LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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June 17, 2014

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

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

33 June 17, 2014
SACHI A. HAMAI
EXECUTIVE OFFICER

Dear Supervisors:

AUTHORIZATION FOR THE DEPARTMENT OF MENTAL HEALTH TO SIGN AND EXECUTE MEMORANDA OF UNDERSTANDING WITH HEALTH NET COMMUNITY SOLUTIONS, INC., AND L.A. CARE HEALTH PLAN FOR COORDINATION OF EXPANDED MEDI-CAL MENTAL HEALTH SERVICES

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval for the Department of Mental Health to enter into Memoranda of Understanding with Health Net Community Solutions, Inc., and L.A. Care Health Plan to meet State and federal requirements for the coordination of mental health services to Los Angeles County Medi-Cal beneficiaries.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize the Director of the Department of Mental Health (Director), or his designee, to:

a) Sign and execute a Memorandum of Understanding (MOU), substantially similar to Attachment A, between the Department of Mental Health (DMH) and L.A. Care Health Plan (L.A. Care) for the provision of coordinating specialty and non-specialty mental health services to Medi-Cal beneficiaries in Los Angeles County. This new MOU is effective January 1, 2014, through December 31, 2017, and is to supersede DMH's existing MOU with L.A. Care.

b) Sign and execute a MOU, substantially similar to Attachment B, between DMH and Health Net Community Solutions, Inc. (Health Net), for the provision of coordinating specialty and non-specialty

mental health services to Medi-Cal beneficiaries in Los Angeles County. This new MOU is effective January 1, 2014, through December 31, 2017, and is to supersede DMH's existing MOU with Health Net.

2. Delegate authority to the Director, or his designee, to sign and execute future required, substantially similar, MOUs with other health plans identified by the California Department of Health Care Services (CDHCS) and Centers for Medicare & Medicaid Services (CMS) to participate in the expansion of specialty and non-specialty mental health services available to Medi-Cal beneficiaries, subject to review and approval as to form by County Counsel. The Director of DMH will notify your Board and the Chief Executive Officer (CEO) in writing within 30 days after execution of each MOU.

3. Delegate authority to the Director, or his designee, to make modifications and/or execute amendments to MOUs described in Recommendations 1 and 2, provided that any such modification or amendment is necessary to improve care coordination, improve operational processes, or meet State or federal requirements related to the coordination of medically necessary mental health services to Medi-Cal beneficiaries, subject to review and approval by County Counsel, and ten days advance notification to your Board and the CEO of such modifications and/or amendments.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of the recommended actions will allow DMH and L.A. Care and Health Net (Health Plans) to meet CDHCS requirements to amend or replace the existing MOUs for coordination of Medi-Cal mental health services. The new requirements are for the Health Plans to provide mental health benefits covered in the State plan to Medi-Cal beneficiaries excluding those specialty mental health services that are provided by DMH as the Local Mental Health Plan (MHP). These requirements are in addition to existing MOU requirements for specialty mental health services provided by mental health plans as outlined in the State regulations. The existing MOUs with L.A. Care and Health Net which were executed in 1999 and 2001, respectively, will be replaced with the ones in Attachment A and Attachment B.

On January 1, 2014, an array of mental health benefits were made available through the Health Plans for Medi-Cal beneficiaries, with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a diagnosed mental health condition.
This expansion of benefits requires close coordination of care by DMH and the Health Plans between specialty and non-specialty mental health systems of care in Los Angeles County for shared beneficiaries. This requires DMH and the Health Plans to coordinate integrated services and ensure that beneficiaries have access to services and treatment.

The MOUs will establish the parties' mutual understandings, commitments, and protocols with respect to how mental health services funded by Medi-Cal will be coordinated and managed by DMH and the Health Plans for beneficiaries, including those receiving services through the Health Plans and their delegated health plans (i.e., Kaiser, Care 1st, Anthem Blue Cross, and others). The new MOUs will continue to address the following areas: 1) covered services and population; 2) oversight

responsibilities of DMH and the Health Plans; 3) tools for screening, assessment, and referral; 4) care coordination between DMH and the Health Plans; 5) the process for information exchange between DMH and the Health Plans; 6) written policies, procedures, Member and Provider educational materials, and reports; 7) mutually satisfactory process for resolving disputes; 8) shared financial accountability strategies between DMH and the Health Plans; and 9) mutual indemnification, insurance, and termination clauses.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 1, Operational Effectiveness and Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

Effective January 1, 2014, CDHCS adjusted the Health Plans capitation payments to include the expanded outpatient non-specialty mental health services provided to Medi-Cal beneficiaries. CDHCS pays the Health Plans a capitated rate to provide mental health services that are within the primary care provider's scope of practice. Additionally, Health Plans are obligated to cover and pay for mental health assessments conducted by licensed mental health professionals of health plan beneficiaries with potential mental health disorders.

Medi-Cal specialty mental health services will continue to be funded by DMH for beneficiaries that meet Medi-Cal medical necessity criteria utilizing federal, State, and existing County funds.

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Section 1915(b) Freedom of Choice waiver entitled Medi-Cal Specialty Mental Health Services requires Medi-Cal beneficiaries needing specialty mental health services to access such services through the county mental health plans. To qualify for the services, Medi-Cal beneficiaries must meet specialty mental health services medical necessity criteria, including having received a covered diagnosis, demonstrating specified impairments, and meeting specific interventions. Regulations governing medical necessity criteria are in Title 9, California Code of Regulations (CCR), Sections 1820.205 (inpatient), 1830.205 (outpatient) and 1830.210 (outpatient for beneficiaries under the age of 21).

Through December 31, 2013, health plan beneficiaries with mental health conditions that did not meet medical necessity criteria for specialty mental health services only had access to limited outpatient mental health services delivered by primary care providers or were referred to Medi-Cal Fee-for-Service mental health providers.

Beginning January 1, 2014, the Health Plans are responsible for the delivery of certain mental health services through their provider networks to 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. Additionally, the Health Plans are obligated to cover and pay for mental health assessments conducted by licensed mental health professionals of health plan

beneficiaries with potential mental health disorders. Specialty mental health services are unchanged and will continue to be provided by DMH, per State regulations.

It is the CDHCS' requirement to have these MOUs signed and executed no later than June 30, 2014.

The attached MOUs have been approved as to form by County Counsel.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Signing and executing these MOUs allows the County to coordinate Medi-Cal benefits into a seamless system of care to improve health outcomes, improve beneficiary satisfaction and reduce health care cost.

Respectfully submitted,

MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

MJS:RS:PRW:mm

Enclosures

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

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, 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 January, 2014 (the "Effective Date"). 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, pursuant to the State Plan, the State has contracted with the Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan, a local health plan so designated by the Los Angeles County Board of Supervisors; and

Whereas, L.A. Care is required to provide physical health services and non-specialty mental health services to Medi-Cal Members through a system of contract providers; and

Whereas, DMH as the LMHP is required to provide specialty mental health services to Medi-Cal beneficiaries, hereafter referred as "Members"; and

Whereas, the services herein described by each party are services required by federal and State regulations and the contract for Medi-Cal Managed Care services between L.A. Care and the State Department of Health Care Services ("DHCS"); and

Whereas, DMH and L.A. Care have agreed 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 as the LMHP. 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. For the purpose of this MOU, the MCP will be referred to as "L.A. Care" and the MHP will be referred to as "DMH".

On January 1, 2014, the following mental health benefits will be 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 therapy with medications.
- Psychiatric consultation.
- Outpatient laboratory, medications, supplies, and supplements (excluding medications as described in a forthcoming DHCS Medi-Cal Managed Care All Plan Letter ("APL"), (Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services and Coordination with County Mental Health Plans).

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

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, Care 1st, and Anthem Blue Cross). The MOU addresses the following areas: 1) covered services and population, 2) oversight of responsibilities of respective parties, 3) screening, process, and referral, 4) care coordination, 5) protocols governing the information exchange of information, 6) reporting and quality improvement requirements, 7) dispute resolution process, 8) after hours procedures, and 9) member and provider education.

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.

"**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 Disordersexcepting those specifically excluded by regulation.
- Specific impairments as a result of the mental disorder or probability of deterioration of an important areas of life functioning.
- Services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment.
- Services must be best delivered in a specialty mental health setting.

HIPAA" - Health Insurance Portability and Accountability Act of 1996, a federal law designed to provide privacy and security standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the Department of Health and Human Services, these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

"**Medi-Cal CMT**"-Behavioral Health Care Management Team means multidisciplinary team that provides care management and 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**"- Program Administration Team means the team composed of staff from the 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 beneficiary who has enrolled in the MCP.

"**Quality Improvement**" means the result of an effective quality improvement system.

"**Quality of Care**" means the degree to which the MCP/MHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services 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" 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.

"**Specialty Mental Health Services**" means the following mental health services covered by MHPs:

- 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 MOU requirements outlined in this document, means a reasonable time period from the date of request for services to the date when the beneficiary 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 MCPs and MHPs.

1. **COVERED SERVICES AND POPULATION**
   L.A. Care shall be responsible for providing enrollees access to 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 will be responsible for Specialty Mental Health Services, as defined in Title 9, Chapter 11. (Attachment 2)

2. **OVERSIGHT RESPONSIBILITIES OF THE MCP AND THE MHP**
   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 the 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 responsibility for provision of screening, assessment, referrals, care management, care coordination and authorization of new Medi-Cal mental health services to eligible Members.
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**

All parties will have a "no wrong door" approach to service access. 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 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 (Attachment 3).
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 (except in emergency situations or in cases when the beneficiary clearly has a significant impairment that the member can be referred directly to L.A. Care.) 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 of Clinical Transfer/Care Coordination form (Attachment 4).
    c. Each Party to this MOU will develop written policies and procedures for these purposes.

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.
C. Continuity of Care and shared treatment protocols for Members receiving both L.A. Care and DMH mental health services.
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. **PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION**

L.A. Care and DMH shall have written policies and procedures governing the exchange of information that address, but are 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 specified under HIPPA.
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. Each party acknowledges that it will comply with consent and requirements pursuant to Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code related to Long-Term Services and Supports Integration.
D. Attachment 5 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.
    i. L.A. Care shall provide to DMH the information described in the attached Protocol for the Sharing of Enrollee/Client Information Protocol (Attachment 5). The parties agree for purposes of this MOU that this information shall be treated as Protected Health Information (PHI).
    ii. 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.
    iii. L.A. Care shall transmit the PHI described in section 1.1 in the manner described in the attached Protocol.
    iv. L.A. Care is responsible for ensuring that the manner in which the information described in section 1.1 is transmitted to DMH complies with HIPAA.
    v. 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.
    vi. 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.
    vii. DMH is responsible for ensuring that the manner in which the information described in section 1.1 is transmitted to DMH complies with HIPAA.
    viii. Signed authorizations to Release Information
        1. 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.

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

6. **REPORTING AND QUALITY IMPROVEMENT REQUIREMENTS**

The L.A. Care and DMH oversight committee (Medi-Cal PAT) shall develop written policies, procedures, and reports to 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 and to monitor member engagement and utilization.

B. No less than semi-annual calendar year reviews of referral and care coordination processes to improve quality of care and reports summarizing quality findings, including systemic strengths of and barriers to effective collaboration between the L.A. Care and DMH.

C. Reports that track cross-system referrals, beneficiary engagement, and service utilization, including, but not limited to, the number of disputes between L.A. Care and DMH, and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by Members receiving such services from L.A. Care and DMH, as well as quality strategies to address duplication of services.

D. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.

7. **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 and DMH should provide mental health services.

A. Dispute Resolution Related to Reimbursement for Services

i. The Medi-Cal Members shall continue to receive clinically appropriate care, including prescriptions, until the dispute is resolved.

ii. 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.

iii. 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).

iv. 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.

v. 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.

8. **AFTER HOURS POLICIES AND PROCEDURES**

Each party ensures the following:

A. Member access after hours.
   a) L.A. Care behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:
      i. Urgent care calls (when a Member is not in an acute crisis, but requires stabilization) will be provided services within 48 (fourth eight) hours.
      ii. Routine office visit calls (when a Member is not in an acute crisis, but requires maintenance) will be scheduled within 10 (ten) business days.

B. 24/7 emergency access.
   a) L.A. Care behavioral health providers shall provide access for Members and will adhere to the following standards:
      i. Life threatening emergencies (when a Member is at immediate risk of self-harm or harm to others) will be provided immediate access to care.
      ii. 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.

9. **MEMBER AND PROVIDER EDUCATION**

A. L.A. Care will develop, in collaboration with DMH, educational materials that explain the mental health and substance abuse and physical health components of the Medi-Cal Expanded Benefit.
B. L.A. Care will develop, in collaboration with DMH, a provider manual that addresses the mental health and substance abuse and physical health components of the Medi-Cal Expanded Benefit.
C. Each respective Party shall provide educational information on referrals and coordination of care via FAQ on their respective websites.

10. **TERM OF MOU**

The Effective date of this MOU shall be January 1, 2014 through December 31, 2017.

11. **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.

12. **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.

13. **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: (i) the termination of the Memorandum of Understanding between CMS and the State of California; (ii) termination of the three way agreement by and among L.A. Care, CMS and DHCS; or (iii) either party may terminate this MOU 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.

14. **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 or 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:

Trudi Carter, MD
Chief Medical Officer
L.A. Care Health Plan
1055 W 7th St
Los Angeles, CA 90017
213-694-1250 ext. 4191

DMH:

Roderick Shaner, MD
Medical Director
Los Angeles County Department of Mental Health
550 South Vermont Avenue, 7th Fl.
Los Angeles, CA 90020
213-738-2469:
Attn: Pansy Washington, District Chief

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.

[SIGNATURES ON FOLLOWING PAGE]

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

By_____ Date: _____

Name:
Title:
L.A. Care

By_____ Date: _____

Marvin J. Southard, D.S.W.
Director
Los Angeles County, Department of Mental Health

ATTACHMENT 1

State of California—Health and Human Services Agency

DHCS

Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 13, 2013

ALL PLAN LETTER 13-021

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE 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 plans (MCPs) for the provision of medically necessary outpatient mental health services. MCPs must provide specified services to adults and children diagnosed with a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in mild to moderate distress or impairment[1] of mental, emotional, or behavioral functioning. 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.

This letter provides updates to the responsibilities of the MCPs for providing mental health services that were described in Policy Letter (PL) 00-001REV[2]. Specialty mental health services (SMHS) provided by county MHPs as described in PL 00-001REV have not changed, and therefore remain the same. The Department of Health Care Services (DHCS) also issued APL 13-018 on November 27, 2013 to address the required memorandum of understanding (MOU) between each MCP and its county MHP.[3]

[1] DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal specialty mental health services differ for children and adults. Therefore, many children with impairments that may be considered moderate meet, and will continue to meet, medical necessity criteria (Title 9, CCR, Section 1830.210) to access Medi-Cal specialty mental health services provided by MHPs.

[2] Policy Letters are available at http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx.

[3] APLs are available at http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

BACKGROUND:

The Section 1915(b) Freedom of Choice waiver entitled Medi-Cal Specialty Mental Health Services requires Medi-Cal beneficiaries needing specialty mental health services to access these services through MHPs. To qualify for these services, beneficiaries must meet specialty mental health services medical necessity criteria including having received a covered diagnosis, demonstrating specified impairments,and meeting specific intervention criteria. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services for beneficiaries under the age of 21.

Regulations governing medical necessity criteria may be found at Title 9, California Code of Regulations (CCR), Sections (§§) 1820.205 (inpatient),[4] 1830.205 (outpatient), and 1830.210 (outpatient for beneficiaries under the age of 21).

1. Pursuant to Title 9, CCR §1830.205, a beneficiary must meet the following criteria to receive outpatient Medi-Cal specialty mental health services:

a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present.

b. Impairment: The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis (see #1.a. above):

i. A significant impairment in an important area of life functioning;

ii. A reasonable probability of significant deterioration in an important area of life functioning; or,

iii. Except as described in #2 below, a reasonable probability a child (e.g. a beneficiary under the age of 21) will not progress developmentally as individually appropriate.

c. Intervention: The proposed intervention is focused on addressing 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, or, except as described in #2 below, allow the child to progress developmentally as individually appropriate. In addition, the beneficiary's condition would not be responsive to physical health care based treatment.

2. Pursuant to Title 9, CCR, §1830.210, for beneficiaries under the age of 21 receiving services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit who do not meet the medical necessity requirements described in #1.b and #1.c above, medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services are met when all of the following exist:

a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present;

---

[4] 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.

b. Impairment: The beneficiary has a condition that would not be responsive to physical health care-based treatment and meets the requirements of Title 22, CCR §51340(e)(3)(A) with respect to the mental illness which provides a list of criteria that apply to the provision of EPSDT supplemental services including, but not limited to, the requirement that the service provided must correct or ameliorate the mental health condition; and,
c. Intervention: The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Through December 31, 2013, MCP beneficiaries with mental health conditions that do not meet medical necessity criteria for specialty mental health services have only had access to limited outpatient mental health services delivered by primary care providers (PCPs) or were referred to Medi-Cal Fee-for-Service mental health providers. DHCS pays MCPs a capitated rate to provide mental health services that are within the PCP's scope of practice (unless otherwise excluded by contract). Effective January 1, 2014, DHCS will adjust MCP capitation payments to include the expanded outpatient mental health services described in this APL.

This letter describes the new policy regarding outpatient mental health services in accordance with sections 29 and 30 of Senate Bill X1 1 of the First Extraordinary Session (Hernandez, Chapter 4, Statutes of 2013), which added §§14132.03 and 14189 to the Welfare and Institutions Code.

POLICY:
Beginning January 1, 2014, MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP's scope of practice. The eligibility and medical necessity criteria for Medi-Cal specialty mental health services provided by MHPs have not changed pursuant to this policy. Specialty mental health services provided by MHPs continue to be available.

MCPs continue to be responsible for the provision of mental health services within the scope of PCP practice. MCPs will also continue to be responsible for the arrangement and payment of all medically necessary Medi-Cal physical health care services, not otherwise excluded by contract, to MCP beneficiaries who require specialty mental health services.

MCP Responsibility for Outpatient Mental Health Services
Effective January 1, 2014, each MCP is obligated to cover and pay for mental health assessments of MCP beneficiaries with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual. This new requirement is in addition to the existing requirement that PCPs offer mental health

services within their scope of practice. MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (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. Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by an MCP nor by an MHP. All services must be provided in a culturally and linguistically appropriate manner.

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 licensed mental health professionals in the MCP provider network within the scope of their 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 codes that are covered can be found in the Medi-Cal Provider Manual.

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 MCP-covered services, 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 specialty mental health services when a mental health diagnosis covered by the MHP results in significant impairment; or

refer children under age 21 to the MHP for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the MCP beneficiary meets medical necessity criteria.

Each MCP is obligated to continue to ensure mental health screening of all beneficiaries by network PCPs. Beneficiaries with positive screening results may be treated by a network PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the MCP must refer the beneficiary to a mental health provider within the MCP network for a mental health assessment. The mental health provider must use a Medi-Cal-approved clinical tool or the set of tools mutually agreed upon with the MHP to assess the beneficiary's disorder, level of impairment, and appropriate care needed. This tool must be identified in the MOU between the MCP and MHP, as discussed in APL 13-018.

If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because the adult beneficiary's level of impairment is mild to moderate, or, for adults and children, the recommended treatment does not meet criteria for Medi-Cal specialty mental health services, then the MCP is required to ensure the provision of the outpatient mental health services listed or other appropriate services within the scope of the MCP's covered services.

Each MCP must ensure its network providers refer beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the 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.

MCPs must also cover outpatient laboratory tests, medications (excluding those listed in Attachment 2), 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 covered services be provided through the MCP's provider network and be subject to a medical necessity determination.

The MCP may negotiate with the MHP to provide the outpatient 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 specialty mental health services. The MCP must coordinate 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.

DHCS will monitor the implementation of this new policy and make adjustments as needed. Reporting requirements and performance metrics are being established with input from MCPs and will be communicated in a separate APL.

If you have any questions regarding this APL, please contact Sarah Royce, MD, MPH at sarah.royce@dhcs.ca.gov or Liana Lianov, MD, MPH, at liana.lianov@dhcs.ca.gov, Medi-Cal Managed Care Division.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments

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 Disorder	(J)	Factitious Disorders
(B)	Disruptive Behavior & Attention Deficit Disorders	(K)	Dissociative Disorders
(C)	Feeding & Eating Disorders of Infancy or Early Childhood	(L)	Paraphilias
(D)	Elimination Disorders	(M)	Gender Identity Disorder
(E)	Other Disorders of Infancy, Early Childhood, or Adolescence	(N)	Eating Disorders
(F)	Schizophrenia & Other Psychotic Disorders	(0)	Impulse-Control Disorders Not Elsewhere Classified
(G)	Mood Disorders	(P)	Adjustment Disorders
(H)	Anxiety Disorders	(Q)	Personality Disorders, excluding Antisocial Personality Disorder
(I)	Somatoform Disorders	(R)	Medication-Induced Movement Disorders related to other included

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision **(1)** above:

(A) A significant impairment in an important area of life functioning.
(B) A probability of significant deterioration in an important area of life functioning.
(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.
(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above,

(B) The expectation is that the proposed intervention will:

(1) Significantly diminish the impairment, or
(2) Prevent significant deterioration in an important area of life functioning, or
(3) Except as provided in Section 1830.210 allow the child to progress developmentally as individually appropriate, and
(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.

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(bX1).
(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 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 available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent service at the beneficiary's otherwise appropriate institution 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®, United States Code.

ATTACHMENT 3

Interim Urgent Behavioral Health Screening Form to Obtain Specialty Mental Health Assessment
Please complete and follow algorithm

*****If this is an emergency, please call 911**

MEMBER INFO

Patient Name: _____ (Last) _____ (First) Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Referring Clinician: _____ Phone: (____) _____

Primary Care Provider _____ Phone: (____) _____ Health Plan: _____

Behavioral Health Diagnoses (1) _____ (2) _____ (3) _____

Documents Included with Referral: ☐**Required consent completed** ☐MD notes ☐H&P ☐Assessment ☐Other: _____

Desired/Existing behavioral health clinician/provider/program, if any: _____

List A (check all that apply):

- ☐Homelessness
- ☐Still symptomatic after 2 standard psychiatric med trials
- ☐History of bipolar disorder or manic episode
- ☐Excessive truancy or failing school
- ☐Substance and/or EtOH addiction and failed SBI
- ☐Behavior problems (aggressive/self-destructive/assaultive)
- ☐Paranoid, hearing voices, seeing things, delusional
- ☐Failing to engage in care
- ☐Worsening ADLs & IADLs as it relates to mental health
- ☐Excessive emergency room visits or 911 calls

List B (check all that apply):

- ☐>2 psychiatric hospitalizations in the past 12 months
- ☐Suicidal/Homicidal preoccupation or behaviors in past 12 months
- ☐>2 incarcerations in past 12 months
- ☐Diagnostic Uncertainty

Referral algorithm based on checked boxes:

☐ 1-2 in list A and none in list B: **Call Beacon Behavioral Health line for consult (use eConsult when available) 877-344-2858**

☐ 3 or more in list A and none in list B **OR** one in each list: **Refer to Beacon Behavioral Health line 877-344-2858**

☐ 2 or more in list A and one in list B **OR** 2 or more in list B: **Refer to County Department of Mental Health line 855-425-8141**

☐ Substance and/or EtOH addiction and failed SBI alone: **Refer to County Substance Abuse Prevention & Control 800-564-6600**

Pertinent Current/Past Information

Current symptoms and impairments:

_____

_____

_____

Brief MH/SUD history:

_____

Brief medical history:

_____

Current Medication(s) & Dosage:

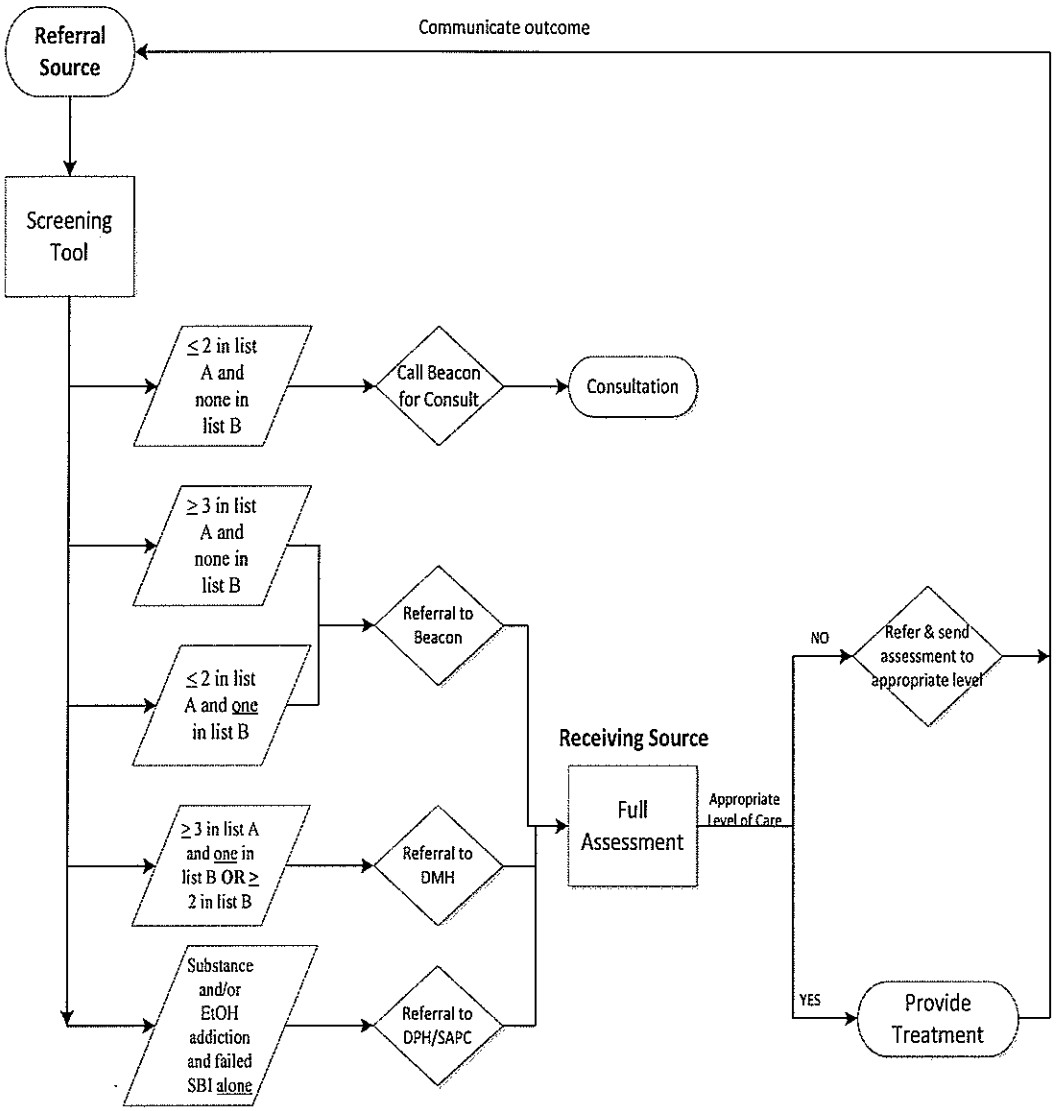
_____

For Receiving Clinician Use ONLY

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

Date communicated assessment outcome with referral source: _____

Behavioral Health Screening for Assessment and Treatment as Medically Necessary



List A:

- Homelessness
- Persistent symptoms after 2 standard med trials
- Hx of bipolar or mania
- Excessive truancy or failing school
- Substance/EtOH and failed SBI
- Behavioral problems
- Paranoia, delusions, hallucination
- Excessive ER visit or 911 calls

List B:

- >2 psych hosp in past 12 mons
- >2 incarceration in past 12 mons
- Suicide/homocide preoccupation or behaviors in past 12 mons
- Diagnostic Uncertainty

Instruction for the Screener

If this is an emergency situation, please call 911

Abbreviation:

H&P: History and Physical exam

EtOH: Alcohol

MH/SUD: Mental Health and Substance use disorder

SBI: Screening and Brief Intervention

ADLs: Activities of Daily Living are basic self-care tasks such as feeding, toileting, grooming, bathing, maintaining continence, walking and transferring, etc.

IADLs: Instrumental Activities of Daily Living are complex skills needed to successfully live independently such as managing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, etc.

Explanation:

- '*Current Eligibility*': other insurances, ie Medicare, private, etc
- *'Caregiver/Guardian'*: parents (for minor), conservator, etc
- *'Required consent completed'*: written consent (Authorization to Exchange Protected Health Information) or verbal consent (when screen over the phone) is required prior to release information to mental health and/or substance use disorder evaluator/receiving clinician (please clearly document)
- *'Desired/Existing behavioral health clinician/provider/program'*: if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact info
- *'Excessive ER visit or 911 calls'*: In comparison to expected numbers of visits or calls that could be reasonably expected as a result of the patient's general physical and behavioral health conditions
- *'Diagnostic uncertainty'*: apply only when it is effecting behavioral health care planning

Referral clinician:

- **Follow visio for algorithm.**
- **If the Member/Client has an existing behavioral health clinician/provider or an open/active case in a program, please refer him/her directly to that treating source and send the written consent (or documentation for a verbal consent via phone) with the screen form to the treating source.**

- **For referrals to Beacon, please send the written consent (or documentation for a verbal consent via phone) with the screen form to the receiving clinician via eFax at 866-422-3413, and then call the Beacon line at 877-344-2858.**
- **For referrals to DMH, please send the written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral center via -scan at xxxxx@dmh.lacounty.gov, and then call the DMH line at 855-425-8141.**
- **For referrals to County Substance Abuse Prevention & Control (DPH SAPC), please send the written consent (or documentation for a verbal consent via phone) with the screen form to , then call the SAPC line at 800-564-6600.**

Receiving clinician:

- **Please make sure to communicate with the referral source regarding the assessment outcome and/or disposition. The completed "Authorization to Exchange PHI" accompanying the Behavioral Health Screening Form permits a response to the referral source without further authorization.**
- **Receiving clinician at Beacon, DMH, and DPH/SAPC will be required to track and send quarterly report to Vilma Diaz, vdiaz@lacare.org, at LA Care as part of the MOU/contract.**
- **After a full assessment and it is determined that the individual's treatment need is better met at a different system of care/level of care, please refer and send the complete assessment document to the appropriate system of care/level of care.**
    - **If the care is determined to be appropriately provided by PCP, contact Beacon to coordinate placement.**
    - **In the event of a disagreement as to the appropriate system of care/level of care, please forward the case to the appropriate identified individual responsible for dispute resolution within your system of care and continue with treatment while decision is pending.**

ATTACHMENT 4

MH 707

CLINICAL TRANSFER/CARE COORDINATION

Revised 02/04/14

Client Information

Name: _____ CIN: _____ DOB: _____

Address: _____ Phone Number: _____

Insurance: ☐ Medi-Cal only ☐ Medicare only ☐ Medi-Medi ☐ Indigent ☐ LA Care ☐

HealthNet ☐ Beacon ☐ MHN

☐ Other

_____

Agency Transferring To/Coordinating With

Name of Agency:

_____

Contact Person: _____ Phone Number: _____

Type of Clinical Transfer/Care Coordination

☐ Transfer ☐ Health Concern ☐ Recommendation/Consultation ☐ Medication reconciliation

☐ Other

_____

Information Requested/Provided

☐ Request for Information:

☐ Information Provided:

(Include diagnosis, medications, pertinent lab; may attach relevant documentation to this Referral Response if appropriate Authorization for Disclosure is obtained/present)

Mental Health Staff Information

Name & Title of Mental Health Staff:

_____

Name of DMH Clinic: _____ Telephone #: _____

Date of Fax: _____ Confirmation #: _____

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Original Copy – Retained by Initiating Program

CLINICAL TRANSFER/CARE COORDINATION

Copy – To Agency Transferring to or Coordinating With

CLINICAL TRANSFER / CARE COORDINATION

Purpose: This form is for the use of Mental Health Staff when transferring a Tier 2 client from a HWLA or DMH-DHS Co-located program to a Service Area Navigator or another DMH program

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.

ATTACHMENT 5

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 the 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, at a minimum, shall contain the following demographic identifying elements:

- **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 System (IS) or successor DMH electronic health record (EHR) to L.A. Care in the form of a fiat text file. Diagnostic and service related data will not be included in the data sent to L.A, Care since the purpose of the exchange is coordination of care. DMH will also not send historical information regarding client contacts with Emergency and/or Acute Psychiatric Services. DMH will, at a minimum, provide the following elements:

- 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
- 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) using one of the following methods:

- A list will be generated for the PCP's own assigned members and distributed by mail
- 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 mail for its respective PCPs. The PPG will then forward a list to PCPs of their respective assigned members via mail

DMH Usage

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

MEMORANDUM OF UNDERSTANDING

Between HEALTH NET COMMUNITY SOLUTIONS, INC., and THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

This Managed Behavioral Health Administrative Services Memorandum of Understanding (the "MOU") is entered into by and among **Health Net Community Solutions Inc**, **(Health Net – "HN")** with its principal office at **(INSERT APPROPRIATE ADDRESS HERE)**, 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 January, 2014 (the "Effective Date"). 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** is designated 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, pursuant to the State Plan, the State has contracted with **Health Net**, a health plan and designated by the Los Angeles Authority County Board of Supervisors and,

Whereas, **Health Net** is required to provide physical health services and non-specialty mental health services to Medi-Cal beneficiaries hereafter referred as "Members" through a system of contract providers and,

Whereas, the Los Angeles County Department of Mental Health as the Department of Mental Health ("DMH") as the LMHP is required to provide specialty mental health services to Medi-Cal Members and,

Whereas, the services herein described by each party are services required by federal and State regulations and the contract between **Health Net** and the California Department of Health Care Services ("DHCS") and,

Whereas, DMH and **Health Net** have agreed 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.

"**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.
- Specific impairments as a result of the mental disorder or probability of deterioration of an important areas of life functioning.
- Services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment.
- Services must be best delivered in a specialty mental health setting.

"**HIPPA**" - Health Insurance Portability and Accountability Act of 1996, a federal law designed to provide privacy and security standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the Department of Health and Human Services, these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

"**Medi-Cal CMT**"-Behavioral Health Care Management Team means multidisciplinary team that provides care management and care coordination and dispute resolution for Medi-Cal services. The Medi-Cal CMT is composed of representatives from DMH, DPH SAPC, **Health Net's Behavioral Health subsidiary-Managed Health Network ("MHN"),** and as appropriate, delegated Health Plans.

"**Medi-Cal PAT**"- Program Administration Team means the team composed of staff from **HN, MHN,** DPH SAPC, 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 beneficiary who has enrolled in the MCP.

"**Quality Improvement**" means the result of an effective quality improvement system.

"**Quality of Care**" means the degree to which the MCP/MHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services 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**" 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

D. **HN/MHN** 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**

All parties will have a "no wrong door" approach to service access. 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 urgent appointments (Attachment 3).

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

C. **HN's** primary care provider shall refer the Member to **MHN** for initial assessment and treatment (except in emergency situation or in cases when the beneficiary clearly has a significant impairment that the Member can be referred directly to HN.) If it is determined by the **MHN behavioral health clinician** that the Member may meet Specialty Mental Health Services Medical Necessity criteria, MHN 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 medical necessity criteria.

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

4. **CARE COORDINATION**

HN/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.

C. Continuity of Care and shared treatment protocols for Members receiving both **MHN Behavioral Health services** and DMH mental health services.

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. **PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION**

HN/MHN and DMH shall have written policies and procedures governing the exchange of information that address, but are not limited to, the following:

A. The parties understand and agree that each party has obligations under the HIPPA 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 specified under HIPPA.

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. esq. and 42 Code of Federal Regulations Part 2.

services by Members receiving such services from HN/MHN and DMH, as well as quality strategies to address duplication of services.

D. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.

7. **DISPUTE RESOLUTION**

HN/MHN 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 HN/MHN and 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
c) disagreements regarding authorization for reimbursement of Medi-Cal services, care management, and care coordination issues.
d) 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).
e) 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.
f) If a decision cannot be made at the executive management level, HN/MHN, 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 HN/MHN 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. 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.
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, HN/MHN, 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.

8. **AFTER HOURS POLICIES AND PROCEDURES**

Each party ensures the following:

A. Member access afterhours.

a) HN/MHN behavioral health providers shall provide telephonic access for Members and will adhere to the following standards:
i. Urgent care calls (when a Member is not in an acute crisis, but requires stabilization) will be provided services within 48 (forty-eight) hours.
ii. Routine office visit calls (when a Member is not in an acute crisis, but requires maintenance) will be scheduled within 10 (ten) business days.

14. **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 HN Community Solutions 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) an other 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 HN Community Solutions 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. HN Community Solutions 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 HN Community Solutions.

G. **Confidentiality:** HN Community Solutions 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. HN Community Solutions and DMH each agree to keep the Confidential Information strictly confidential. HN Community Solutions and DMH agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. HN Community Solutions and DMH agree that nothing in this MOU shall be construed as a limitation of (i) disclosures to counsel or 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, HN Community Solutions 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 15 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:

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

By_____ Date: _____

Name:
Title:
HN Community Solutions

By_____ Date: _____

Marvin J. Southard, D.S.W.
Director
Los Angeles County, Department of Mental Health

and meeting specific intervention criteria. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services for beneficiaries under the age of 21.

Regulations governing medical necessity criteria may be found at Title 9, California Code of Regulations (CCR), Sections (§§) 1820.205 (inpatient),[4] 1830.205 (outpatient), and 1830.210 (outpatient for beneficiaries under the age of 21).

1. Pursuant to Title 9, CCR §1830.205, a beneficiary must meet the following criteria to receive outpatient Medi-Cal specialty mental health services:

a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present.

b. Impairment: The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis (see #1.a. above):

i. A significant impairment in an important area of life functioning;

ii. A reasonable probability of significant deterioration in an important area of life functioning; or,

iii. Except as described in #2 below, a reasonable probability a child (e.g. a beneficiary under the age of 21) will not progress developmentally as individually appropriate.

c. Intervention: The proposed intervention is focused on addressing 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, or, except as described in #2 below, allow the child to progress developmentally as individually appropriate. In addition, the beneficiary's condition would not be responsive to physical health care based treatment.

2. Pursuant to Title 9, CCR, §1830.210, for beneficiaries under the age of 21 receiving services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit who do not meet the medical necessity requirements described in #1.b and #1.c above, medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services are met when all of the following exist:

a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present;

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[4] 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.

services within their scope of practice. MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (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. Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by an MCP nor by an MHP. All services must be provided in a culturally and linguistically appropriate manner.

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 licensed mental health professionals in the MCP provider network within the scope of their 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 codes that are covered can be found in the Medi-Cal Provider Manual.

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 MCP-covered services, 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 specialty mental health services when a mental health diagnosis covered by the MHP results in significant impairment; or

DHCS will monitor the implementation of this new policy and make adjustments as needed. Reporting requirements and performance metrics are being established with input from MCPs and will be communicated in a separate APL.

If you have any questions regarding this APL, please contact Sarah Royce, MD, MPH at sarah.royce@dhcs.ca.gov or Liana Lianov, MD, MPH, at liana.lianov@dhcs.ca.gov, Medi-Cal Managed Care Division.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments

(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 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 available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent service at the beneficiary's otherwise appropriate institution 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®, United States Code.

Brief MH/SUD history:

_____

Brief medical history:

_____

Current Medication(s) & Dosage:

_____

For Receiving Clinician Use ONLY

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

Date communicated assessment outcome with referral source: _____

Instruction for the Screener

If this is an emergency situation, please call 911

Abbreviation:

H&P: History and Physical exam

EtOH: Alcohol

MH/SUD: Mental Health and Substance use disorder

SBI: Screening and Brief Intervention

ADLs: Activities of Daily Living are basic self-care tasks such as feeding, toileting, grooming, bathing, maintaining continence, walking and transferring, etc.

IADLs: Instrumental Activities of Daily Living are complex skills needed to successfully live independently such as managing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, etc.

Explanation:

- '*Current Eligibility*': other insurances, ie Medicare, private, etc
- *'Caregiver/Guardian'*: parents (for minor), conservator, etc
- *'Required consent completed'*: written consent (Authorization to Exchange Protected Health Information) or verbal consent (when screen over the phone) is required prior to release information to mental health and/or substance use disorder evaluator/receiving clinician (please clearly document)
- *'Desired/Existing behavioral health clinician/provider/program'*: if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact info

ATTACHMENT 4

MH 707

CLINICAL TRANSFER/CARE COORDINATION

Revised 02/04/14

Client Information

Name: _____ CIN: _____

DOB: _____

Address: _____ Phone Number: _____

Insurance: ☐ Medi-Cal only ☐ Medicare only ☐ Medi-Medi ☐ Indigent ☐ LA Care ☐

HealthNet ☐ Beacon ☐ MHN

☐ Other

_____

Agency Transferring To/Coordinating With

Name of Agency:

_____

Contact Person: _____ Phone Number: _____

Type of Clinical Transfer/Care Coordination

☐ Transfer ☐ Health Concern ☐ Recommendation/Consultation ☐ Medication reconciliation

☐ Other

_____

Information Requested/Provided

☐ Request for Information:

☐ Information Provided:

(Include diagnosis, medications, pertinent lab; may attach relevant documentation to this Referral Response if appropriate Authorization for Disclosure is obtained/present)

Mental Health Staff Information

Name & Title of Mental Health Staff:

_____

Name of DMH Clinic: _____ Telephone #: _____

Date of Fax: _____ Confirmation #: _____

ATTACHMENT 5

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 Health Net Community Solutions (HN) 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 HN 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, at a minimum, shall contain the following demographic identifying elements:

- **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**
- **HN/MHN Internal MHC Member Number**
- **Primary Care Physician Name**
- **Primary Care Physician Contact Phone Number**
- **Primary Care Physician Address**

HN **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 System (IS) or successor DMH electronic health record (EHR) to HNin the form of a fiat text file. Diagnostic and service related data will not be included in the data sent to HN since the purpose of the exchange is coordination of care. DMH will also not send historical information regarding client contacts with Emergency and/or Acute Psychiatric Services. DMH will, at a minimum, provide the following elements:

- 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
- Mental Health Provider Primary Contact Name

The response data file will be placed on a secured server administered and maintained by the DMH. HN will retrieve the file and distribute the mental health provider contact information to its Primary Care Providers (PCP) using one of the following methods:

- A list will be generated for the PCP's own assigned members and distributed by mail
- 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 mail for its respective PCPs. The PPG will then forward a list to PCPs of their respective assigned members via mail

DMH Usage

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

"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 term "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.