members to call the ACCESS line.

B. Provider access afterhours
   a. Health Net and its behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:

(i) Provide a toll free number connecting Members to clinical staff coverage 24 hours/day, 7 days/week, 365 days/year to respond to all member and provider calls, including, emergent, urgent and routine calls.

(ii) DMH shall instruct Health Plan Providers to call the ACCESS line for 24/7 emergency access.

C. 24/7 emergency access

a. Health Net and its behavioral health providers shall provide access for Members and will adhere to the following standards:

(i) Provide a toll free number for Members, which would instruct Members to call "911" in emergency situations.

(ii) Ensure life threatening emergencies (when a Member is at immediate risk of self-harm or harm to others) will be provided immediate access to care with assistance of emergency services.

(iii) Ensure non-life threatening emergency calls (when a Member's risk of self-harm or harm to others is not imminent but Member requires a safe environment) will be provided access and availability to a provider within 6 (six) hours.

b. DMH instructs members to call 911 to access emergency services.

(i) Situations involving Non-Life Threatening Emergencies (when a Member's risk of self-harm or harm to others is not imminent, but the Member requires acute intervention) will be provided availability to a Field Access Team.

11. MEMBER AND PROVIDER EDUCATION

A. Health Net will develop, in collaboration with DMH, educational materials, develop and provide trainings to clarify mental health and substance use disorder components of the Medi-Cal benefit.

B. Each respective Party shall develop educational materials regarding referrals and coordination of care on their respective websites.

12. TERM OF MOU

A. The Effective date of this MOU shall be July 1, 2019 through June 30, 2024. Either party may terminate this MOU by giving at least 30 days written notice to the other party and as provided in Article 15 below.

13. INDEMNIFICATION

Health Net and DMH shall indemnify, defend and hold harmless each other, their elected and appointed officers, directors, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any property, resulting from the misconduct, negligent acts, errors or omissions by the other party or any of its officers, directors, employees, agents, successor or assigns related to this MOU, its terms and conditions, including without limitation a breach or violation of any State or Federal privacy and/or security laws, regulations and guidance relating to the disclosure of PHI, personally identifiable information or other confidential information of a party hereunder. The terms of this Article 13 shall survive termination of this MOU.

14. 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.

15. TERMINATION

Either Party may terminate this MOU with or without cause upon thirty (30) days written notice to the other Party. This MOU may be terminated immediately upon the mutual written agreement of the Parties. 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.

16. MISCELLANEOUS TERMS

A. **No Third Party Beneficiaries:** Nothing in this MOU shall confer upon any person other than the parties any rights, remedies, obligations, or liabilities whatsoever.

B. **Regulatory References:** Statutory and/or regulatory references in this MOU shall mean the section as in effect or as amended.

C. **Interpretation:** Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the Medicaid requirements of DHCS and CMS.

D. **Supervening Circumstances:** Neither Health Net nor DMH shall be deemed in violation of any provision of this MOU if it is prevented from performing any of its obligations by reason of: (a) severe weather and storms; (b) earthquakes or other natural occurrences; (c) strikes or other labor unrest; (d) power failures; (e) nuclear or other civil or military emergencies; (f) acts of legislative, judicial, executive, or administrative authorities; or (g) another circumstances that are not within its reasonable control. The Supervening Circumstances shall not apply to obligations imposed under applicable laws and regulations or obligations to pay money.

E. **Amendment**: 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 DMH and/or SAPC or Health Net and shall be effective immediately on the effective date of the requirements.

F. **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. Health Net 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 Health Net.

G. **Confidentiality:** Health Net and DMH agree to hold all confidential or proprietary information or trade secrets of each other clearly marked or otherwise identified as confidential ("Confidential Information") in trust and confidence. Health Net and DMH each agree to keep the Confidential Information strictly confidential. Health Net and DMH agree that Confidential Information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net and DMH 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. In the event DMH is required to defend an action under either of the foregoing acts, Health Net agrees to defend and indemnify DMH from all costs and expenses,

including reasonable attorney's fees, in any action or liability arising from the defense of such action. The terms of this Article 16 Section G shall survive termination of this MOU.

H. **Governing Law:** 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.

I. Notice**:** Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Article 16 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by documentation of delivery. All notices shall be addressed as follows:

Health Net Community Solutions, Inc.
11971 Foundation Place
Rancho Cordova, CA 95670
Attn: President, State Health Programs

Los Angeles County Department of Mental Health
550 South Vermont 7th Floor
Los Angeles, CA 90020
213-738-2469:
Attn: Johnathan Sherin, M.D., Ph.D

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section.

J. **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.

K. **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.

L**.** **Status as Independent Entities**: None of the provisions of this MOU is intended to create, nor shall be deemed or construed to create any relationship between Health Net and DMH other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this MOU. Neither Health Net nor DMH. Nor any of their respective agents, employees or representatives shall be construed to be the agent employee or representatives of the other.

M**.** **Entire Agreement**: This MOU represent the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this MOU shall be valid or binding.

N. **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.

[SIGNATURES ON FOLLOWING PAGE]

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.

Health Net Community Solutions, Inc.	**County of Los Angeles, Department of Mental Health**
	(Legibly Print Name of Provider)
Authorized Signature:	**Authorized Signature:**
Print Name: Abbie A. Totten	**Print Name:** Johnathan Sherin, M.D., Ph.D
Title: VP, Government Programs Policy & Strategic Initiatives	**Title:** Director
Date:	**Date:**
	Tax Identification Number:

Included in Agreement	Attachment/Exhibit	
	Attachment 1: DHCS All Plan Letter 17-018 (Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services) **Attachment 2**: Title 9 California Code of Regulations Chapter II - Medi-Cal Specialty Mental Health Services Article 2. Provision of Services **Attachment 3:** Los Angeles Department of Mental Health and Health Net Data Exchange Protocol **Attachment 4:** Provider Communication Form **Attachment 5:** APL 17-010 (Non-Emergency Medical and Non-Medical Transportation Services)	Attachment I

ATTACHMENT 1
TO
MEMORANDUM OF UNDERSTANDING

DHCS ALL PLAN LETTER 17-018

Medi-Cal Managed Care Plan Responsibilities For Outpatient Mental Health Services

State of California—Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

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

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

PURPOSE:

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

This letter supersedes APL 13-021 and provides updates to the responsibilities of the MCPs for providing mental health services. Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061[3] describes existing requirements regarding the provision of SMHS by MHPs, which have not changed as a result of coverage of non-specialty, outpatient mental health services by MCPs and the fee-for-service (FFS) Medi-Cal program. The requirements outlined in Information Notice 16061 remain in effect.

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

BACKGROUND:

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

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

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

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

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

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

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

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

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

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

[8] The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol a07.doc

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

POLICY:

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

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

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

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

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

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

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

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

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

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

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

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Original signed by Nathan Nau

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

Attachments

[9] The provider manual for the Two Plan Model can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan z01.doc The provider manual for the Geographic Managed Care Model can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc z01.doc The provider manual for the County Organized Health Systems can be found at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/.../mcpcohsz01.doc The provider manual for Imperial, San Benito, and Regional Models can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial z01.doc

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

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

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

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

13 Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

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

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

These drugs are listed in the Medi-Cal Provider Manual in the following link: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmcz01.doc

ATTACHMENT 2

Title 9 California Code of Regulations Chapter II - Medi-Cal Specialty Mental Health Services Article 2. Provision of Services

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

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

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

1. Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
   - A. Pervasive Developmental Disorders, except Autistic Disorders
   - B. Disruptive Behavior and Attention Deficit Disorders
   - C. Feeding and Eating Disorders of Infancy and Early Childhood
   - D. Elimination Disorders
   - E. Other Disorders of Infancy, Childhood, or Adolescence
   - F. Schizophrenia and other Psychotic Disorders
   - G. Mood Disorders
   - H. Anxiety Disorders
   - I. Somatoform Disorders
   - J. Factitious Disorders
   - K. Dissociative Disorders
   - L. Paraphilias
   - M. Gender Identiy Disorders
   - N. Eating Disorders
   - O. Impulse Control Disorders Not Elsewhere Classified
   - P. Adjustment Disorders
   - Q. Personality Disorders, excluding Antisocial Personality Disorder
   - R. Medication-Induced Movement Disorders related to other included diagnoses
2. Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
   - A. A significant impairment in an important area of life functioning.
   - B. A probability of significant deterioration in an important area of life functioning.
   - C. Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.
3. Must meet each of the intervention criteria listed below:
   - A. The focus of the proposed intervention is to address the condition identified in (2) above.
   - B. The expectation is that the proposed intervention will
     - i. Significantly diminish the impairment, or
     - ii. Prevent significant deterioration in an important area of life functioning, or
     - iii. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
   - C. The condition would not be responsive to physical health care based treatment.

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

NOTE: Authority cited: Section 14680, Welfare and Institution Code. Reference: Section 5777 and 14684, Welfare and Institution Code.

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

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:
   1. The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
   2. The beneficiary has a condition that would not be responsive to physical health care based treatment, and
   3. The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

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

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

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

ATTACHMENT 3

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH/HEALTH NET DATA EXCHANGE PROTOCOL

Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty mental health care among enrollees of Health Net Community Solutions (HN), (Health Net) who are also clients of the Los Angeles County Department of Mental Health (DMH). In no way should this document supersede or replace the Memorandum of Understanding between the above mentioned parties. This document serves as a protocol for the exchange of protected identifying information between the two parties.

Data Exchange Details

DMH will provide a secured location for Health Net to place a data file of Members, initially in the form of a flat text file, on an interval agreed upon by DMH and Health Net . Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, shall contain the following demographic identifying elements as available:

- **Member First Name**
- **Member Last Name**
- **Member Social Security Number**
- **Member CIN**
- **Member Date of Birth**
- **Member Residence Address**
- **Member Residence City**
- **Member Residence State**
- **Member Residence Zip**
- **Member Race**
- **Health Net Internal MHC Member Number**
- **Primary Care Physician Name**
- **Primary Care Physician Contact Phone Number**
- **Primary Care Physician Address**

Match Details

Upon receipt of the Member file DMH shall load the data to the DMH Enterprise Data Warehouse. DMH shall maintain a historical table of beneficiaries and their respective eligibility information. DMH shall conduct a match of concomitant beneficiaries between Health Net and DMH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or "match" like clients of DMH and Health Net The match is performed in "tiers" where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to the next algorithm. This process continues until a positive match is found or the record has been passed through

all tier criteria. For example, records that do not match on Tier 0 will pass to Tier **1,** etc. Each Tier contains unique criteria, which must be met in order to match records. The criteria may contain fuzzy match variables weighted at specified degrees, where a higher weight specifies that the variable must match to a greater precision. The following is a summary of criteria and variable weights:

Tier 0:

- Member CIN weighted at 100%

Tier 1:

- Member Social Security Number weighted at 100%
- Member Date of Birth weighted at 100%

Tier 2:

- Member Social Security Number weighted at 85%
- Member Full Name weighted at 90%

Tier 3:

- Member Social Security Number weighted at 85%
- Member Last Name weighted at 85%

Tier 4:

- Member Social Security Number weighted at 100%
- Member Year of birth weighted at 100%

Tier 5:

- Member Full Name weighted at 90%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Tier 6:

- Member Full Name weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100% Or
- Member Full Name Order reversal weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Health Net Usage

Upon completion of the match, DMH shall extract and provide (as described below), matched clients who currently have an open and active episode in the DMH Integrated Behavioral Health Information System (IBHIS) to Health Net in the form of a fiat text file. Diagnostic and service related data will be included in the data sent to Health Net since the purpose of the exchange is coordination of care. DMH will also send historical information regarding client contacts with Emergency and/or Acute Psychiatric Services. DMH will, at a minimum, provide the following elements:

Member service data

Member demographic data

Member diagnostic data

Other elements include the following: Admission Date of Episode, Last Mental Health Contact Date, Mental Health Provider ID, Mental Health Provider Name, Mental Health Provider Address, Mental Health Provider Contact Phone Number and Mental Health Provider Primary Contact Name

The response data file will be placed on a secured server administered and maintained by the DMH. Health Net will retrieve the file and distribute the mental health provider contact information to its Primary Care Providers (PCP), Plan Partners and Participating Provider Groups (PPG's) as appropriate using one of the following methods:

- A list will be generated for the PCP's own assigned members and distributed via provider portal
- Data will be accessible via a Provider Portal with security controls which limit display to the PCP's assigned members based on user credentials
- A list will be generated to the Participating Provider Group (PPG) via provider portal for its respective PCPs. The PPG will then forward a list to PCPs of their respective assigned members

DMH Usage

After processing the Member data, DMH will upload the PCP information for matched clients to the DMH IBHIS or successor DMH EHR. Mental Health treatment providers will then be able to access the data via the IBHIS. The information will be displayed as supplemental detail in order to facilitate coordination of care with Primary Care Providers. Access to IBHIS is controlled via user credentials.

DEFINITIONS

"Breach" has the same meaning as the term "breach" in 45 C.F.R. § 164.402.

"Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

"Electronic Health Record" has the same meaning as the term "electronic health record" in the HITECH Act, 42 U.S.C. section 17921. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

"Electronic Media" has the same meaning as the term "electronic media" in 45 C.F.R. § 160.103. Electronic Media means (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. The term "Electronic Media" draws no distinction between internal and external data, at rest (that is, in storage) as well as during transmission.

"Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103. Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

"Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

"Minimum Necessary" refers to the minimum necessary standard in 45 C.F.R. § 162.502 (b) as in effect or as amended.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164, also referred to as the Privacy Regulations.

"Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. Protected Health Information includes information that (i) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. "Protected Health Information" includes Electronic Health Information.

"Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

"Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

"Security Rule" means the Security Standards for the Protection of Electronic Health Information also referred to as the Security Regulations at 45 Code of Federal Regulations (C.F.R.) Part 160 and 164.

"Unsecured Protected Health Information" has the same meaning as the terra "unsecured protected health information" in 45 C.F.R. § 164.402.

"Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

ATTACHMENT 4

MH 707
Revised 9/14/15

PROVIDER COMMUNICATION

TYPE OF COMMUNICATION REQUESTED:
☐ INFORMATION EXCHANGE ONLY ☐ CONSULTATION (Use Page 1)
☐ REFERRAL ☐ TRANSFER ☐ NOTIFICATION OF DISCHARGE (Use Pages 1 and 2)
*Indicates required sections for ALL communication types

SENDER*	RECIPIENT*
Agency:	Agency:
Contact Person:	Contact Person:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
E-mail:	E-mail:

RENDERING PROVIDER INFORMATION*

Name: _____ Title: _____

Contact Information (if different from Sender information above): _____

Provider Signature: _____ Date: _____

CLIENT INFORMATION*

Name: _____ Medi-Cal CIN: _____ DOB: _____

Address: _____ Phone Number: _____

Gender: _____ Client's Preferred Language: _____ Caregiver's Name (if applicable): _____

Caregiver's Preferred Language: _____ Caregiver's Phone Number: _____

Payor Source: ☐ Medi-Cal Only ☐ Medicare Only ☐ Medi-Medi ☐ Uninsured ☐ Other _____

DOCUMENTS ☐ **PROVIDED** – or – ☐ **REQUESTED*** *Note: The release of Protected Health Information may require a signed client authorization under certain circumstances.*

Check as many boxes as applicable: ☐ Authorization ☐ History & Physical ☐ Laboratory (specify) _____
☐ Assessment ☐ Assessment Summary ☐ Treatment Plan ☐ Treatment Summary ☐ Problem List ☐ Medication List
☐ Progress Notes ☐ Consultation Outcome ☐ Discharge Plan ☐ Other (specify) _____ ☐ None
Explanation/Additional Comments: _____

COMPLETE THE SECTION BELOW THAT CORRESPONDS TO THE TYPE OF COMMUNICATION REQUEST

Information Exchange Only – Required Information

Sender must complete form through "Documents Provided or Requested" section above. No additional information necessary.

Request for Care Consultation - Required Information

Description of question or request: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY
Name: DMH ID#:
Agency: Provider #:
Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

MH 707
Revised 9/14/15

PROVIDER COMMUNICATION

Notification of Referral for Services - Required Information

Reason(s) for Referral: ☐ Health Care Services ☐ Substance Use Disorder Services ☐ Housing Assistance ☐ Employment Assistance ☐ Non-specialty Mental Health Services ☐ Specialty Mental Health Services (see below) ☐ Other: _____

Explanation/Additional Comments: _____

Additional Information Required for Specialty Mental Health Services Referral**

Recently released (within past 15 days) from: ☐ Jail ☐ Juvenile Hall ☐ Inpatient facility

☐ Current thoughts of suicide/self-harm? ☐ Current thoughts of homicide/harm to others? ☐ Evidence of grave disability?

Is the individual currently taking psychiatric medication for which a refill may be necessary? ☐ Y ☐ N If yes, # of days remaining? _____

**Medi-Cal Managed Care Plans: For urgent referrals, please use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment. For routine referrals, either form may be used.

Notification of Transfer of Services - Required Information

Discharge Date: _____ Description of client's current services: _____

Reason for Transfer of Care: ☐ Client in need of a higher level of care ☐ Client in need of a lower level of care

☐ Client would like services in a different Service Area ☐ Client in need of services not offered at agency

☐ Client no longer meets specialty mental health criteria ☐ Other: _____

Rendering Provider's Supervisor: _____ Title: _____

Signature: _____ Date: _____

Notification of Discharge from Care - Required Information

Discharge Date: _____

Reason for Discharge: ☐ Treatment goals met ☐ Assessment does not indicate need for services

☐ Client requests termination of services ☐ Client in need of a lower level of care ☐ Needed services are unavailable

☐ Client absent from services (missed appointments/unable to contact) ☐ Further services would not produce additional benefits

☐ Client unwilling to participate in necessary payment, billing, and reimbursement

☐ Other: _____

Discharge Summary: _____

FOR RECIPIENT USE ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

Outcome of Transfer/Referral: ☐ Client Accepted for Services ☐ Client Did Not Show* ☐ Client Declined Services*

☐ Other: _____ *Transferring/referring provider to follow up with individual

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date disposition sent to transfer/referral source: ____/____/____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY

Name: DMH ID#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

PROVIDER COMMUNICATION FORM INSTRUCTIONS

Purpose This form is for use by providers to communicate about client services and care. Specifically, the form can be used for the following reasons:

Communication Type	Communication Purpose
Information Exchange for Coordination of Care	To facilitate exchange of information between providers regarding a shared patient/client for coordination of care.
Transfer of Care	To request confirmation of the transfer of responsibility for patient/client care from one treating mental health provider to another when the current mental health provider is discontinuing services.
Referral for Services	To request services for a patient/client not provided by the provider/agency.
Care Consultation	To request the clinical expertise or opinion of another provider regarding treatment of a patient/client currently under the care of the requesting provider.
Discharge from Care	To notify another treating provider when the current treating provider has discontinued patient's/client's services. For information only; does not indicate a transfer of responsibility for patient/client care or require feedback or follow-up unless desired by recipient.

Completion Instructions

The following sections are required for all communication types.

Type of Communication Requested:
- Select the reason for using this form.

Sender:
- The person completing the form should fill in their information as requested on the form.

Recipient:
- The person completing the form (Sender) should complete the information for who the form is intended to be sent (Recipient).

Rendering Provider Information:
- If the agency using this form does not have rendering providers, this section should be used by the person who is making the request on behalf of the individual/client.
- Fill in rendering provider name and title. If person completing the form is not the rendering provider, contact information for the rendering provider should also be completed.
- Provider signature and date should always be completed.

Client Information:
- Fill-in the specific client information requested on the form.
- If appropriate, enter in the caregiver's name, preferred language, and phone number. These fields are not required to be completed.
- Payor Source: only one box should be checked; if "Other" is checked, fill in the specific payor source information.

Documents Provided or Requested:
- The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.

- Check whether the documents listed are provided with the communication or requested from the recipient.
- Check off the information that is being requested or provided. Multiple boxes may be checked and additional comments may be provided. If "Laboratory" is checked, please identify the types of labs. If "Other" is checked, please specify.

Of the sections following, only complete the one that is listed as "Required Information" for the communication type for which the form is being completed. After completing the required section, no further information is needed and the form is complete.

Information Exchange Only – Required Information:
- If the form is being completed only for the purpose of information exchange, no further information is required.

Request for Care Consultation – Required Information:
- Provide a written description of the question or request.

Notification of Referral for Services – Required Information:
- Check the reason for referral. More than one box may be checked if offered by the recipient, and comments can be provided. If "Other" is checked, please specify.
- If the referral is for Specialty Mental Health Services, complete the "Additional Information" section.
- Medi-Cal Managed Care plans and providers referring a patient/client for an urgent appointment must use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment referral.

Notification of Transfer of Services – Required Information:
- Complete the discharge date and include a description of the client's services.
- Check the reason for transfer of care. If "Other" is checked, please specify.
- The name, title, and signature of the rendering provider's supervisor are required.

Notification of Discharge from Care – Required Information:
- Complete the discharge date and reason for discharge. If "Other" is checked, please specify.
- Provide a summary of the discharge in the space provided on the form.

For Recipient Use Only:
- If sending the Provider Communication form, do not complete this section.
- If receiving the Provider Communication form for the purpose of Referral or Transfer:
    - Check the outcome of the transfer or referral. If "Other" is checked, please specify.
    - Complete the assigned case manager/MD/Therapist name and contact information.
    - Complete the date that the disposition was sent to the transfer or referral source, and fax the form to the contact person listed in the "Sender" portion of the form.

NOTE: Sharing information must comply with all HIPAA rules. DMH Directly Operated staff should refer to DMH Policy & Procedures related to HIPAA Privacy. Other providers should refer to their own legal counsel and policies.

Filing Procedures for DMH:
- Paper Chart: File chronologically in Section 2 Correspondence of the Clinical Record
- IBHIS: Scan into the Correspondence folder.

ATTACHMENT 5
TO
MEMORANDUM OF UNDERSTANDING

DHCS ALL PLAN LETTER 17-010 (Revised)

Non-Emergency Medical and Non-Medical Transportation Services

JENNIFER KENT
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED*)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

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

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

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

[1] CMS-2333-F

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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

REQUIREMENTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEMT Physician Certification Statement Forms

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions for Non-Medical Transportation Services:

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

Non-Medical Transportation Private Vehicle Authorization Requirements

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

[21] VEH Section 465

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

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

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

Non-Medical Transportation Authorization

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

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

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

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

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

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment II

MEMORANDUM OF UNDERSTANDING

Between L.A. CARE HEALTH PLAN and THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

This Managed Behavioral Health Administrative Services Memorandum of Understanding ("MOU") is entered into by and among **The Local Initiative Health Authority of Los Angeles County operating as and doing business as L.A. Care Health Plan ("L.A. Care"),** an independent public agency with its principal office at 1055 West 7th Street, 10th floor, Los Angeles, California 90017, and the **Los Angeles County Department of Mental Health ("DMH"),** operating as the Los Angeles County Local Mental Health Plan ("LMHP") with its principal office located at 550 South Vermont Ave, Lost Angeles, California 90020, effective as of the 1st day of July, 2019 (the "Effective Date") through and including the 30th day of June 2024 for a term of five (5) fiscal years. L.A. Care and DMH are sometimes referred to herein as "Party" or "Parties."

Whereas, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provisions of specified Medi-Cal benefits; and

Whereas, L.A. Care is the Local Initiative Health Authority created by the Los Angeles County Board of Supervisors, and as such, is a duly constituted public agency, created pursuant to Welfare and Institutions Code Sections 14087.38(b) and 14087.96 through 14087.9725, and Los Angeles County Ordinance (Chapter 3.37); and

Whereas, L.A. Care is required under its contract with DHCS (the "Medi-Cal Plan Contract") to provide physical health services and non-specialty mental health services to Medi-Cal members through a network of contracted providers and,

Whereas, DMH and L.A. Care agree on the importance of health care services in the amelioration and/or management of mental health problems, and the importance of mental health services to the well-being of the individual and that coordination, collaboration, consultation and communication are of significant importance in the treatment and management of mental health and physical health conditions of Members.

NOW THEREFORE, the parties hereto agree as follows:

PURPOSE

The purpose of this MOU is to coordinate Medi-Cal mental health services between L.A. Care and DMH. This MOU replaces and supersedes the existing MOU between L.A. Care and DMH. The responsibilities set forth in this MOU are in addition to the responsibilities for specialty mental health services provided by the Mental Health Plan ("MHP") as outlined in Title 9, Chapter 11 — Medi-Cal Specialty Mental Health Services Regulations and Exhibits 11 and 12 of the current Medi-Cal Managed Care Health Plan ("MCP") contract for Medi-Cal Managed Care services between the California Department of Health Care Services ("DHCS") and L.A. Care.

On January 1, 2014, the following mental health benefits became available through L.A. Care for Medi-Cal 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 and covered according to State regulations:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring drug therapy.
- Psychiatric consultation.

- Outpatient laboratory, medications, supplies, and supplements (excluding medications as described in the DHCS Medi-Cal Managed Care All Plan Letter ("APL"), (Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services).

The State requires that L.A. Care execute an MOU with DMH for the purpose of coordinating care between specialty and non-specialty mental health systems of care for shared Members of Los Angeles County.

Further, this MOU sets forth the Parties' mutual understandings, commitments, and protocols with respect to how specialty and non-specialty mental health services funded by Medi-Cal will be coordinated and managed by DMH and L.A. Care for Members, including those Members receiving Medi-Cal services through L.A. Care delegated health plans (e.g., Kaiser, Blue Shield of California Promise, and Anthem Blue Cross). The MOU addresses the following areas: 1) Covered services and population, 2) Oversight of responsibilities of respective parties, 3) Screening, assessment, and referral, 4) Care coordination, 5) Pharmacy and laboratory services 6) Gray area services 7) Protocols governing the exchange of information, 8) Reporting and quality improvement requirements, 9) Dispute resolution process, 10) After-hours procedures, 11) Member and provider education, 12) Term of MOU, 13) Indemnification, 14) Insurance, 15)Termination, and 16) Miscellaneous terms.

DEFINITIONS — The following Definitions shall apply to this MOU:

"California Department of Health Care Services (DHCS)" means the single State department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children Services, Genetically Handicapped Persons Program, Child Health and Disabilities Prevention, and other health related programs. DHCS provides State oversight of the MCPs and the MHPs in all California counties, including L.A. Care as an MCP and DMH as the MHP for Los Angeles County.

"CMS"- Center for Medicare and Medicaid Services is a federally run agency responsible for administering Medicare, Medicaid and the State Children's Insurance Plan.

"Determination of Specialty Mental Health Criteria" means the process for identifying the presence of criteria for provision of specialty mental health services as described in Title 9, California Code of Regulations (CCR) Sections 1820.205, 1830.205, 1830.210. Criteria for Medi-Cal specialty mental health services include:
One or more of the disorders identified in the current Diagnostic and Statistical Manual of Mental Disorders excepting those specifically excluded by regulation.

- Significant impairment in an important area of life functioning as a result of the included mental disorder or probability of significant deterioration of an important area of life functioning.
- Services must address the impairment, be expected to significantly diminish the impairment, and the condition would not be responsive to physical health care based treatment.
- Services must be best delivered in a specialty mental health setting.

"DPH/SAPC" -Department of Public Health/Substance Abuse Prevention and Control are the Los Angeles County departments responsible for the prevention and treatment of substance use disorder, among other responsibilities.

"HIPAA" - Health Insurance Portability and Accountability Act of 1996, a federal law, Public Law 104-191 and its implementing regulations, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, which provide federal rights and protections for individually identifiable health information held by covered entities, as defined therein.

Health Homes - Pursuant to the Affordable Care Act Section 2703, Health Homes Program is Medicaid coordinated care for the full range of physical and behavioral health services and community-based long term services and supports needed by members with chronic conditions.

"MCP"- Managed Care Plans are systems of care organized to assist beneficiaries with choices of doctors, pharmacies, clinics and specialists.

"Medi-Cal CMT"-A multidisciplinary behavioral health Care Management Team that provides care management, care coordination and dispute resolution for Medi-Cal services. The Medi-Cal CMT is composed of representatives from DMH, DPH SAPC, L.A. Care's Delegated Behavioral Health Entity, and as appropriate, delegated Health Plans.

"Medi-Cal PAT"- A Program Administration Team composed of staff from L.A. Care, DPH SAPC, L.A. Care's Behavioral Health Entity, and DMH that provides program oversight of the Medi-Cal CMT.

"Medically Necessary" or **"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.

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. Medical necessity for specialty mental health services is defined at Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210.1

"Member"- means an eligible Medi-Cal beneficiary who has enrolled in L.A. Care.

"MHP"- Mental Health Plan is the portion of Medi-Cal services defined as "specialty mental health services."

"Provider Communication Form" – This form (MH 707) is for the use by providers to communicate about client services and care (See Attachment 4). Specifically, the form can be used for the following reasons:

- Information Exchange for Coordination of Care- To facilitate exchange of information between providers regarding a shared patient/client for coordination of care.
- Transfer of care- To request confirmation of the transfer of responsibility for patient/client care from one treating mental health provider to another when the current mental health provider is discontinuing services.
- Referral for Services- To request services for a patient/client not provided by the provider/agency.
- Care Consultation- To request the clinical expertise or opinion of another provider regarding treatment of a patient/client currently under the care of the requesting provider.
- Discharge from Care- To notify another treating provider when the current treating provider has discontinued patient's/client's services. For information only; does not indicate a transfer of responsibility for patient/client care or require feedback or follow-up unless desired by recipient.

"Quality Improvement"- means the result of systematic approach to the analysis of practice performance and efforts to improve performance especially in the area of care coordination.

"Quality of Care"- means the degree to which a health care delivery system increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health se vices that are consistent with current professional knowledge in at least one of the six domains of quality, as specified by the Institute of Medicine. The six domains are as follows: efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

"Required By Law"-, for the purposes of the MOU requirements outlined in this document, means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative

demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

"Screening Form"- The Behavioral Health Screening Form (MH 731) is utilized to triage level of care by applying the designed algorithm. The algorithm establishes the symptoms/impairments: necessary to initiate a referral for a priority appointment at a DMH directly operated or contracted clinic. The screening form is transmitted to the DMH Appointment Line, and a follow up phone call will provide the appointment information. In addition, the Screening Form establishes the referral pathway for substance abuse services.

"Specialty Mental Health Services"- means the following mental health services covered by DMH:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation, and collateral).
  - Medication support services.
  - Day treatment intensive services.
  - Day rehabilitation services.
  - Crisis intervention services.
  - Crisis stabilization services.
  - Targeted case management services.
  - Therapeutic behavioral services.

  Residential services:
  - Adult residential treatment services.
  - Crisis residential treatment services.

  Inpatient services:
  - Acute psychiatric inpatient hospital services.
  - Psychiatric inpatient hospital professional services.
  - Psychiatric health facility services.

"Timely"- for the purposes of the MOU requirements outlined in this document, means a reasonable time period from the date of request for services to the date when the Member receives medically necessary mental health services. Timeliness also applies to the provision of information that may positively impact the course of treatment, would not negatively impact the Member's condition or delay the provision of services. All timeliness standards must be consistent with Knox-Keene access standards and the contract requirements for L.A. Care and DMH.

"Whole Person Care" - A program that coordinates Behavioral Health, Social Services and Physical Heath for Medi-Cal beneficiaries that have repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement with two or more chronic conditions: with mental health and/or substance abuse disorders; who are currently experiencing homelessness; and/or who are at risk of homelessness including individuals who will experience homelessness upon release from institutions (e.g. hospital, skilled nursing facility, rehabilitation facility, jail/prison etc.).

1. COVERED SERVICES AND POPULATION

A. L.A. Care shall be responsible for providing Members all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medi-Cal as developed by the DHCS (Attachment 1). DMH shall be responsible for providing Members all medically necessary Specialty Mental Health Services, as defined in Title 9, Chapter 11. (Attachment 2)

2. OVERSIGHT RESPONSIBILITIES OF L.A. CARE AND DMH

A. L.A. Care shall be responsible for administrative services related to health care management and for their subcontracted provider network services.

B. An L.A. Care and DMH mental health Medi-Cal oversight team (Medi-Cal PAT) composed of senior representatives of L.A. Care and DMH shall have responsibilities for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.

C. L.A. Care and DMH multidisciplinary team (Medi-Cal CMT) shall have oversight responsibility for provision of screening, assessment, referrals, care management, care coordination and authorization of Lew Medi-Cal mental health services to eligible Members when appropriate.

D. L.A. Care and DMH oversight team (Medi-Cal PAT) is distinct from the multidisciplinary team (Medi-Cal CMT), but membership in the teams may overlap.

3. SCREENING, ASSESSMENT AND REFERRAL

There will be multiple entry paths for Members to access mental health services. Referrals may come from, but not limited to, primary care physicians, providers, health plans, County Departments, and self-referral by calling L.A. Care's toll free behavioral health number that will be available 24 hours, 7 days a week for screening, and referral.

A. L.A. Care and DMH shall use an agreed upon tool for screening and functionally determining level of care for urgent appointments.

B. DMH shall accept L.A. Care staff, providers, and Members' referrals for determination of Medical Necessity for Specialty Mental Health Services.

C. L.A. Care's primary care provider shall refer the Member to L.A. Care mental health network provider for initial assessment and treatment.

D. If it is determined by the L.A. Care mental health provider that the Member may meet Specialty Mental Health Services Medical Necessity criteria, the L.A. Care mental health provider shall refer the Member to DMH for further assessment and treatment.

   a. DMH shall refer Members to L.A. Care when the service needed does not meet the Specialty Mental Health Services Medical Necessity criteria.

   b. For Members in need of transition in level of care, the process will encompass a mutually agreed upon transition protocol utilizing the Clinical Transfer/Care Coordination form.

   c. Each Party to this MOU will develop written policies and procedures for these screening, assessment, and treatment.

4. CARE COORDINATION

L.A. Care and DMH shall have written policies and procedures that address, but are not limited to, the following:

A. A process for assignment of an Interdisciplinary Team (Medi-Cal CMT) to coordinate a Member's care when necessary, as determined by mutually agreed upon protocols.

B. Coordination of ongoing care for Members in transition and programs such as Whole Person Care and Health Homes Programs as developed and directed by DHCS. LA Care and DMH will develop and agree to written policies and procedures for coordinating care for beneficiaries enrolled in the LA Care Health Homes Program and receiving Medi-Cal specialty mental health services through DMH.

C. Continuity of Care including shared treatment plans for Members receiving both L.A. Care and DMH mental health services, as legally permitted.

D. Timely information exchange during referral, active treatment and inpatient phases, including: Member demographic information; diagnosis; treatment plan; medications prescribed; laboratory results; referrals/discharges to/from inpatient and crisis services; and known changes in condition that may adversely impact the Member's health and welfare.

E. Identification of mental health clients that need physical health care services and referral of those clients to the Primary Care Physician (PCP) assigned to that Member.

5. PHARMACY AND LABORATORY SERVICES

A. The Los Angeles County Department of Mental Health (DMH) contracts with a Pharmacy Benefits Management (PBM) application to adjudicate claims and manage the pharmacy network for uninsured members. For clients with Medi-Cal, DMH providers will use the Medi-Cal formulary and send clients to a local retail pharmacy of the members choosing to obtain the psychotropic medications. Retail pharmacies send claims directly to the State or the Medi-Cal Managed Care Health Plan (MCP) for payment based on their coverage provisions.

B. The MCP should be made aware that DMH has a "chargeback" process, whereby DMH reviews medication claims processed over the previous month and determines if another payor has financial responsibility for that claim (i.e. State, MCP, etc.) and DMH then contacts the pharmacy to validate whether the claim was incorrectly billed to and paid for by DMH. If appropriate, the pharmacy will reverse the claim and rebill the appropriate payor. This process can take place up to 60 days after the medication was dispensed.

C. The Managed Care Plans should honor the State's timeline for claims adjudication.

D. DMH contracts with a Laboratory Service Provider (LSP) for laboratory services for DMH clients. Due to the volume of clients and the client population, DMH offers onsite phlebotomy services and clients may also go to draw stations of the LSP, as needed. DMH only maintains financial responsibility and therefore will only pay the LSP for clients who are uninsured. The LSP must enter into an agreement with the MCP so that the LSP can bill the Mental Health Plan (MHP) when appropriate.

   a. The MCP agrees to use the DMH laboratory service list as the available list of labs that DMH providers can order for MHP covered clients.

   b. The MCP will not require any preauthorization for labs ordered by DMH providers for MHP covered clients.

6. GRAY AREA SERVICES

LACDMH is responsible for specialty mental health services for covered diagnoses. However, a covered diagnosis may be present at the same time as a member has a diagnosis related to fixed neurological deficits with behavioral manifestations. If there is a co-occurring mental health diagnosis then specialty mental health services may be authorized by DMH to treat the symptoms related to the covered diagnosis only. Gray area cases will be addressed within the Medi-Cal Care Management Team (CMT) meeting format.

A. Eating Disorders: Once a member has been assessed by LACDMH to meet medical necessity criteria for the SMI range of severity, when diagnosed with an included eating disorder, then outpatient treatment may be available at a DMH directly operated or contracted clinic. If the DMH assessment results in a need for inpatient or intermediate levels of care, then DMH may coordinate with the MCP to provide inpatient or intermediate levels of services in a timely manner. DMH will be responsible for payment for services related to the treatment of the covered diagnosis.

B. Electroconvulsive Treatment (ECT): If the member has been assessed by DMH to meet the criteria for ECT treatment to address their included diagnosis, other less invasive treatments being found to be ineffective, then DMH may co-ordinate Electroconvulsive Treatment services with the MCP. DMH will be responsible for payment of the psychiatric professional services only. The MCP will be responsible for payment of facility fees and anesthesia service

   DMH will annually budget in the amount of $240,000 per County's fiscal year starting with the fiscal year 2019-20 for the approved psychiatric professional services associated with ECT. Throughout each County fiscal year while this MOU is in effect, MH will routinely monitor the cost of psychiatric professional services associated with ECT and may increase the budget, if necessary, through pre-approved delegated authority or action of its Board of Supervisors for the purposes of ensuring that Members who require psychiatric professional services associated with ECT are provided access to

such care without interruption or delay. The MCP will not be responsible in any way whatsoever for DMH's cost of psychiatric professional services provided for ECT.

C. Traumatic Brain Injury (TBI): While Traumatic Brain Injury and its manifestations are not an DMH included diagnosis, if a member is assessed by DMH as having a co-occurring covered diagnosis that meets the criteria then specialty mental health services may be authorized. Non-specialty mental health services will be covered by the MCP.

D. Dementia: While Dementia and its manifestations are not an DMH included diagnosis, if a member is assessed by DMH as having a co-occurring covered diagnosis that meets the criteria then specialty mental health services may be authorized. Non-specialty mental health services will be covered by the MCP.

E. Medical Inpatient Hospitalization Requiring Transfer to Psychiatric Beds:
Medi-Cal beneficiaries initially hospitalized on a medical floor for treatment of a medical condition who have co-occurring psychiatric symptoms and meet criteria for involuntary detention cannot be transferred to an acute psychiatric hospital until medically cleared, other than occasions when their combined treatment needs can be met at LAC-USC.

The DMH Psychiatric Mobile Response Team will not assess members who are admitted on the medical floor except if they are under the care of the Department of Child and Family Services or Probation. In other cases, the hospital should contact Fee – For -Service hospitals to access a bed and then arrange for a Psychiatric Emergency Team to transfer the patient so that an evaluation can be conducted. In the future it is anticipated that DMH will implement a hospital bed allocation system available via the DMH ACCESS line. Processes and procedures related to this system will be developed when the system becomes operational. The Intensive Care Division at DMH is the key point of contact for questions related to inpatient admissions or transfers between levels of care.

In all cases specialty mental health services, whether inpatient or out-patient, will be initiated/will require with an assessment by DMH. Each member and their needs are different and it may require coordination between the MCP and DMH to determine how best to meet their needs.

7. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

L.A. Care and DMH shall have a mutually agreed upon process detailing the exchange of information that addresses, but is not limited to, the following:

A. The parties understand and agree that each party has obligations under HIPAA with respect to the confidentiality, privacy, and security of patients' health information, and that each must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including, when required, the use of appropriate authorizations.

B. Each party acknowledges that it may have additional obligations under other State or federal laws that may impose on that party additional restrictions with respecting to the sharing of information, including but not limited to the Confidentiality of Medical Information Act, Welfare and Institutions Code Section 5328 et seq. and 42 Code of Federal Regulations Part 2.

C. Attachment 3 sets forth the understanding of the parties regarding the exchange of data to coordinate care for Members, including protocols governing the secure and legally permissible exchange of information, to ensure coordination of physical health, mental health, and substance abuse services.

   a. L.A. Care shall provide to DMH the information described in the attached Protocol for the Sharing of Enrollee/Client Information Protocol (Attachment 3). The parties agree for purposes of this MOU that this information shall be treated as Protected Health Information (PHI).

   b. L.A. Care and DMH have reviewed the attached Protocol and have jointly determined that the PHI described in section 1 meets the minimum necessary standard.

   c. L.A. Care shall transmit the PHI described in attachment 3 in the manner described in the attached Protocol.

d. L.A. Care is responsible for ensuring that the manner in which the information described in attachment 3 is transmitted to DMH complies with HIPAA.
e. DMH shall use the PHI described in section 1 solely for purposes of determining which L.A. Care enrollees are also DMH clients and thereafter for purposes of coordinating care.
f. DMH shall transmit to L.A. Care the PHI of matched individuals, i.e., L.A. Care enrollees who are also DMH clients, in the manner described in the attached Protocol.
g. DMH is responsible for ensuring that the manner in which the information described in attachment 3 is transmitted to L.A. Care complies with HIPAA.
h. Signed authorizations to Release Information
    i. HIPAA permits a covered entity to use PHI for its own treatment or health care operations, including coordination of care, to disclose PHI for treatment activities of another health care provider, and to disclose PHI to another covered entity for certain health care operations activities (such as coordination of care) of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested.

    ii. Signed authorizations to release information will be required for exchange of all information between providers not covered under treatment or coordination of care. Form, content and recording of authorizations to release information and revocation will be managed by DMH in accordance with applicable regulations.

8. REPORTING AND QUALITY IMPROVEMENT REQUIREMENTS

The L.A. Care and DMH oversight committee (Medi-Cal PAT) shall address quality improvement requirements for mental health services including, but not limited to:

A. Regular meetings, as agreed upon by L.A. Care and DMH, to review the referral and care coordination process.
B. No less than semi-annual calendar year reviews of referral and care coordination processes to improve quality of care.
C. Performance measures and quality improvement initiatives to be determined as required by regulatory and accredited governing bodies.

9. DISPUTE RESOLUTION

L.A. Care and DMH will follow a mutually agreed upon review process to facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether L.A. Care or DMH should provide mental health services.

A. Dispute Resolution Related to Reimbursement for Services
    a. The Medi-Cal Members shall continue to receive clinically appropriate care, including prescriptions, until the dispute is resolved.
    b. First level disputes will be addressed by Medi-Cal CMT. Disputes may include disagreements regarding authorization for reimbursement of Medi-Cal services, care management, and care coordination issues.
    c. Second level disputes will be addressed by the Medi-Cal Program Administration Team (PAT) within regulatory timeframes and a decision will be made and reported back to the Medi-Cal Care Management Team (Medi-Cal CMT).
    d. Third level disputes will be addressed by executive management staff from each of the organizations. The executive management staff will review the dispute and report back to the Medi-Cal PAT within regulatory timeframes from the date the dispute was received.
    e. If a decision cannot be made at the executive management level, L.A. Care, DMH and DPH agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505.

B. Dispute Resolution Related to Issues other than Reimbursement for Services, the dispute resolution process between L.A. Care and DMH related to provider relations and contracting is as follows:

a. First level disputes will be addressed by executive management staff from each of the Parties.
b. Second level disputes will be addressed by executive management staff from each of the organizations. The executive management staff will review the dispute and report back to the Medi-Cal PAT within regulatory timeframes from the date the dispute was received.
c. If a decision cannot be made at the executive management level, L.A. Care, DMH and DPH agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505.
d. The Medi-Cal Members shall continue to receive clinically appropriate care, including prescriptions, until the dispute is resolved.

10. AFTER HOURS POLICIES AND PROCEDURES

Each party ensures the following:

A. Member access afterhours.
   a. L.A. Care and it's behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:
      (i) Provide a toll free number connecting Members to clinical staff coverage 24 hours/day, 7 days/week, 365 days/year to respond to all member and provider calls, including, emergent, urgent and routine calls.
      (ii) DMH shall instruct Members to call the ACCESS line.

B. Provider access afterhours
   a. L.A. Care and it's behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:
      (i) Provide a toll free number connecting Members to clinical staff coverage 24 hours/day, 7 days/week, 365 days/year to respond to all member and provider calls, including, emergent, urgent and routine calls.
      (ii) DMH shall instruct Health Plan Providers to call the ACCESS line for 24/7 emergency access.

C. 24/7 emergency access
   a. L.A. Care and its behavioral health providers shall provide access for Members and will adhere to the following standards:
      (i) Provide a toll free number for Members which would instruct Members to call "911" in emergency situations.
      (ii) Ensure life threatening emergencies (when a Member is at immediate risk of self-harm or harm to others) will be provided immediate access to care with assistance of emergency services.
      (iii) Ensure non-life threatening emergency calls (when a Member's risk of self-harm or harm to others is not imminent but Member requires a safe environment) will be provided access and availability to a provider within 6 (six) hours.
   b. DMH instructs members to call 911 to access emergency services.
      (i) Situations involving Non-Life Threatening Emergencies (when a Member's risk of self-harm or harm to others is not imminent, but the Member requires acute intervention) will be provided availability to a Field Access Team.

11. MEMBER AND PROVIDER EDUCATION

A. L.A. Care will develop, in collaboration with DMH, educational materials, develop and provide trainings to clarify mental health and substance use disorder components of the Medi-Cal benefit.

B. Each respective Party shall develop educational materials regarding referrals and coordination of care on their respective websites.

12. TERM OF MOU

The Effective date of this MOU shall be July 1, 2019 through June 30, 2024.

13. INDEMNIFICATION

L.A. Care and DMH shall indemnify, defend and hold harmless each other, their elected and appointed officers, directors, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any property, resulting from the misconduct, negligent acts, errors or omissions by the other party or any of its officers, directors, employees, agents, successor or assigns related to this MOU, its terms and conditions, including without limitation a breach or violation of any State or Federal privacy and/or security laws, regulations and guidance relating to the disclosure of PHI, personally identifiable information or other confidential information of a party hereunder. The terms of this Article 11 shall survive termination of this MOU.

14. 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.

15. TERMINATION

Either Party may terminate this MOU with or without cause upon thirty (30) days written notice to the other Party. This MOU may be terminated immediately upon the mutual written agreement of the Parties. 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.

16. MISCELLANEOUS TERMS

A. **No Third Party Beneficiaries:** Nothing in this MOU shall confer upon any person other than the parties any rights, remedies, obligations, or liabilities whatsoever.

B. **Regulatory References:** Statutory and/or regulatory references in this MOU shall mean the section as in effect or as amended.

C. **Interpretation:** Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the Medicaid requirements of DHCS and CMS.

D. **Supervening Circumstances:** Neither L.A. Care nor DMH shall be deemed in violation of any provision of this MOU if it is prevented from performing any of its obligations by reason of: (a) severe weather and storms; (b) earthquakes or other natural occurrences; (c) strikes or other labor unrest; (d) power failures; (e) nuclear or other civil or military emergencies; (f) acts of legislative, judicial, executive, or administrative authorities; or (g) another circumstances that are not within its reasonable control. The Supervening Circumstances shall not apply to obligations imposed under applicable laws and regulations or obligations to pay money.

E. **Amendment**: 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 DMH and/or SAPC or L.A. Care and shall be effective immediately on the effective date of the requirements.

F. **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. L.A. Care 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 L.A. Care.

G. **Confidentiality:** L.A. Care and DMH agree to hold all confidential or proprietary information or trade secrets of each other clearly marked or otherwise identified as confidential ("Confidential Information") in trust and confidence. L.A. Care and DMH each agree to keep the Confidential Information strictly confidential. L.A. Care and DMH agree that Confidential Information shall be used only for the purposes contemplated herein, and not for any other purpose. L.A. Care and DMH 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. In the event DMH is required to defend an action under either of the foregoing acts, L.A. Care agrees to defend and indemnify DMH from all costs and expenses, including reasonable attorney's fees, in any action or liability arising from the defense of such action. The terms of this Section shall survive termination of this MOU.

H. **Governing Law:** 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.

I. **Notice:** Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Section 14 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by documentation of delivery. All notices shall be addressed as follows:

L.A. CARE:

John Baackes
Chief Executive Officer
L.A. Care Health Plan
1055 W 7th St 10th floor
Los Angeles, CA 90017
213-694-1250 ext. 4191

_____

_____

_____

DMH:

John Sherin, M.D., Ph.D
Director
Los Angeles County Department of Mental Health
550 South Vermont Avenue, 12th Fl.
Los Angeles, CA 90020
213-738-2469:

_____
_____
_____

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section.

J. **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.

K. **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.

L. **Status as Independent Entities**: None of the provisions of this MOU is intended to create, nor shall be deemed or construed to create any relationship between L.A. Care and DMH other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this MOU. Neither L. A. Care nor DMH. Nor any of their respective agents, employees or representatives shall be construed to be the agent employee or representatives of the other.

M. **Entire Agreement**: This MOU represent the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this MOU shall be valid or binding.

N. **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.

IN WITNESS WHEREOF, the parties have caused this MOU on the date first written.

L.A. Care Health Plan	**County of Los Angeles,** **Department of Mental Health**
	(Legibly Print Name of Provider)
Authorized Signature:	**Authorized Signature:**
Print Name: John Baackes	**Print Name:** Johnathan Sherin, M.D., Ph.D
Title: Chief Executive Officer	**Title:** Director
Date:	**Date:**

ATTACHMENT 1

State of California—Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

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

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

PURPOSE:

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

This letter supersedes APL 13-021 and provides updates to the responsibilities of the MCPs for providing mental health services. Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061[3] describes existing requirements regarding the provision of SMHS by MHPs, which have not changed as a result of coverage of non-specialty, outpatient mental health services by MCPs and the fee-for-service (FFS) Medi-Cal program. The requirements outlined in Information Notice 16061 remain in effect.

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[1] DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS, medical necessity is less stringent than it is for adults; therefore, children with low levels of impairment may meet medical necessity criteria SMHS (CCR, Title 9 Sections § 1830.205 and §1830.210).

[2] The term "non-specialty" in this context is used to differentiate the mental health services covered and provided by MCPs and the FFS Medi-Cal program from the SMHS covered and provided by MHPs. It is not intended to describe the providers of these services as non-specialist providers.

[3] MHSUDS Information Notices are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

BACKGROUND:

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

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

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

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

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

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

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

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

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

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

[8] The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol a07.doc

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

POLICY:

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

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

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

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

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

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

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

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

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

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

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

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Original signed by Nathan Nau

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

Attachments

[9] The provider manual for the Two Plan Model can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan z01.doc The provider manual for the Geographic Managed Care Model can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc z01.doc The provider manual for the County Organized Health Systems can be found at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/.../mcpcohsz01.doc The provider manual for Imperial, San Benito, and Regional Models can be found at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial z01.doc

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

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

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

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

13 Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

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

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

These drugs are listed in the Medi-Cal Provider Manual in the following link: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmcz01.doc

ATTACHMENT 2

Title 9 California Code of Regulations Chapter II - Medi-Cal Specialty Mental Health Services Article 2. Provision of Services

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

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

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

1. Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
   - A. Pervasive Developmental Disorders, except Autistic Disorders
   - B. Disruptive Behavior and Attention Deficit Disorders
   - C. Feeding and Eating Disorders of Infancy and Early Childhood
   - D. Elimination Disorders
   - E. Other Disorders of Infancy, Childhood, or Adolescence
   - F. Schizophrenia and other Psychotic Disorders
   - G. Mood Disorders
   - H. Anxiety Disorders
   - I. Somatoform Disorders
   - J. Factitious Disorders
   - K. Dissociative Disorders
   - L. Paraphilias
   - M. Gender Identiy Disorders
   - N. Eating Disorders
   - O. Impulse Control Disorders Not Elsewhere Classified
   - P. Adjustment Disorders
   - Q. Personality Disorders, excluding Antisocial Personality Disorder
   - R. Medication-Induced Movement Disorders related to other included diagnoses
2. Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
   - A. A significant impairment in an important area of life functioning.
   - B. A probability of significant deterioration in an important area of life functioning.
   - C. Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.
3. Must meet each of the intervention criteria listed below:
   - A. The focus of the proposed intervention is to address the condition identified in (2) above.
   - B. The expectation is that the proposed intervention will
     - i. Significantly diminish the impairment, or
     - ii. Prevent significant deterioration in an important area of life functioning, or
     - iii. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
   - C. The condition would not be responsive to physical health care based treatment.

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

NOTE: Authority cited: Section 14680, Welfare and Institution Code. Reference: Section 5777 and 14684, Welfare and Institution Code.

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

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:
   1. The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
   2. The beneficiary has a condition that would not be responsive to physical health care based treatment, and
   3. The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

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

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

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

ATTACHMENT 3

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH/L.A. CARE DATA EXCHANGE PROTOCOL

Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty mental health care among enrollees of L.A. Care Health Plan (L.A. Care) who are also clients of the Los Angeles County Department of Mental Health (DMH). In no way should this document supersede or replace the Memorandum of Understanding between the above mentioned parties. This document serves as a protocol for the exchange of protected identifying information between the two parties.

Data Exchange Details

DMH will provide a secured location for L.A. Care to place a data file of Members, initially in the form of a flat text file, on an interval agreed upon by DMH and L.A. Care. Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, shall contain the following demographic identifying elements as available:

- **Member First Name**
- **Member Last Name**
- **Member Social Security Number**
- **Member CIN**
- **Member Date of Birth**
- **Member Residence Address**
- **Member Residence City**
- **Member Residence State**
- **Member Residence Zip**
- **Member Gender**
- **Member Ethnicity**
- **Member Race**
- **L.A. Care Internal MHC Member Number**
- **Primary Care Physician Name**
- **Primary Care Physician Contact Phone Number**
- **Primary Care Physician Address**

Match Details

Upon receipt of the Member file DMH shall load the data to the DMH Enterprise Data Warehouse. DMH shall maintain a historical table of beneficiaries and their respective eligibility information. DMH shall conduct a match of concomitant beneficiaries between L.A. Care and DMH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or "match" like clients of DMH and L.A. Care. The match is

performed in "tiers" where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to the next algorithm. This process continues until a positive match is found or the record has been passed through all tier criteria. For example, records that do not match on Tier 0 will pass to Tier **1,** etc. Each Tier contains unique criteria, which must be met in order to match records. The criteria may contain fuzzy match variables weighted at specified degrees, where a higher weight specifies that the variable must match to a greater precision. The following is a summary of criteria and variable weights:

Tier 0:

- Member CIN weighted at 100%

Tier 1:

- Member Social Security Number weighted at 100%
- Member Date of Birth weighted at 100%

Tier 2:

- Member Social Security Number weighted at 85%
- Member Full Name weighted at 90%

Tier 3:

- Member Social Security Number weighted at 85%
- Member Last Name weighted at 85%

Tier 4:

- Member Social Security Number weighted at 100%
- Member Year of birth weighted at 100%

Tier 5:

- Member Full Name weighted at 90%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Tier 6:

- Member Full Name weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100% Or
- Member Full Name Order reversal weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

LA. Care Usage

Upon completion of the match, DMH shall extract and provide (as described below), matched clients who currently have an open and active episode in the DMH Integrated Behavioral Health Information System (IBHIS) to L.A. Care in the form of a fiat text file. Diagnostic and service related data will be included in the data sent to L.A, Care since the purpose of the exchange is coordination of care. DMH will also send historical information regarding client contacts with Emergency and/or Acute Psychiatric Services. DMH will, at a minimum, provide the following elements:

Member service data

Member demographic data

Member diagnostic data

Other elements include the following: Admission Date of Episode, Last Mental Health Contact Date, Mental Health Provider ID, Mental Health Provider Name, Mental Health Provider Address, Mental Health Provider Contact Phone Number and Mental Health Provider Primary Contact Name

The response data file will be placed on a secured server administered and maintained by the DMH. L.A. Care will retrieve the file and distribute the mental health provider contact information to its Primary Care Providers (PCP), Plan Partners and Participating Provider Groups (PPG's) as appropriate using one of the following methods:

- A list will be generated for the PCP's own assigned members and distributed via provider portal
- Data will be accessible via a Provider Portal with security controls which limit display to the PCP's assigned members based on user credentials
- A list will be generated to the Participating Provider Group (PPG) via provider portal for its respective PCPs. The PPG will then forward a list to PCPs of their respective assigned members

DMH Usage

After processing the Member data, DMH will upload the PCP information for matched clients to the DMH IBHIS or successor DMH EHR. Mental Health treatment providers will then be able to access the data via the IBHIS. The information will be displayed as supplemental detail in order to facilitate coordination of care with Primary Care Providers. Access to IBHIS is controlled via user credentials.

DEFINITIONS

"Breach" has the same meaning as the term "breach" in 45 C.F.R. § 164.402.

"Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

"Electronic Health Record" has the same meaning as the term "electronic health record" in the HITECH Act, 42 U.S.C. section 17921. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

"Electronic Media" has the same meaning as the term "electronic media" in 45 C.F.R. § 160.103. Electronic Media means (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. The term "Electronic Media" draws no distinction between internal and external data, at rest (that is, in storage) as well as during transmission.

"Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103. Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

"Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

"Minimum Necessary" refers to the minimum necessary standard in 45 C.F.R. § 162.502 (b) as in effect or as amended.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164, also referred to as the Privacy Regulations.

"Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. Protected Health Information includes information that (i) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. "Protected Health Information" includes Electronic Health Information.

"Required By Law' means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

"Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

"Security Rule" means the Security Standards for the Protection of Electronic Health Information also referred to as the Security Regulations at 45 Code of Federal Regulations (C.F.R.) Part 160 and 164.

"Unsecured Protected Health Information" has the same meaning as the terra "unsecured protected health information" in 45 C.F.R. § 164.402.

"Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

ATTACHMENT 4

MH 707
Revised 9/14/15

PROVIDER COMMUNICATION

TYPE OF COMMUNICATION REQUESTED:
☐ INFORMATION EXCHANGE ONLY ☐ CONSULTATION (Use Page 1)
☐ REFERRAL ☐ TRANSFER ☐ NOTIFICATION OF DISCHARGE (Use Pages 1 and 2)
*Indicates required sections for ALL communication types

SENDER*	RECIPIENT*
Agency:	Agency:
Contact Person:	Contact Person:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
E-mail:	E-mail:

RENDERING PROVIDER INFORMATION*

Name: _____ Title: _____

Contact Information (if different from Sender information above): _____

Provider Signature: _____ Date: _____

CLIENT INFORMATION*

Name: _____ Medi-Cal CIN: _____ DOB: _____

Address: _____ Phone Number: _____

Gender: _____ Client's Preferred Language: _____ Caregiver's Name (if applicable): _____

Caregiver's Preferred Language: _____ Caregiver's Phone Number: _____

Payor Source: ☐ Medi-Cal Only ☐ Medicare Only ☐ Medi-Medi ☐ Uninsured ☐ Other _____

DOCUMENTS ☐ **PROVIDED** – or – ☐ **REQUESTED*** *Note: The release of Protected Health Information may require a signed client authorization under certain circumstances.*

Check as many boxes as applicable: ☐ Authorization ☐ History & Physical ☐ Laboratory (specify) _____
☐ Assessment ☐ Assessment Summary ☐ Treatment Plan ☐ Treatment Summary ☐ Problem List ☐ Medication List
☐ Progress Notes ☐ Consultation Outcome ☐ Discharge Plan ☐ Other (specify) _____ ☐ None
Explanation/Additional Comments: _____

COMPLETE THE SECTION BELOW THAT CORRESPONDS TO THE TYPE OF COMMUNICATION REQUEST

Information Exchange Only – Required Information

Sender must complete form through "Documents Provided or Requested" section above. No additional information necessary.

Request for Care Consultation - Required Information

Description of question or request: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY
Name: DMH ID#:
Agency: Provider #:
Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

MH 707
Revised 9/14/15

PROVIDER COMMUNICATION

Notification of Referral for Services - Required Information

Reason(s) for Referral: ☐ Health Care Services ☐ Substance Use Disorder Services ☐ Housing Assistance ☐ Employment Assistance ☐ Non-specialty Mental Health Services ☐ Specialty Mental Health Services (see below) ☐ Other: _____

Explanation/Additional Comments: _____

Additional Information Required for Specialty Mental Health Services Referral**

Recently released (within past 15 days) from: ☐ Jail ☐ Juvenile Hall ☐ Inpatient facility

☐ Current thoughts of suicide/self-harm? ☐ Current thoughts of homicide/harm to others? ☐ Evidence of grave disability?

Is the individual currently taking psychiatric medication for which a refill may be necessary? ☐ Y ☐ N If yes, # of days remaining? _____

**Medi-Cal Managed Care Plans: For urgent referrals, please use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment. For routine referrals, either form may be used.

Notification of Transfer of Services - Required Information

Discharge Date: _____ Description of client's current services: _____

Reason for Transfer of Care: ☐ Client in need of a higher level of care ☐ Client in need of a lower level of care

☐ Client would like services in a different Service Area ☐ Client in need of services not offered at agency

☐ Client no longer meets specialty mental health criteria ☐ Other: _____

Rendering Provider's Supervisor: _____ Title: _____

Signature: _____ Date: _____

Notification of Discharge from Care - Required Information

Discharge Date: _____

Reason for Discharge: ☐ Treatment goals met ☐ Assessment does not indicate need for services

☐ Client requests termination of services ☐ Client in need of a lower level of care ☐ Needed services are unavailable

☐ Client absent from services (missed appointments/unable to contact) ☐ Further services would not produce additional benefits

☐ Client unwilling to participate in necessary payment, billing, and reimbursement

☐ Other: _____

Discharge Summary: _____

FOR RECIPIENT USE ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

Outcome of Transfer/Referral: ☐ Client Accepted for Services ☐ Client Did Not Show* ☐ Client Declined Services*

☐ Other: _____ *Transferring/referring provider to follow up with individual

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date disposition sent to transfer/referral source: ____/____/____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY

Name: DMH ID#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

PROVIDER COMMUNICATION FORM INSTRUCTIONS

Purpose This form is for use by providers to communicate about client services and care. Specifically, the form can be used for the following reasons:

Communication Type	Communication Purpose
Information Exchange for Coordination of Care	To facilitate exchange of information between providers regarding a shared patient/client for coordination of care.
Transfer of Care	To request confirmation of the transfer of responsibility for patient/client care from one treating mental health provider to another when the current mental health provider is discontinuing services.
Referral for Services	To request services for a patient/client not provided by the provider/agency.
Care Consultation	To request the clinical expertise or opinion of another provider regarding treatment of a patient/client currently under the care of the requesting provider.
Discharge from Care	To notify another treating provider when the current treating provider has discontinued patient's/client's services. For information only; does not indicate a transfer of responsibility for patient/client care or require feedback or follow-up unless desired by recipient.

Completion Instructions

The following sections are required for all communication types.

Type of Communication Requested:
- Select the reason for using this form.

Sender:
- The person completing the form should fill in their information as requested on the form.

Recipient:
- The person completing the form (Sender) should complete the information for who the form is intended to be sent (Recipient).

Rendering Provider Information:
- If the agency using this form does not have rendering providers, this section should be used by the person who is making the request on behalf of the individual/client.
- Fill in rendering provider name and title. If person completing the form is not the rendering provider, contact information for the rendering provider should also be completed.
- Provider signature and date should always be completed.

Client Information:
- Fill-in the specific client information requested on the form.
- If appropriate, enter in the caregiver's name, preferred language, and phone number. These fields are not required to be completed.
- Payor Source: only one box should be checked; if "Other" is checked, fill in the specific payor source information.

Documents Provided or Requested:
- The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.

- Check whether the documents listed are provided with the communication or requested from the recipient.
- Check off the information that is being requested or provided. Multiple boxes may be checked and additional comments may be provided. If "Laboratory" is checked, please identify the types of labs. If "Other" is checked, please specify.

Of the sections following, only complete the one that is listed as "Required Information" for the communication type for which the form is being completed. After completing the required section, no further information is needed and the form is complete.

Information Exchange Only – Required Information:
- If the form is being completed only for the purpose of information exchange, no further information is required.

Request for Care Consultation – Required Information:
- Provide a written description of the question or request.

Notification of Referral for Services – Required Information:
- Check the reason for referral. More than one box may be checked if offered by the recipient, and comments can be provided. If "Other" is checked, please specify.
- If the referral is for Specialty Mental Health Services, complete the "Additional Information" section.
- Medi-Cal Managed Care plans and providers referring a patient/client for an urgent appointment must use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment referral.

Notification of Transfer of Services – Required Information:
- Complete the discharge date and include a description of the client's services.
- Check the reason for transfer of care. If "Other" is checked, please specify.
- The name, title, and signature of the rendering provider's supervisor are required.

Notification of Discharge from Care – Required Information:
- Complete the discharge date and reason for discharge. If "Other" is checked, please specify.
- Provide a summary of the discharge in the space provided on the form.

For Recipient Use Only:
- If sending the Provider Communication form, do not complete this section.
- If receiving the Provider Communication form for the purpose of Referral or Transfer:
    - Check the outcome of the transfer or referral. If "Other" is checked, please specify.
    - Complete the assigned case manager/MD/Therapist name and contact information.
    - Complete the date that the disposition was sent to the transfer or referral source, and fax the form to the contact person listed in the "Sender" portion of the form.

NOTE: Sharing information must comply with all HIPAA rules. DMH Directly Operated staff should refer to DMH Policy & Procedures related to HIPAA Privacy. Other providers should refer to their own legal counsel and policies.

Filing Procedures for DMH:
- Paper Chart: File chronologically in Section 2 Correspondence of the Clinical Record
- IBHIS: Scan into the Correspondence folder.

ATTACHMENT 5
TO
MEMORANDUM OF UNDERSTANDING

DHCS ALL PLAN LETTER 17-010 (Revised)

Non-Emergency Medical and Non-Medical Transportation Services

JENNIFER KENT
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED*)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

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

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

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

[1] CMS-2333-F

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

REQUIREMENTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEMT Physician Certification Statement Forms

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions for Non-Medical Transportation Services:

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

Non-Medical Transportation Private Vehicle Authorization Requirements

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

[21] VEH Section 466

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

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

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

Non-Medical Transportation Authorization

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

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

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

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

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

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division