

COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

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August 13, 2013

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

26 August 13, 2013

Sachi A. Hamai
SACHI A. HAMAI
EXECUTIVE OFFICER

Dear Supervisors:

AUTHORIZATION FOR THE DEPARTMENTS OF MENTAL HEALTH, PUBLIC HEALTH, AND PUBLIC SOCIAL SERVICES TO SIGN AND EXECUTE MEMORANDA OF UNDERSTANDING WITH HEALTH NET COMMUNITY SOLUTIONS, INC., AND L.A. CARE HEALTH PLAN FOR THE PROVISION OF SPECIALTY MENTAL HEALTH, SUBSTANCE USE DISORDER TREATMENT, AND IN-HOME SUPPORTIVE SERVICES FOR THE CAL MEDICONNECT PROGRAM

**(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request approval for the Departments of Mental Health, Public Health, and Public Social Services to enter into separate Memoranda of Understanding with Health Net Community Solutions, Inc., and L.A. Care Health Plan to meet State and federal requirements for the Cal MediConnect Program.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize the Director of Mental Health, or his designee, to:
 - a) Sign and execute a Memorandum of Understanding (MOU), substantially similar to Attachment A, between Department of Mental Health (DMH) and L. A. Care Health Plan (L.A. Care) for implementation of the Cal MediConnect Program.
 - b) Sign and execute a MOU, substantially similar to Attachment B, between DMH and Health Net Community Solutions, Inc., (Health Net) for implementation of the Cal MediConnect Program.

2. Authorize the Director of Public Health, or his designee, to:

- a) Sign and execute a MOU, substantially similar to Attachment C, between Department of Public Health (DPH) and L.A. Care for implementation of the Cal MediConnect Program.
- b) Sign and execute a MOU, substantially similar to Attachment D, between DPH and Health Net for implementation of the Cal MediConnect Program.

3. Authorize the Director of Public Social Services, or his designee, to:

- a) Sign and execute a MOU, substantially similar to Attachment E, between Department of Public Social Services (DPSS) and L.A. Care for implementation of the Cal MediConnect Program.
- b) Sign and execute a MOU, substantially similar to Attachment F, between DPSS and Health Net for implementation of the Cal MediConnect Program.

4. Delegate authority to the Directors of DMH, DPH, and DPSS, or each of their designees, to make modifications and/or execute amendments to any of the Cal MediConnect Program MOUs provided that any such modification or amendment is necessary to improve care coordination, improve operational efficiencies, or meet State or federal requirements, subject to review and approval by County Counsel and notification to your Board and the Chief Executive Officer (CEO) prior to any such modification or amendment.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of the recommended actions will allow the DMH, DPH, and DPSS to execute MOUs with L.A. Care and Health Net (Health Plans), to meet Centers for Medicare and Medicaid Services' (CMS) and State requirements pertaining to the coordination and integration of services to beneficiaries who meet medical necessity criteria for specialty mental health (MH) services and substance use disorder (SUD) treatment, and the coordination of In-Home Supportive Services (IHSS) to beneficiaries who meet IHSS eligibility criteria.

The Cal MediConnect Program is a three-year demonstration program for coverage of individuals with eligibility for both Medicare and Medi-Cal. The intent is to develop a seamless system of care coordination and care management for beneficiaries enrolled in this project. The Cal MediConnect Program coordinates medical, mental health, substance use, and Long Term Services and Supports (LTSS) (including IHSS services).

Under the Cal MediConnect Program, the Health Plans have primary administrative and program responsibility for care management, care coordination, and authorization for Medicare reimbursement of MH services and SUD treatment. The Health Plans are required to coordinate with DMH, DPH, and DPSS to ensure that beneficiaries have access to services and treatment.

The MOUs will establish the parties' mutual understandings, commitments, and protocols with respect to how MH, SUD, and IHSS services funded by Medicare and Medi-Cal will be coordinated and managed by DMH, DPH, DPSS and the Health Plans for beneficiaries, including those receiving services through the Health Plans and their delegated health plans. The MOUs will address the following areas: 1) the roles and responsibilities of DMH, DPH, DPSS and the Health Plans, 2) how care will be coordinated between DMH, DPH, DPSS and the Health Plans, 3) the process for

information exchange between DMH, DPH, DPSS and the Health Plans, and 4) shared financial accountability strategies between DMH, DPH and the Health Plans. The DPSS MOUs are non-financial.

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

The DMH and DPH MOUs describe the Health Plans' authorization and reimbursement processes for Medicare eligible services under the Cal MediConnect Program. All Medicare and non-specialty Medi-Cal mental health services will be the responsibility of the Health Plans under the Cal MediConnect Program and funding for those services is included in the Health Plans' capitation payment from the State. Medi-Cal specialty mental health services not covered by the Medicare benefit will not be included in the Health Plan's capitation payment. Medi-Cal specialty MH services will continue to be funded by DMH for beneficiaries that meet Medicare and Medi-Cal medical necessity criteria utilizing existing County funds. Medi-Cal specialty SUD services for beneficiaries that meet Drug/Medi-Cal (DMC) medical necessity criteria will continue to be funded by Medi-Cal and State Realignment revenues, with services administered through DPH. While highly unlikely, if enrollment for specialty mental health and SUD services not covered by Medicare and State Realignment revenues for DMC services for individuals who are currently Medi-Cal eligible exceeds 1,500, additional County funds may be needed to match federal funds to cover this increase in referrals.

Additionally, these MOUs also address shared financial accountability strategies to improve coordination of services and reduce cost shifting between Medicare and Medi-Cal specialty MH and SUD services. DMH, DPH and the Health Plans will develop formal financial arrangements for shared cost savings resulting from achieving shared performance metrics.

Although the Health Plans will have the responsibility to coordinate services provided by the IHSS Program, California Department of Social Services will continue to administer and provide funding for the IHSS Program through the new Maintenance of Effort (MOE) structure. The role and responsibilities for DPSS will not change. The IHSS services covered under the DPSS MOUs have no additional net County cost impact, once the MOE is met.

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and satisfaction for beneficiaries of both the Medicare and Medi-Cal programs, referred to as dual-eligible beneficiaries, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including Los Angeles County, were selected by the State to implement a three-year demonstration project for Medicare and Medi-Cal beneficiaries. L.A. Care and Health Net were the two local managed care health plans selected by the California Department of Health Care Services (CDHCS) and the CMS to provide health, MH, SUD, and LTSS services to beneficiaries

enrolled in the Cal MediConnect Program.

The goals of Cal MediConnect Program are to coordinate health, MH, SUD and LTSS services; to integrate two fee-for-service benefits into a managed care system; to improve health outcomes; to assist beneficiaries with living independently; and to reduce cost. To achieve these goals, DMH, DPH, DPSS and the Health Plans will establish Care Management teams composed of staff from each of the organizations. These teams will develop individual health care plans, authorize services for Medicare reimbursement, coordinate care and provide oversight of the project. To ensure continuity of care, DMH and DPH providers will be credentialed by each of the Health Plans or their delegated health plans to become members of the Health Plan's network for the delivery of MH and SUD services funded by Medicare. Beneficiaries who do not enroll in the Cal MediConnect Program will not be subject to the requirements of these MOUs.

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

CONTRACTING PROCESS

CMS requires that the individual Health Plans execute a MOU with DMH, DPH, and DPSS for the beneficiaries enrolled in the Cal MediConnect Program and who meet eligibility criteria for specialty mental health services, SUD treatment, and IHSS services. For DMH only, in addition to the MOUs, a separate contracting process will be required in order to establish conditions for provision by DMH of Medicare funded services and payment by the Health Plans. DMH will return to your Board for the purposes of executing contractual agreements with L.A. Care Health Plan and Health Net for Medicare reimbursement at a future date.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

If the MOUs are not signed and executed, Los Angeles County may be at risk of losing the opportunity to coordinate Medicare and 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



SHERYL L. SPILLER
Director



JONATHAN E. FIELDING, M.D., M.P.H.
Director and Health Officer

MJS:CCS:RK:sk

Enclosures

c: Chief Executive Office
County Counsel
Executive Officer, Board of Supervisors
Department of Public Health
Department of Public Social Services
Chairperson, Mental Health Commission

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MEMORANDUM OF UNDERSTANDING

By and Between

L.A. Care Health Plan
and the

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

for

IMPLEMENTATION OF THE

CAL MEDICCONNECT PROGRAM

FOR MEDICARE-MEDI-CAL BENEFICIARIES

This Memorandum of Understanding (“MOU”) is made and entered into on the _____ day of _____, 2013 by and between the Local Initiative Health Authority for Los Angeles, dba and operating as L.A. Care Health Plan (“L.A. Care”) an independent local public agency, and the Los Angeles County Department of Mental Health as the local mental health plan (“LMHP”) in Los Angeles County for the purpose of providing access to all medically necessary Behavioral Health Services currently covered by Medicare and Medi-Cal to Beneficiaries enrolled in the Dual Eligibles Demonstration Project.

I. RECITALS

Whereas, California's Coordinated Care Initiative was created through a public process involving stakeholders and health care consumers and enacted through SB 1008 (Chapter 22, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012); and

Whereas, a component of the Coordinated Care Initiative includes a three-year demonstration program which will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a health plan for Dual Eligible Beneficiaries;

Whereas, L.A. Care, has been selected by the State Department of Health Care Services (“DHCS”) as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County; and

Whereas, health plans participating in the Dual Eligibles Demonstration Project (“**Demonstration Health Plans**”) will provide eligible beneficiaries all mental health and substance use services, generally collectively referred to as “Behavioral Health Services”, currently covered by Medicare and Medi-Cal; except that county administered Specialty Mental Health Services and county administered Drug Medi-Cal substance use treatment services will not be included in the Demonstration Health Plans' capitation payments from DHCS, and such Specialty Mental Health Services and Drug Medi-Cal substance use treatment services shall continue to be financed and administered by the counties;

Whereas, in Los Angeles County, the agencies that administer Specialty Mental Health Services and Drug Medi-Cal substance use treatment services are, respectively, the Los Angeles County Department of Mental Health as the Local Mental Health Plan (“**LMHP**”) and the Los Angeles County Department of Public Health (“**DPH**”), Substance Abuse Prevention and Control (“**SAPC**”);

Whereas, Demonstration Health Plans and county agencies are required to have written agreements outlining how they will coordinate services;

Whereas, the Coordinated Care Initiative provides State authority for the Dual Eligibles Demonstration Project, and

Whereas, the DHCS has finalized a Memorandum of Understanding with the Centers for Medicare & Medicaid Services (“**CMS**”) for the Dual Eligibles Demonstration Project (“**CMS/DHCS MOU**”); and

Whereas, further, the DHCS, CMS and L.A. Care are finalizing a three-way agreement for the Dual Eligibles Demonstration Project; and

Whereas, in anticipation of federal approval and the finalizing of all required agreements, L.A. Care and the LMHP have entered into this MOU for purposes of implementing the Behavioral Health Services portion of the Dual Eligibles Demonstration Project.

II. PARTIES

L.A. Care, a licensed California Managed Care Health Plan, has been selected by the DHCS as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County. As a component of the Dual Eligibles Demonstration Project, L.A. Care is required to provide physical health services and certain Behavioral Health Services for Beneficiaries, and to coordinate care for the needs of Beneficiaries.

The County of Los Angeles Department of Mental Health (“**DMH**”) is the LMHP responsible for providing medically necessary Specialty Mental Health Services to eligible Medicare and Medi-Cal beneficiaries of Los Angeles County. Under the Dual Eligibles Demonstration Project, the LMHP will provide Medi-Cal Specialty Mental Health Services

for Beneficiaries who meet Medi-Cal medical necessity criteria, and, with L.A. Care, coordinate Medicare and Medi-Cal services.

III. BACKGROUND

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (**CCI**) to enhance health outcomes and beneficiary satisfaction for beneficiaries of both the Medicare and Medi-Cal programs, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including Los Angeles County, were selected by the State to implement a three-year demonstration project for Medicare and Medi-Cal beneficiaries, referred to as the Dual Eligibles Demonstration Project. L.A. Care is one of two local managed care health plans selected by the DHCS and CMS in Los Angeles County to provide health, mental health, substance abuse and Long Term Services and Supports (“**LTSS**”) services to Beneficiaries enrolled in the Dual Eligibles Demonstration Project (or sometimes referred to herein as the “Demonstration Project”).

Under the Demonstration Project, all Medicare and non-specialty Medi-Cal mental health services are the responsibility of L.A. Care and included in its capitation payment for the Demonstration Project. Medi-Cal specialty mental health services not covered by Medicare benefits will not be included in L.A. Care’s capitation payment from DHCS. L.A. Care and the LMHP will collaborate to ensure Beneficiaries have access to coordinated Medicare and Medi-Cal services. Medi-Cal Specialty Mental Health Services will continue to be provided or arranged for by and the financial responsibility of the LMHP for Beneficiaries that meet Medi-Cal medical necessity criteria.

IV. PURPOSE

This MOU sets forth the Parties’ mutual understandings, commitments, and protocols regarding how Behavioral Health Services funded by Medicare and Medi-Cal will be coordinated and managed by the LMHP and L.A. Care for Beneficiaries. Among other things, this MOU addresses: 1) the roles and responsibilities of L.A. Care and the LMHP, 2) how care will be coordinated by and between L.A. Care and the LMHP, 3) the process for information exchange between L.A. Care and the LMHP, and 4) shared financial accountability strategies.

V. DEFINITIONS

Behavioral Health Services (or “Behavioral Health”)

Mental Health Services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations and any mental health benefits and substance abuse available under the Medicare Program.

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Behavioral Health Care Management Team (“BHCMT”)

Multidisciplinary team that provides care management and care coordination for Medicare and Medi-Cal Behavioral Health Services, and authorization for Medicare services to Beneficiaries enrolled in the Demonstration Project. The BHCMT is composed of representatives from the LMHP, L.A. Care’s Delegated Behavioral Health Entity, delegated Health Plans SAPC.

Behavioral Health Care Plan

The care plan developed by a Beneficiary and the Beneficiary’s BHCMT that describes the authorized Behavioral Health Services to be provided to the Beneficiary.

Beneficiary

An individual who is eligible for both Medicare and Medi-Cal benefits and who is enrolled in the Dual Eligibles Demonstration Project and who receives covered services through LA Care.

Care Coordination

The management of physical, LTSS and Behavioral Health Services for Beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

Coordinated Care Initiative (“CCI”)

California’s coordinated care model that intends seamless access to the full continuum of medical, social, LTSS and Behavioral Health Services to Beneficiaries.

Confidentiality of Medical Information Act

A State law, California Civil Code Section 56 et. seq., which governs the confidentiality of medical information, as defined therein; this law specifies when medical information is required and permitted to be disclosed by health care providers and others.

Dual Eligibles Demonstration Project or Demonstration Project

The three-year CCI demonstration project involving an agreement or agreements between the Demonstration Health Plans, DHCS and CMS for coverage of individuals with eligibility for both Medicare and Medi-Cal.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, Public Law 104-191 and its implementing regulations, including Standards for the Privacy of Individually Identifiable Health Information and the Health Insurance Reform: Security Standards at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), including its implementing regulations, which provide federal protections for individually identifiable health information held by covered entities, as defined therein.

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Interdisciplinary Care Team (ICT)

A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of Beneficiaries. The ICT also includes a representative from the BHCMT.

L.A. Care Behavioral Health Entity

L.A. Care's contracted Behavioral Health Entity that assists L.A. Care in meeting the Behavioral Health and care coordination needs of certain Beneficiaries covered through the Dual Eligibles Demonstration Project.

L.A. Care Delegated Health Plan

L.A. Care's direct subcontracted health plans that assists L.A. Care in implementing the Dual Eligibles Demonstration Project under the three-way contract between CMS, DHCS, and L.A. Care.

Local Mental Health Plan ("LMHP")

The Los Angeles County Department of Mental Health which is the local county agency that has responsibility for administering public and Specialty Mental Health Services.

Local Mental Health Plan Providers

Specialty Mental Health Providers who deliver mental health services through the LMHP.

Long Term Services and Supports ("LTSS")

Those services and supports described in Welfare and Institutions Code Section 141861, subdivision (b).

Medi-Cal

California's Medicaid health care program of medical assistance benefits under Title XIX of the Social Security Act.

Medicare

Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease ("ESRD") or Amyotrophic Lateral Sclerosis ("ALS").

Primary Care Provider ("PCP")

A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary through the Dual Eligibles Demonstration Project.

Program Administration Team ("PAT")

A team composed of staff from the MHN and/or L.A. Care, L.A. Care's Behavioral Health Entity, LMHP, and SAPC that provides program oversight of the BHCMT.

Protected Health Information ("PHI")

Individually identifiable health information as defined by 45 C.F.R. Section 160.103.

Specialty Mental Health Services

Services provided through the LMHP as defined by Title 9, California Code of Regulations (CCR) Section 1810.247 and in accordance with Chapter 11 of Title 9.

State Department of Health Care Services (DHCS)

The State department that has responsibility for administering health care services funded Medi-Cal.

Welfare and Institutions Code Section 5328 et. seq.

The State laws governing the confidentiality of information and records of the LMHP and LMHP Providers; this law specifies that all information and records received in the course or providing services are confidential and specifies when such information is required or permitted to be disclosed.

VI. APPLICABLE DOCUMENTS

Addenda I, II, III, and IV are attached to and form a part of this MOU. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or contents or description of task or responsibility between the MOU and the addendum, or between addenda, such conflict or inconsistency shall be resolved in a manner that advances the purpose and intent of this MOU. Addenda to this Agreement are as follows:

Addendum I

Cal Medi-Connect Coordination of Care Policy and Procedures [Behavioral Health] Policy and Procedure. This Policy sets forth the coordination of care procedures that the Parties and their applicable related entities will follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum II

DMH and DPH Authorization and Care Management Flow Charts. Addendum II sets forth the process flows and guidelines that the Parties and their applicable related entities in the Demonstration Project agree to follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum III

Mental Health Benefits in the Duals Demonstration Matrix. Addendum III sets forth a listing of the Behavioral Health Services to be provided to Beneficiaries and the Party that will have financial responsibility for provision of that Service as defined by DHCS for the Demonstration Project.

Addendum IV

Exchange of Information Related to the Dual Eligibles Demonstration Project Beneficiaries.

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VII. ROLES AND RESPONSIBILITIES

L.A. Care has primary administrative and program responsibility for care management, care coordination and authorization for reimbursement for Behavioral Health Services covered by Medicare under the Demonstration Project.

A. Behavioral Health Services Administrative Arrangements

L.A. Care has contracted with its L.A. Care Behavioral Health Entity to assist L.A. Care in meeting the Behavioral Health Services and care coordination needs of Beneficiaries. L.A. Care's Behavioral Health Entity is the focal point for most Behavioral Health Services activities including, but not limited to, provider network development, the referral process, coordination of care, claims and billing functions between L.A. Care and LMPH.

LMPH shall enter into arrangements as necessary with L.A. Care's Behavioral Health Entity to implement this MOU and the Demonstration Project.

L.A. Care's Behavioral Health Entity shall:

1. Develop formal arrangements with L.A. Care's delegated health plans for administration and provision of Behavioral Health Services for Beneficiaries.
2. Develop and contract a Behavioral Health Services provider network that includes, but is not limited to, the LMHP and LMHP Providers.
3. Lead and be the focal point for all Behavioral Health Services coordination activities between L.A. Care, L.A. Care's delegated health plans, and LMHP.
4. Lead and/or participate in the BHCMT.
5. Act as lead liaison between LMHP, L.A. Care and L.A. Care's delegated health plans.
6. Process Medicare Behavioral Health Services claims payment to Behavioral Health Services network providers which include, but are not limited to, LMHP Providers.

B. Care Management Teams

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care, L.A. Care, LMHP and SAPC, shall establish three interagency care management teams for Behavioral Health composed of, but not limited to, representatives from each of the entities.

The interagency care management teams are responsible, as described below, for ensuring that health, mental health, substance abuse and LTSS services are easily accessible and coordinated for Beneficiaries, including Beneficiaries receiving Medicare Behavioral Health through L.A. Care delegated health plans. No L.A. Care

delegated health plan shall have care management teams other than the three types of teams specified below.

1. Program Administration Team (“PAT”) has the following shared responsibilities:
 - 1.1. Develop algorithms, and policies and procedures to assist the BHCMT in its day to day operations.
 - 1.2. Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 - 1.3. Conduct program evaluation.
 - 1.4. Resolve disputes between L.A. Care and the LMHP.
 - 1.5. Identify and resolve provider relations issues.

2. Behavioral Health Care Management Team (“BHCMT”) led by L.A. Care’s Behavioral Health Entity has the following shared responsibilities:
 - 2.1. Authorize covered Behavioral Health Services based upon algorithms developed by PAT. Develop individual Behavioral Health Care Plans.
 - 2.2. Coordinate care between physical health, mental health and substance abuse providers.
 - 2.3. Monitor individual clinical progress.
 - 2.4. Reassess individual service needs.
 - 2.5. Refer and link to appropriate services.
 - 2.6. Serve as the liaison to the Interdisciplinary Care Team for Beneficiaries that also need non Behavioral Health Services.
 - 2.7. Resolve disputes between L.A. Care and LMHP.

3. Interdisciplinary Care Team (“ICT”). L.A. Care and L.A. Care’s Delegated Health Plans are responsible for facilitating ICTs to provide care management services to Beneficiaries, including those Beneficiaries receiving services through L.A. Care’s Delegated Health Plans, that present with complex and multiple health, mental health, substance abuse conditions and may also need LTSS. The ICT will include, but is not limited to, health care staff, BHCMT, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate and as permitted by law.

For further guidance regarding the role of and processes applicable to the Care Management Teams refer to Addendums I and II to this MOU.

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C. Referrals and Criteria

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care for purposes of referring Beneficiaries for Behavioral Health Services, L.A. Care, LMHP, and SAPC agree to the following protocols, as further described in Addenda I, II and III to this MOU.

1. Referral Process for Behavioral Health Services

- 1.1. The Dual Eligibles Demonstration Project shall have a “no wrong door” approach to service access, with multiple entry paths for Beneficiaries to access Behavioral Health Services. Referrals may come from various sources including, but not limited to, Beneficiary self-referrals.
- 1.2. All incoming referrals or requests for Behavioral Health Services shall be screened and triaged according to procedures established by the BHCMT to determine Behavioral Health need, and to refer and link Beneficiaries to a Behavioral Health provider and/or to SAPC for substance use disorders treatment and recovery services.

2. Referral Process for non-Behavioral Health Services

- 2.1. The LMHP shall identify Beneficiaries that need physical health care services and refer these Beneficiaries to the BHCMT in the manner described in Addendum I and Addendum II attached to this MOU.

3. Determination of LMHP Service Criteria

- 3.1. The criteria for provision of Specialty Mental Health Services are set forth in 9 CCR Sections 1820.205, 1830.205, 1830.210. Criteria for Medi-Cal Specialty Mental Health Services include, but are not limited to:
 - 3.1.1. One or more of the disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, currently used by DHCS to determine Medi-Cal medical necessity, excepting those disorders specifically excluded by regulation.
 - 3.1.2. Specific impairments as a result of the mental disorder or probability of deterioration of an important area[s] of life functioning.
 - 3.1.3. Services that must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment.
 - 3.1.4. Services must be best delivered in a specialty mental health setting.

4. Determination of Medicare Non-Specialty Mental Health Service Criteria
 - 4.1. L.A. Care shall provide Behavioral Health Services to Beneficiaries as listed in Addendum III.
 - 4.2. Description of Covered Medi-Cal Specialty Mental Health Services are included in Addendum III.

D. Credentialing

The LMHP has a large network of licensed providers, both directly employed by the LMHP or contracted with the LMHP, that delivers clinical services at LMHP owned or LMPH provider treatment sites. In the event that the health plan accrediting entity requires the LMHP network providers to be credentialed, the following terms apply:

1. Upon determination by L.A. Care or L.A. Care's Behavioral Health Entity that LMHP's credentialing process meets the required standards, L.A. Care agrees to delegate to the LMHP the credentialing of those LMHP providers who are directly employed by the LMHP for purposes of becoming Medicare-reimbursable providers in the Dual Eligibles Demonstration Project. The LMHP must credential all licensed providers in accordance with the requirements of the relevant accrediting and regulatory entities that govern and review L.A. Care's credentialing processes and policies. In addition, credentialing of directly employed licensed providers in the LMHP network, if necessary, must be consistent with County civil service rules.
2. L.A. Care and/or L.A. Care's Behavioral Health Entity are responsible for credentialing those providers contracted with the LMHP (i.e., those who are not directly employed by the LMHP), who are Medicare reimbursable, for the purposes of becoming Medicare-reimbursable providers in the Dual Eligibles Demonstration Project.

All contracted providers in the LMHP network shall be eligible to participate in the credentialing process.

3. The standards for the credentialing of providers shall satisfy the requirements of L.A. Care, CMS, National Committee on Quality Assurance ("NCQA"), and other applicable regulatory entities or requirements. LMHP providers must meet the Medicare credentialing requirements and standards to be eligible for reimbursement for Medicare services provided pursuant to the Dual Eligibles Demonstration Project.
4. As part of any delegation of credentialing to the LMHP, L.A. Care may perform periodic oversight audits to ensure that the required standards are met on an ongoing basis. Any such audits shall, except as otherwise necessary to satisfy the requirements of CMS, DHCS, DMHC, NCQA, URAC and other applicable regulatory entities, and the three-way agreement to be

entered into by and among CMS, the State and L.A. Care, be conducted in a manner consistent with rules applicable to Los Angeles County employment for those licensed providers directly employed by the LMHP, which rules shall be communicated by the LMHP to L.A. Care. Any information obtained from LMPH in conducting such audits shall be considered confidential and shall, except as otherwise required by CMS, NCQA, URAC, or other applicable regulatory entity, not be disclosed by L.A. Care. Nothing in this section shall be construed to prevent L.A. Care from disclosing any document if such disclosure is required by law, or by an order issued by a court of competent jurisdiction.

5. Providers and provider sites must be dually credentialed in both LMHP's and Medicare managed health plan networks at all times in order to provide Medical reimbursable service to Beneficiaries.
6. Any failure of a provider or provider site to meet the applicable credentialing standards and requirements as determined by L.A. Care, LMHP or its delegated entities will automatically result in removal of that provider or provider site as a credentialed provider of Behavioral Health Services to Beneficiaries.
7. L.A. Care and LMHP will notify each other promptly of any changes in provider or provider site network credentialing status or compliance.

E. Financial Responsibility: Reimbursement Process for Medicare Behavioral Health Services Provided by LMHP Providers

Primary financial responsibility of and between the parties for Behavioral Health Services for the Demonstration Project are based on the matrix provided by DHCS as set forth in Addendum III, attached hereto. Further provisions and processes for reimbursement of Behavioral Health Services shall be specified in a separate provider agreement between LMHP and L.A. Care and/or L.A. Care's Behavioral Health Entity.

For further information regarding financial responsibility and processes for the provision of Behavioral Health Services to Beneficiaries covered by Medicare, refer to the Addenda attached to this MOU.

F. Beneficiary and Provider Education

1. L.A. Care will develop, in collaboration with the LMHP, education materials that explain the Behavioral Health and substance abuse components of the Demonstration Project.
2. LMPH will provide L.A. Care staff with training on LMHP programs, eligibility and assessment criteria, services available, and how to review and

understand data made available for coordination of care to L.A. Care and/or L.A. Care's Behavioral Health Entity. Initial trainings will be provided prior to implementation of the Demonstration Project, and on an as-needed basis, but not less than annually.

3. L.A. Care will provide LMPH staff with opportunities for training on Plan benefits and procedures. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative, and on an as-needed basis, but not less than annually.
4. The LMHP will train its providers on procedures for filing claims and reimbursement of Medicare services, care coordination and care management requirements established by L.A. Care.
5. L.A. Care will train its providers on procedures for Behavioral Health care coordination, care management requirements, referral processes, claims and reimbursement issues.
6. L.A. Care will develop, in collaboration with the LMHP, a provider manual that addresses the Behavioral Health and substance abuse components of the Demonstration project.
7. L.A. Care and the LMHP will provide information and education about the Demonstration Project to potential eligible enrollees, their family members, caregivers and to Beneficiaries enrolled in the Demonstration Project to assist them with making informed decisions related to their health care needs.

G. Dispute Resolution Related to Reimbursement for Services

1. First Level Disputes: All disputes "First Level Disputes" shall be submitted to the BHCMT for resolution. First Level Disputes may include, but are not limited to, disagreements regarding authorization for or reimbursement of Medicare and or Medi-Cal services.
2. Second Level Disputes: If the BHCMT cannot resolve a First Level Dispute to the satisfaction of either or both parties, the dispute shall be submitted to the PAT within mutually agreed upon timeframes. The PAT shall inform the BHCMT of its decision
3. Third Level Disputes: If the PAT cannot resolve a Second Level Dispute to the satisfaction of either or both parties, the dispute shall be addressed by executive management from the LMHP and L.A. Care. The executive management shall review the dispute and inform the PAT of its decision.
4. If resolution cannot be reached at the executive management level within agreed upon timeframes, L.A. Care and LMHP agree to follow the resolution

of dispute process in accordance with 9, sections 1810.370, 1850.505 and 1850.525, and the contract between L.A. Care and DHCS and CMS.

H. Dispute Resolution Related to Provider Relations

1. First Level Disputes: Disputes between L.A. Care and the LMHP regarding provider relations and contracting shall be submitted to the PAT.
2. Second Level Disputes: If satisfactory resolution of a dispute cannot be reached by the PAT, the dispute shall be addressed and resolved by the executive management staff from L.A. Care and the LMHP.

VIII. COORDINATION OF CARE

A. Point of Contact for Clinical Issues

1. L.A. Care contact staff is the Senior Director of Health Services. L.A. Care's Behavioral Health Entity shall designate a contact staff. L.A. Care's delegated health plans will designate a contact staff.
2. The LMHP contact staff is the Medical Director.
3. SAPC contact staff is the designated Program Director.

B. Care Coordination Activities

1. L.A. Care shall conduct a Health Risk Assessment that includes Behavioral Health screenings for all Beneficiaries enrolled with L.A. Care in the Demonstration Project. L.A. Care will refer Beneficiaries with specific mental health and substance abuse findings from the screenings to the PCP for potential linkage to a mental health provider and/or substance abuse provider.
2. The ICT or member thereof shall refer Beneficiaries to the BHCMT if the PCP or the Beneficiary believes that mental health services beyond the scope of practice of the PCP are required.
3. The PCP, LMHP provider, Beneficiary and the BHCMT shall collaboratively develop a Behavioral Health Care Plan for the Beneficiary
4. The LMHP provider and PCP shall share Protected Health Information (PHI) as needed for the purpose of care coordination in accordance with the Exchange of Data MOU attached hereto as Addendum IV and to the extent permitted by law.

5. LMHP providers shall submit written documentation that contains treatment coordination information to the beneficiary's PCP in accordance with Addendum IV and to the extent permitted law.
6. L.A. Care's PCP shall submit written documentation that contains treatment coordination information to the Beneficiary's mental health provider in accordance with Addendum IV and to the extent permitted by law.
7. L.A. Care shall establish a process for reviewing and updating care plans as clinically indicated, such as following a hospitalization, a significant change in health or well-being, in level of care, or a request for change of provider, and for coordinating with the LMHP Provider when necessary.
8. The LMHP, L.A. Care and SAPC providers may participate in case conferencing and conduct regular meetings to review the care coordination process.
9. L.A. Care shall coordinate with the LMHP and SAPC to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
10. L.A. Care shall develop procedures and coordinate direct transfers between inpatient psychiatric services and inpatient medical services and involve the BHCMT for the purpose of care management and care coordination.

C. Case Consultation

In accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws, the LMHP and L.A. Care shall establish processes that facilitate consultation and coordination of psychiatric and medical treatment and care plans.

1. The LMHP providers may provide information, education, and consultation to L.A. Care PCPs regarding Behavioral Health related issues to improve coordination of care and care management.
2. L.A. Care PCPs may provide information, education, and consultation to LMHP providers on medical issues to improve coordination of care and care management.
3. Consultation between L.A. Care PCPs and LMHP providers may be facilitated by various means including, but not limited to:
 - 3.1. Direct consultation
 - 3.1.1. Telephonic consultation

3.1.2. E-mail consultation

3.1.3. Telepsychiatry/Telemedicine

3.2. Facilitated case conference by BHCMT or ICT concerning care management planning

IX. EXCHANGE OF INFORMATION

- A. The parties understand and agree that each party has obligations under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (“HIPAA”) as amended by subtitle D, Privacy, of the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, as further implemented by the Omnibus HIPAA rule, 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 HIPAA.
- 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 respect 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 C.F.R. Part 2.
- C. Each party acknowledges that it will comply with consent 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. Addendum IV sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information, to ensure coordination of physical health, mental health, and substance abuse services.

X. SHARED FINANCIAL ACCOUNTABILITY STRATEGIES

The LMHP, L.A. Care and SAPC (pursuant to a separate memorandum of understanding entered into with SAPC) agree to comply with the Shared Accountability Performance Metrics and requirements, as specified in the DHCS/CMS MOU and the three-way contract between CMS, DHCS, and L.A. Care. The goal of Shared Accountability Performance Metrics is to develop coordination strategies to reduce inappropriate cost shifting between Medicare and Medi-Cal Specialty Mental Health Services and develop a formal financial arrangement strategy for shared cost savings. The strategies build on the performance-based withhold in the capitation rates of 1%, 2% and 3% respectively for years one, two

and three of the Dual Eligibles Demonstration Project. If the specified shared accountability measures are achieved, L.A. Care shall provide an incentive payment to LMHP and SAPC under mutually agreeable terms and pay a percentage of the recovered funds attributed to that measure to LMHP and SAPC. This payment shall be structured in a way that does not offset Los Angeles County's Certified Public Expenditure (CPE).

The LMHP, L.A. Care and SAPC agree to modify and update their respective MOUs to incorporate the Behavioral Health Shared Accountability Standards in accordance with the three-way contract once that Contract is final.

XI. INDEMNIFICATION

L.A. Care and the LMHP 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 damage whatsoever, including but not limited to death or injury to any person and damage to 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 VIII shall survive termination of this MOU.

XII. 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 sufficient for liabilities which may arise from or relate to this MOU.

XIII. TERM

This MOU is effective _____2013, ("Effective Date") and, unless terminated earlier as provided herein, shall continue in effect so long as necessary to implement the Dual Eligibles Demonstration Project or for three years from the Effective Date, whichever date is earlier. The term of this MOU may be extended by the parties upon their mutual written agreement.

XIV. 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 effective March 27, 2013; (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

XV. 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 requirements of the Dual Eligibles Demonstration Project.
- D. Supervening Circumstances:** Neither L.A. Care nor LMHP 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) any 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 the Dual Eligibles Demonstration Project shall not require the consent of LMHP and/or SAPC or L.A. Care and shall be effective immediately on the effective date of the requirement.
- 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 party which consent shall not be unreasonably withheld. L.A. Care expressly reserves the right to 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:** LA Care and LMHP 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 LMHP each agree to keep the foregoing strictly confidential. L.A. Care and LMHP agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. L.A. Care and LMHP agree that nothing in

- 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 obligation 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 LMHP 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 LMHP, nor any of their respective agents, employees or representatives, shall be construed to be the agent, employee or representative of the other.
- M. Entire Agreement:** This MOU represents 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 facsimile 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 executed 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

ADDENDUM I

 <p>TITLE: CAL MEDI-CONNECT COORDINATION OF CARE POLICIES AND PROCEDURES “NO WRONG DOOR”</p> <p>SERVICE AREA: BEHAVIORAL HEALTH</p> <p>DEPARTMENT: HEALTH SERVICES</p>	Policy and Procedure Number		BH01			
	Total No. of Pages		7			
	Dates					
	Effective Date					
	Review/Revision Date					
	Review Date					
	Supersedes Policy Number					
	PPSA/Mandated		YES		NO	
	Administrative		YES		NO	X
	Applies to:					
	D SNP Medicare		YES		NO	
	Cal Medi-Connect		YES	X	NO	

1.0 POLICY:

- 1.1 L.A. Care health plan is responsible for providing beneficiaries seamless access to all medically necessary behavioral health services (mental health and substance use disorder treatment) currently covered by Medicare and Medicaid.
- 1.2 L.A. Care will coordinate with county agencies to ensure enrollees have seamless access to these services.
- 1.3 L.A. Care will ensure coordination of behavioral health with medical care and long-term services and supports

2.0 DEFINITION(S):

- 2.1 **Addiction** is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving. (Authority – Substance Abuse and Mental Health Services Administration, A Treatment Improvement Protocol 54 and the American Society of Addiction Medicine)
- 2.2 **BH** means Behavioral Health which includes Mental Health and Substance Use Disorder Services
- 2.3 **BHCMT** means Behavioral Health Care Management Team.
- 2.4 **Behavioral Health Care Management Team (BHCMT)** Multidisciplinary team that provides care management, care coordination and authorization for reimbursement of Medicare services to beneficiaries enrolled in the Demonstration project. The team is composed of representatives from the Local Mental Health Plan, Health Plans, and the Department of Public Health
- 2.5 **Behavioral Health Care Plan** The care plan developed by a beneficiary and the beneficiary’s Behavioral Health Care Management Team that describes the authorized services to the beneficiary.

- 2.6 BHP** means Behavioral Health Providers
- 2.7 Care Coordination** The management of services for beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.
- 2.8 DMH** means County Department of Mental Health.
- 2.9 DPH** means County Department of Public Health
- 2.10 Health Plan “The Plan” or “Plan”** refers to LA Care
- 2.11 Interdisciplinary Care Team (ICT)** A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of beneficiaries with complex needs.
- 2.12 LMHP** Los Angeles County Department of Mental Health (DMH) which is the local county agency that has responsibility for administering public mental health services.
- 2.13 Primary Care** means a basic level of health care usually rendered in ambulatory setting by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. Primary care emphasizes caring for the member's general health needs as opposed to specialist focusing on specific needs. This means providing care for the majority of health care problems, including, but not limited to, preventive services acute and chronic conditions, and psychosocial issues.
- 2.14 Primary Care Provider (PCP)** means a person responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).
- 2.15 Program Administration Team (PAT)** A team composed of staff from the Health Plan, DMH, and SAPC that provides program oversight of the Behavioral Health Care Management Team.
- 2.16 Specialty Mental Health Service** means: Medi-Cal specialty mental health services and health plans and counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. These criteria can be summarized as the following:
- 2.16.1** Diagnosis – one or more of the specified MediCal included diagnosis and Statistical Manual of Mental Disorders;
- 2.16.2** Impairment – significant impairment or probability of deterioration of an

important area of life functioning, or for children a probability the child won't progress appropriately;

2.16.3 Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment

2.17 **Specialty Substance Use Disorder Treatment Services** are outpatient, residential, prevention, recovery, and support services which are made available to persons with substance use disorders. Services are directed towards alleviating and/or preventing substance use among individuals. Types of services, as described in Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards, include assessment, screening, evaluation, crisis intervention, individual, group, family counseling, collateral, vocational, detoxification, medication assisted treatment services, aftercare, and education services on tuberculosis and sexually transmitted diseases.

2.18 **Specialty Substance Use Disorder Treatment Services Provider** means an entity / organization contracted with Los Angeles County, Department of Public Health Substance Abuse Prevention and Control and is certified or licensed to provide specialty substance use disorder treatment services. Individuals providing counseling services must be registered, certified or licensed in accordance with the California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000.

2.19 **Subcontracted Plan** means a health maintenance organization or any other health care service plan licensed under the Knox -Keene Act which has entered into a service agreement with the Local Initiative of L.A. County (LA Care) to provide or arrange for health care services to Medi-Cal members, and to perform the other duties and responsibilities as set forth in such Plan Partner's Services Agreement with the Local Initiative.

3.0 PROCEDURE:

3.1 The Demonstration project has a "no wrong door" approach to service access. There will be multiple entry paths for beneficiaries to access behavioral health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling L.A. Care's Behavioral Health toll free number that will be available 24 hours, 7 days a week for service authorization and referral. Sources of referrals will also be educated on expeditiously referring Behavioral Health cases to L.A. Care's Behavioral Health toll free number.

3.2 Calls will be screened and triaged to establish eligibility and determine BH needs. and refer and link beneficiaries to BH providers. The assessments will be conducted using guidelines developed by the Program Administration Team (PAT).

3.2.1 If the member does not require BH services, he/she is referred to the health plans member services department.

3.2.2 If the member does require BH services appropriate authorization and referral will be given.

3.2.3 In cases of Crisis, the caller will be appropriately directed to emergency services.

3.3 Beneficiaries that are enrolled in the Demonstration project may walk in or present to a BH provider without an appointment to obtain services. The BH provider will be required to secure authorization from the BHCMT via the toll free number prior to rendering reimbursable services, with the exception of psychiatric crisis or emergency.

3.3.1 Initially the BHCMT will determine if the member is in need of emergent, urgent or routine Behavioral Health Services. Beneficiaries experiencing a BH crisis will be immediately referred to emergency services including psychiatric hospitals.

3.3.1.1 An emergency (behavioral health) is defined as an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition including symptoms of intoxication or withdrawal .

3.3.1.2 Emergency behavioral health services will be provided in accordance with the symptoms listed above.

3.3.1.3 The use of 911 services will be incorporated as necessary.

3.3.2 If the member is in need of non urgent BH or additional services, the BHCMT will determine the members' Care Management level based on guidelines developed by PAT. In all cases, coverage under Medicare is primary.

3.4 Care Management level determination includes the following:

3.4.1 Low Intensity CM Medicare: These services include but may not be limited to the following services, as covered by Medicare:

3.4.1.1 Outpatient services within the scope of primary care which may be completed by behavioral health physician

3.4.1.2 Outpatient Psychiatric services such as medication management, assessment, individual and group therapy delivered by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office, clinic, or hospital outpatient department.

3.4.1.3 Psychological / Psychiatric testing / assessment

3.4.1.4 Institutions for Mental Diseases (Mental Health Rehab Center or Skilled Nursing Facility)

3.4.2 High Intensity CM Medicare: These services include but may not be limited to the following services as covered by Medicare

3.4.2.1.1 Psychiatric Inpatient Hospital services for acute conditions

3.4.2.1.2 Partial hospitalization / Intensive Outpatient services

3.4.2.1.3 Substance Use Disorder (SUD) detox

3.4.3 Low Intensity CM Medi-Cal/Medicare:

3.4.3.1.1 Mental health services (individual and group therapy, assessment, collateral, plan development)

3.4.3.1.2 Medication support services (prescribing, administering, dispensing and monitoring drug interactions and

contraindications of psychiatric medications, including the evaluation of need, clinical effectiveness and side effects; obtaining informed consent; education; collateral and plan development)

3.4.3.1.3 Day rehabilitation

3.4.3.1.4 Methadone Clinic

3.4.3.1.5 Targeted Case Management

3.4.4 High Intensity CM Medi-Cal/Medicare:

3.4.4.1.1 Intensive Day treatment

3.4.4.1.2 Crisis intervention

3.4.4.1.3 Psychiatric Emergency Services

3.4.4.1.4 Crisis stabilization

3.4.4.1.5 Adult Residential Treatment Services

3.4.5 Beneficiaries that do not meet criteria for specialty mental health services will be referred and linked back to L.A. Care provider network by the BHCMT.

3.5 Referral Process for non BH Care Services

3.5.1 Beneficiaries with co occurring medical conditions or with need for other ancillary or medical services may be referred by the BHCMT to the ICT that is developed by the Health Plan for coordinating all care requirements of the beneficiary

3.5.2 Any BHP may identify behavioral health beneficiaries that need physical health care services and refer the beneficiaries to the BHCMT care manager.

3.5.3 L.A. Care's BHCMT care manager will identify the Primary Care Physician (PCP) assigned to the beneficiary and refer and link the beneficiary to the PCP for health care services as needed.

4.0 STRUCTURAL CONSIDERATIONS FOR BH CARE COORDINATION:

4.1 Care Management Teams

4.1.1 Program Administration Team (PAT) will have the following shared responsibilities:

4.1.1.1 Develop guidelines and policies and procedures to assist the Behavioral Health Care Management Team in its day to day operations.

4.1.1.2 Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.

4.1.1.3 Program evaluation.

4.1.1.4 Resolve disputes between L.A. Care and the LMHP.

4.1.1.5 Identify and resolve issues between LA Care & DMH / DPH provider relations.

4.1.2 Behavioral Health Care Management Team (BHCMT) will have the following shared responsibilities:

4.1.2.1 Authorize reimbursement based upon developed guidelines by PAT.

4.1.2.2 Develop a behavioral health care plan.

4.1.2.3 Coordinate care between physical health, mental health, substance abuse and LTSS providers through the ICT.

4.1.2.4 Monitor clinical progress.

4.1.2.5 Reassess service needs.

4.1.2.6 Refer and link to appropriate services.

4.1.2.7 Serve as the liaison to the ICT as needed.

4.1.3 ICT will be facilitated by L.A. Care to provide needed care management services to all beneficiaries. The team will include health care staff, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate. The LMHP will provide consultation to the team and ensure mental health needs are addressed.

5.0 CARE COORDINATION:

5.1 Care Coordination Activities

- 5.1.1 L.A. Care will conduct a Health Risk Assessment for all beneficiaries enrolled in the Demonstration project that also includes BH screenings. L.A. Care will refer beneficiaries with specific mental health and substance abuse findings from the screening to the PCP for linkage to a mental health provider and/or substance use disorder provider.
- 5.1.2 L.A. Care's PCP will refer beneficiaries through the toll free BH number to the BHCMT if services required are outside the scope of the PCP or if the beneficiary request services from mental health or DPH.
- 5.1.3 The BHP and or LMHP provider, beneficiary and the BHCMT will work closely together to develop an individual care plan.
- 5.1.4 If needed DPH provider will secure a signed consent from the beneficiary to share PHI with the BH and or LMHP and the PCP for the purpose of care coordination.
- 5.1.5 BHP and or LMHP providers will submit written documentation that contains treatment coordination information to the beneficiary's primary care physician within 30 days from the initial mental health visit, annually, and when there are significant changes in diagnosis, medications or other aspects of care plans.
- 5.1.6 L.A. Care PCP will submit written documentation that contains treatment coordination information to the beneficiary's mental health provider within 30 days after the initial primary care visit, annually, and when there are significant changes in diagnosis, medications or other aspects of the care plans.
- 5.1.7 L.A. Care will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with the BHP and or LMHP provider when necessary.
- 5.1.8 The BHP and or LMHP, L.A Care and DPH providers may participate in case conferencing as needed and conduct regular meetings to review the care coordination process.
- 5.1.9 L.A. Care's BHCMT will coordinate with the BHP and or LMHP and DPH to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
- 5.1.10 L.A. Care will develop procedures and coordinate direct transfers between psychiatric inpatient hospitals and inpatient medical hospital services and involve the BHCMT for purpose of care management and care coordination.

5.2 Exchange of information

- 5.2.1 Successful Care Coordination is accomplished through exchange of information between providers and entities involved in the care for beneficiaries enrolled in the

program. Refer to Policy and Procedure XXXXX for details on Exchange of Information.

6.0 AUTHORITY:

- 6.1 California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
- 6.2 Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
- 6.3 Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Members, D. Mental Health Services
- 6.4 MMCD Policy letter 00-01
- 6.5 Title 9, CCR, Chapter 11, Division 1, Section(s): 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205(b)(1); 1830.210; 1850.210(I); 1850.505
- 6.6 Title 22, CCR, Chapter 3, Article 4, Section(s) 51305; 51311; 51313; 51183
- 6.7 Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards
- 6.8 Welfare and Institutions Code Section 5600.3; and 14016.5

7.0 REFERENCE(S):

- 7.1 L.A. Care Health Plan Model of Care 2013
- 7.2 Memorandum of Understanding Between L.A. Care and L.A. County Department of Mental Health
- 7.3 Authorization and Care Management Flow Chart “No Wrong Door” February 27, 2013

Accountability Matrix	
Responsible Department(s)	Policy Section #

ELECTRONICALLY APPROVED BY THE FOLLOWING			
	Officer	Director	Regulatory Affairs &

			Compliance
Name			
Department			
Title			
IF APPLICABLE			
Board of Governors		Motion Number:	

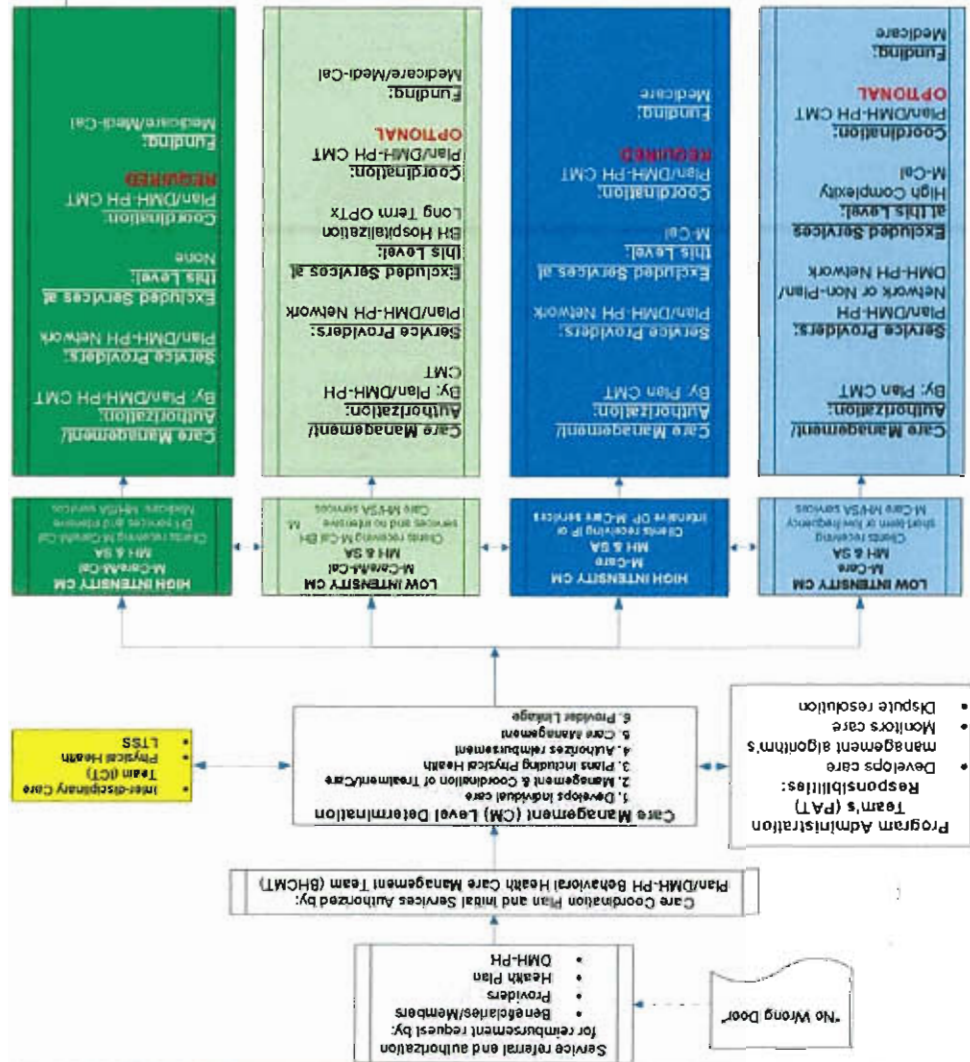
*Note: Please write "N/A" for the Name, Department, and Title of the Director if this approval is not applicable.

Policy History				
Date	Department	Policy or Section #	Comment(s)	Next or Annual Review Date

DMH & DPH Proposed Authorization and Care Management Flow Chart

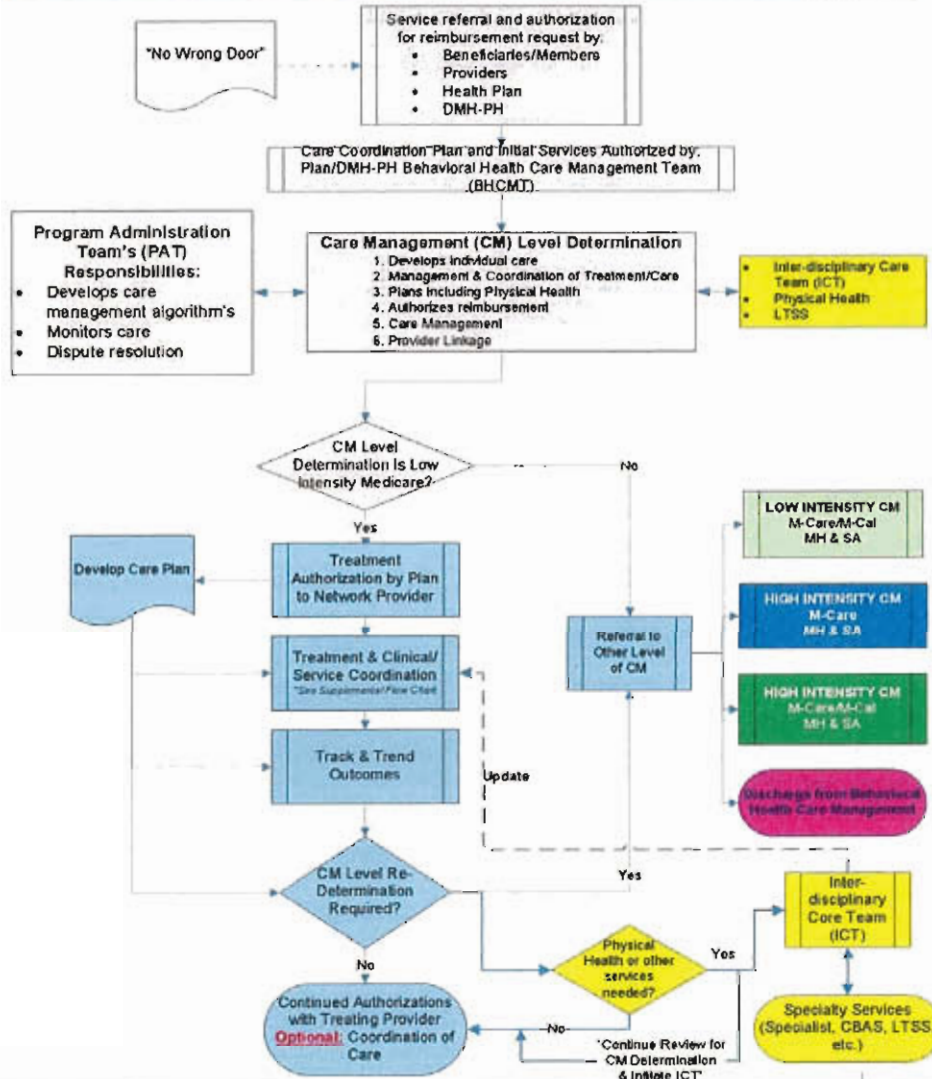
Addendum II

Friday, July 19, 2013



**DMH & DPH
Authorization & Care Management Low Intensity Medicare Flow Chart**

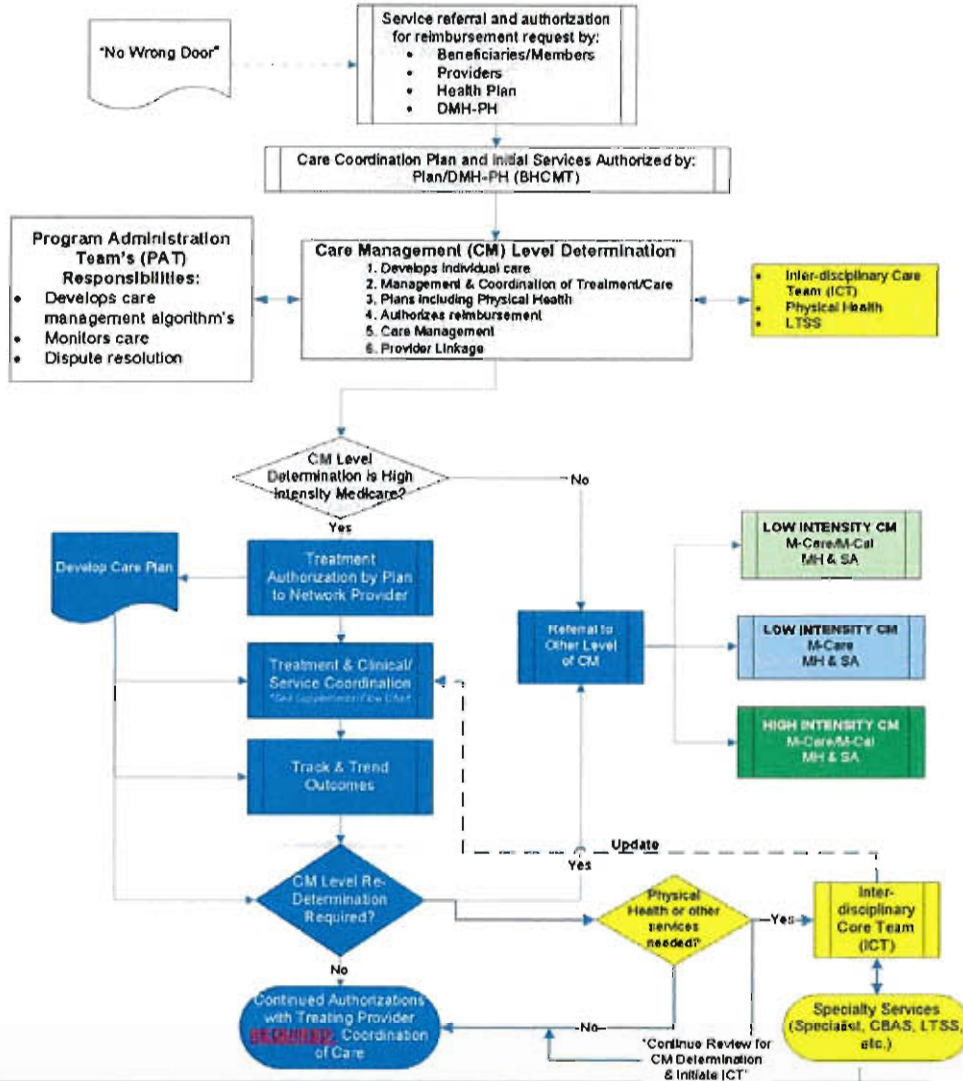
Friday, July 19, 2013



* Complex behavioral health care cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

**DMH & DPH
Authorization & Care Management High Intensity Medicare Flow Chart**

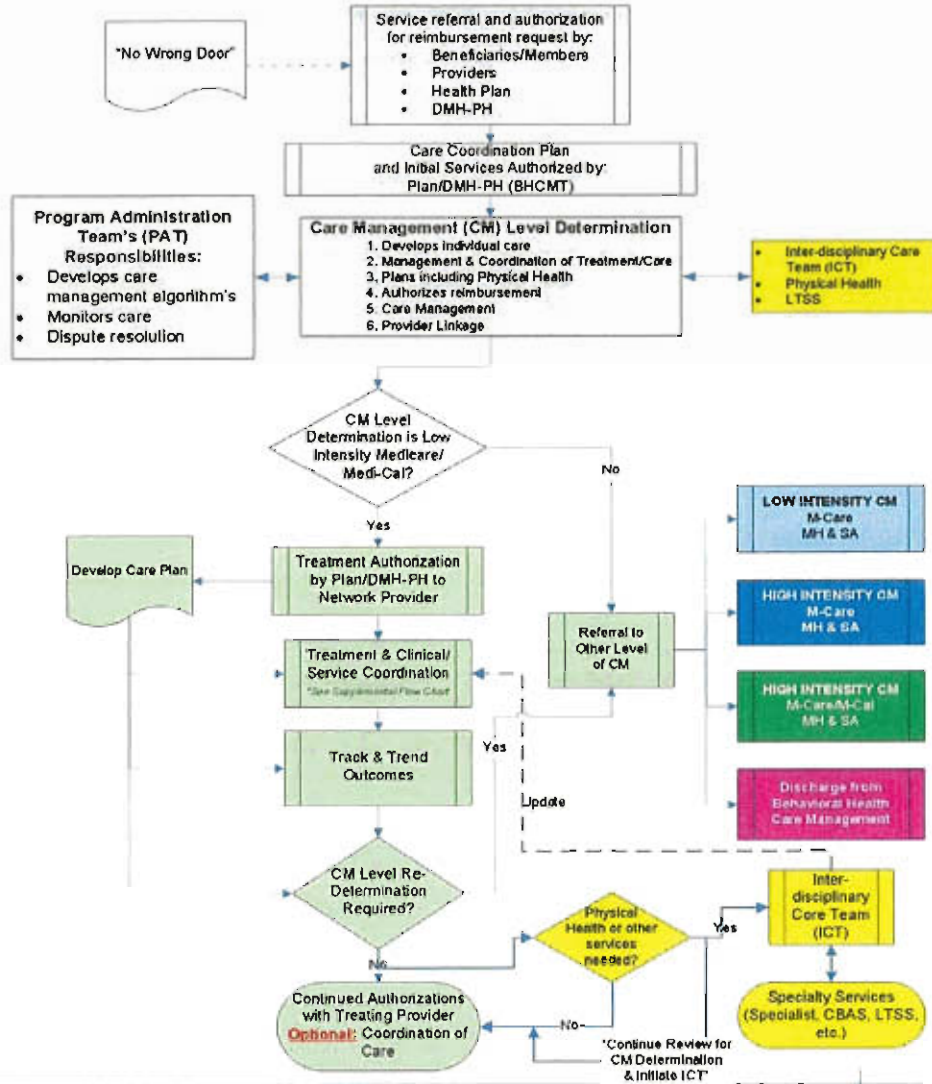
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

**DMH & DPH
Authorization & Care Management Low Intensity Medicare/Medi-Cal Flow Chart**

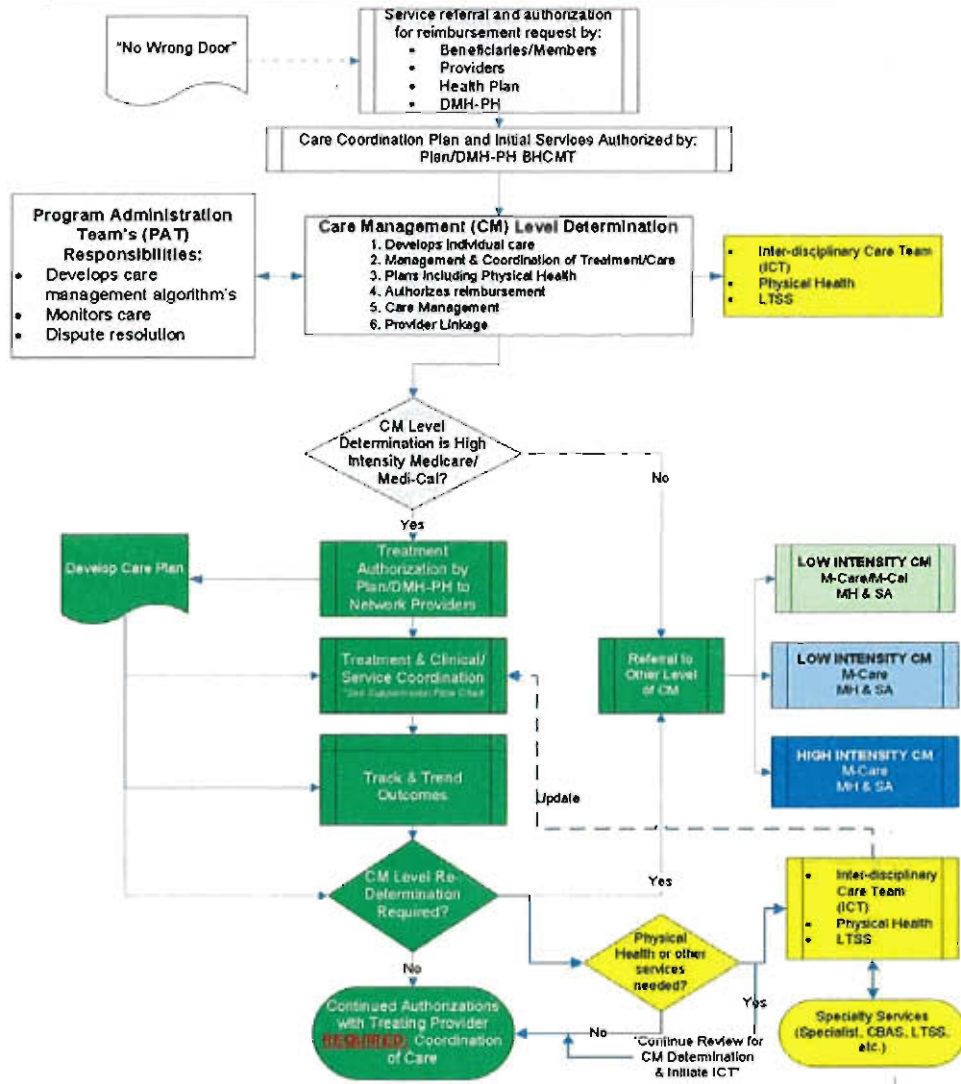
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**DMH & DPH
Authorization & Care Management High Intensity Medicare/Medi-Cal Flow Chart**

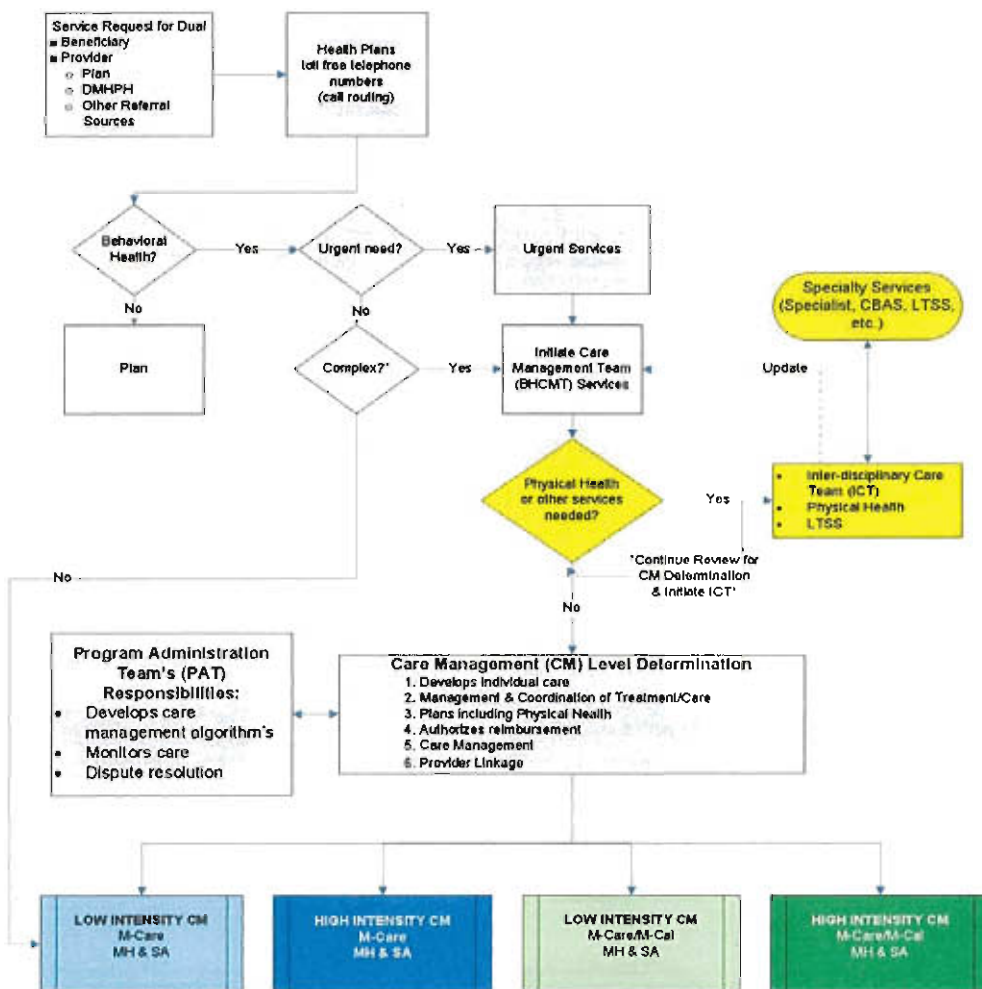
Friday, July 19, 2013



¹ Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
² The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

DMH & DPH Care Management Level Determination Flow Chart

Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

Behavioral Health Benefits in the Cal MediConnect Program

Coverage Responsibility Matrix

Updated February 27, 2013

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be “carved out”). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1+2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California’s 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

To determine medical necessity for Drug Medi-Cal Substance Abuse Services, health plans and counties will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

Coverage Matrix 1: Mental Health Benefits

Inpatient Services			
	Type of Service	Benefit Coverage	Primary financial responsibility under the Demonstration
Psychiatric inpatient care in a general acute hospital	Facility Charge	Medicare <i>Subject to coverage limitations *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Inpatient care in free-standing psychiatric hospitals (16 beds or fewer)	Facility Charge	Medicare <i>Subject to coverage limitations and depends on facility and license type *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Psychiatric health facilities (PHFs) (16 beds or fewer)	Facility Charge <i>(Most are not Medicare certified)</i>	Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
Emergency Department	Facility Charges	Medicare	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Long-Term Care			
Skilled Nursing Facility	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
SNF-STP (fewer than 50% beds)	Facility Charges	Medicare/Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

Institutes for Mental Disease

	Long-term care	Benefit Coverage	Primary financial responsibility under the Demonstration
SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)[§]	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Not covered by Medicare or Medi-Cal+	County
	Facility Charge ages 65 and older	Medi-Cal	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Mental health rehabilitation centers (MHRCs) (IMD)	Facility Charges	Not covered by Medicare or Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Psychiatric health facilities (PHFs) with more than 16 beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	County	County
	Facility Charge ages 65 and older (<i>most are not Medicare certified</i>)	Medi-Cal*	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Free-standing psychiatric hospital with 16 or more beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Medicare*	Health plan
	Facility Charge ages 65 and older	Medicare	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan

* Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his Medicare psychiatric hospital coverage then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters [02-06](#) and [10-02](#).

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

§ Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act

Outpatient Mental Health Services

		Primary Financial Responsibility	
Type of Service	Benefit Coverage	Patient meets criteria for MHP specialty mental health services [^]	Patient does NOT meet criteria for MHP specialty mental health services
Pharmacy	Medicare	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	Medicare	Health Plan	Health Plan
Outpatient services within the scope of primary care	Medicare	Health Plan	Health Plan
Psychiatric testing/ assessment	Medicare	Health Plan	Health Plan
Mental health services [§] <i>(Individual and group therapy, assessment, collateral)</i>	Medicare	Health plan	Health Plan
Mental health services [§] <i>(Rehabilitation and care plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication support services [§] <i>(Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)</i>	Medicare	Health plan	Health Plan
Medication support services [§] <i>(instruction in the use, risks and benefits of and alternatives for medication; and plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day rehabilitation	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis intervention	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis stabilization	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Adult Residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Targeted Case Management	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria

[^] 1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

[§] Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

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

Coverage Matrix 2: Substance Use Disorder Benefit

	Type of Service	Benefit Coverage	Demonstration Responsibility
Inpatient Acute and Acute Psychiatric Hospitals	Detoxification	Medicare	Health Plan
	Treatment of Drug Abuse ¹ (Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90)	Medicare	Health Plan
Outpatient	Alcohol Misuse Counseling: one alcohol misuse screening (SBIRT) per year. Up to four counseling sessions may be covered if positive screening results. <i>Must be delivered in a primary care setting.</i> ²	Medicare	Health Plan
	Group or individual counseling by a qualified clinician	Medicare	Health Plan
	Subacute detoxification in residential addiction program outpatient	Medicare	Health Plan
	Alcohol and/or drug services in intensive outpatient treatment center	Medicare	Health Plan
	Extended Release Naltrexone (vivitrol) treatment	Medicare	Health Plan
	Methadone maintenance therapy	Drug Medi-Cal	County Drug & Alcohol ³
	Day care rehabilitation	Drug Medi-Cal	County Drug & Alcohol
	Outpatient individual and group counseling (<i>coverage limitations</i>) ⁴	Drug Medi-Cal	County Drug & Alcohol
	Perinatal residential services	Drug Medi-Cal	County Drug & Alcohol

¹ Medicare inpatient detoxification and/or rehabilitation for drug substance abuse when it is medically necessary. Coverage is also available for treatment services provided in the hospital outpatient department to patients who, for example, have been discharged for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. [Click here to learn more.](#)

² Medicare coverage explanation: [Click here to learn more.](#)

³ In San Diego and Orange Counties, county alcohol and drug do not provide these services. Providers have direct contracts with the State.

⁴ Title 22, Section 51341.1 limits DMC individual counseling to the intake, crisis intervention, collateral services and treatment and discharge planning.

Exchange of Information, Including PHI, Related to the Beneficiaries in the Cal MediConnect Program.

1. PURPOSE

This Addendum addresses how LMHP and Health Net will share information to coordinate care of Beneficiaries with severe and persistent mental disorders. Individuals with severe and persistent mental disorders have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their mental health service provider functions as their primary connection to the overall healthcare system.

In order to coordinate care for such Beneficiaries, the parties must identify those Beneficiaries who are enrollees of Health Net and clients of LMHP Providers ("Common Members"). This Addendum documents how the parties will share information to (a) identify Common Members in compliance with the requirements of all applicable Federal and State laws and regulations, and (b) provide coordinated care to the Common Members pursuant to the Cal MediConnect Program.

2. DATA MATCHING

Performing a data match to identify Common Members and transmitting the results to the entities providing services to the Common Members helps achieve two important results:

- a) The matched data can help alert healthcare providers to ongoing mental health needs and interventions in Common Members. These mental health needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and mental health providers that can improve the health status and treatment outcomes of those served.
- b) Results of this match would also provide LMHP with information that would allow LMPH Providers to more efficiently and effectively facilitate access to much needed physical healthcare services for Common Members by identifying available primary care resources.

3. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

3.1 To the extent allowed by HIPAA and applicable State and Federal privacy laws, Health Net shall provide to LMHP the data described in Attachment IV-A, Health Net Beneficiary Data Exchange Protocol ("Protocol"). LMHP shall use this data solely to determine whether Beneficiaries are Common Members.

- a) For those Beneficiaries who are determined to be Common Members, LMHP and Health Net shall use the data for the purposes of coordinating care.
 - b) For those Beneficiaries who are determined not to be Common Members, LMHP shall not use the data for any other purposes, and shall return it to Health Net and remove it from all systems where the data was used or stored.
- 3.2 Health Net and LMHP have reviewed the attached Protocol and agree that the data described in the Protocol complies with HIPAA's minimum necessary standard. **[Note to LMHP: HN is still reviewing the Protocol]**
- 3.3 The parties shall comply with the HIPAA Security Rule in transmitting, receiving and maintaining PHI exchanged in accordance with the Protocol.

4. HIPAA OBLIGATIONS OF THE PARTIES

- 4.1 Health Net and LMPH acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.
- 4.2 Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent unpermitted uses or disclosures of such PHI.

5. BUSINESS ASSOCIATE-OBLIGATIONS

- 5.1 The parties acknowledge that for the purposes of conducting the data matching, LMHP shall be acting in the capacity of a Business Associate of Health Net, with respect to the receipt of PHI for Beneficiaries who are not Common Members.
- 5.2 The parties shall enter into a Business Associate Agreement for the data matching requirements.
- 5.3 Upon completion of the data matching, LMHP shall not retain any PHI for Health Net Beneficiaries who are not Common Members. Such PHI shall be destroyed or returned in accordance with the terms of the Business Associate Agreement.

HEALTH NET BENEFICIARY DATA EXCHANGE PROTOCOL

1. Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty mental health care among Common Members. In the event of an inconsistency between this Protocol and Addendum IV, Addendum IV shall govern.

2. Data Exchange - Data Matching

2.1 Demographic Data. LMHP will provide a secured location for Health Net to place a data file of individuals identified as Beneficiaries, initially in the form of a flat text file, on an interval agreed upon by LMHP and Health Net. Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, referred to as the Dual Eligibles 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
- Health Net Internal MHC Member Number **[kp note to HN internal: Does this field apply to HN?]**
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address

2.2 Match Details. Upon receipt of the Dual Eligibles file, LMHP shall load the data to the Department of Mental Health (“DMH”) Enterprise Data Warehouse. LMHP shall maintain a historical table of dual eligible beneficiaries and their respective eligibility information. LMHP shall conduct a match of concomitant Beneficiaries between Health Net and DMH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or “match” like clients of LMHP and Health Net. The match is performed in “tiers” where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to the next algorithm. This

process continues until a positive match is found or the record has been passed through all tier criteria. For example, records that do not mach 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:

- a) Tier 0:
 - Member CIN weighted at 100%
- b) Tier 1:
 - Member Social Security Number weighted at 100%
 - Member Date of Birth weighted at 100%
- c) Tier 2:
 - Member Social Security Number weighted at 85%
 - Member Full Name weighted at 90%
- d) Tier 3:
 - Member Social Security Number weighted at 85%
 - Member Last Name weighted at 85%
- e) Tier 4:
 - Member Social Security Number weighted at 100%
 - Member Year of birth weighted at 100%
- f) Tier 5:
 - Member Full Name weighted at 90%
 - Member Date of Birth weighted at 100%
 - Member Gender weighted at 100%
- g) 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%

3. Data Exchange – Care Coordination

- 3.1 Health Net Usage. Upon completion of the match, LMHP shall extract and provide (as described below), Common Members who currently have an open and active episode in the DMH Integrated System (IS) or successor

DMH electronic health record (EHR) to Health Net in the form of a flat text file. LMHP will, at a minimum, provide the following elements:

- Admission Data 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
- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

The response data file will be placed on a secured server administered and maintained by the LMHP. Health Net will retrieve the file for the purposes of coordinating Common Members care and for no other purpose by distributing the mental health provider contact information to its Primary Care Providers (PCP) for the purposes of coordinating Common Members care 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

Health Net shall not use or disclose the information for any other purpose.

3.2 LMHP Usage. In addition to the demographic data provided pursuant to Section 2.1, Health Net will provide the following data elements for Common Members to LMHP in the form of a flat text file:

- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

After processing the Beneficiary data, LMHP will upload the PCP and other pertinent information for Common Members to the DMH IS or successor DMH EHR. LMHP 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.

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MEMORANDUM OF UNDERSTANDING

By and Between

Health Net Community Solutions, Inc.
and the

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

for

IMPLEMENTATION OF THE

CAL MEDICONNECT PROGRAM

FOR MEDICARE-MEDI-CAL BENEFICIARIES

This Memorandum of Understanding (“MOU”) is made and entered into on the _____ day of _____, 2013 by and between Health Net Community Solutions, Inc., (“Health Net”) and the Los Angeles County Department of Mental Health as the local mental health plan (“LMHP”) in Los Angeles County. For the purpose of providing access to all medically necessary Behavioral Health Services currently covered by Medicare and Medi-Cal to Beneficiaries enrolled in the Cal MediConnect Program.

I. RECITALS

Whereas, California's Coordinated Care Initiative was created through a public process involving stakeholders and health care consumers and enacted through SB 1008 (Chapter 22, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012); and

Whereas, a component of the Coordinated Care Initiative includes a three-year demonstration program which will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a health plan for eligible Medicare and Medi-Cal beneficiaries;

Whereas, Health Net, has been selected by the State Department of Health Care Services (“**DHCS**”) as one of the health plans to administer the Cal MediConnect Program in Los Angeles County; and

Whereas, health plans participating in the Cal MediConnect Program (“**Demonstration Health Plans**”) will provide eligible beneficiaries all mental health and

substance use services, generally collectively referred to as “Behavioral Health Services”, currently covered by Medicare and Medi-Cal; except that county administered Specialty Mental Health Services and county administered Drug Medi-Cal substance use treatment services will not be included in the Demonstration Health Plans' capitation payments from DHCS, and such Specialty Mental Health Services and Drug Medi-Cal substance use treatment services shall continue to be financed and administered by the counties;

Whereas, in Los Angeles County, the agencies that administer Specialty Mental Health Services and Drug Medi-Cal substance use treatment services are, respectively, the Los Angeles County Department of Mental Health as the Local Mental Health Plan (“**LMHP**”) and the Los Angeles County Department of Public Health (“**DPH**”), Substance Abuse Prevention and Control (“**SAPC**”);

Whereas, Demonstration Health Plans and county agencies are required to have written agreements outlining how they will coordinate services;

Whereas, the Coordinated Care Initiative provides State authority for the Cal MediConnect Program, and

Whereas, the DHCS has finalized a Memorandum of Understanding with the Centers for Medicare & Medicaid Services (“**CMS**”) for the Cal MediConnect Program (“**CMS/DHCS MOU**”); and

Whereas, further, the DHCS, CMS and Health Net are finalizing a three-way agreement for the Cal MediConnect Program; and

Whereas, in anticipation of federal approval and the finalizing of all required agreements, Health Net and the LMHP have entered into this MOU for purposes of implementing the Behavioral Health Services portion of the Cal MediConnect Program.

II. PARTIES

Health Net Community Solutions, Inc. (“**Health Net**”), a licensed California health care service plan under the Knox Keene Act, has been selected by the DHCS as one of the health plans to administer the Cal MediConnect Program in Los Angeles County. As a component of the Cal MediConnect Program, Health Net is required to provide physical health services and certain Behavioral Health Services for Beneficiaries, and to coordinate care for the needs of Beneficiaries.

The County of Los Angeles Department of Mental Health (“**DMH**”) is the LMHP responsible for providing medically necessary Specialty Mental Health Services to eligible Medicare and Medi-Cal beneficiaries of Los Angeles County. Under the Cal MediConnect Program, the LMHP will provide Medi-Cal Specialty Mental Health Services for Beneficiaries who meet Medi-Cal medical necessity criteria, and, with Health Net, coordinate Medicare and Medi-Cal services. Drug Medi-Cal substance

use treatment services will be provided by SAPC and documented in a separate memorandum of understanding between Health Net and the SAPC.

III. BACKGROUND

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (**CCI**) to enhance health outcomes and beneficiary satisfaction for beneficiaries of both the Medicare and Medi-Cal programs, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including Los Angeles County, were selected by the State to implement a three-year demonstration project for Medicare and Medi-Cal beneficiaries, referred to as the Cal MediConnect Program. Health Net is one of two local managed care health plans selected by the DHCS and CMS in Los Angeles County to provide health, mental health, substance abuse and Long Term Services and Supports (“**LTSS**”) services to Beneficiaries enrolled in the Cal MediConnect Program (or sometimes referred to herein as the “Demonstration Project”).

Under the Demonstration Project, all Medicare and non-specialty Medi-Cal mental health services are the responsibility of Health Net and included in its capitation payment for the Demonstration Project. Medi-Cal specialty mental health services not covered by Medicare benefits will not be included in Health Net’s capitation payment from DHCS. Health Net and the LMHP will collaborate to ensure Beneficiaries have access to coordinated Medicare and Medi-Cal services. Medi-Cal Specialty Mental Health Services will continue to be provided or arranged for by and the financial responsibility of the LMHP for Beneficiaries that meet Medi-Cal medical necessity criteria.

IV. PURPOSE

This MOU sets forth the Parties’ mutual understandings, commitments, and protocols regarding how Behavioral Health Services funded by Medicare and Medi-Cal will be coordinated and managed by the LMHP and Health Net for Beneficiaries. Among other things, this MOU addresses: 1) the roles and responsibilities of Health Net and the LMHP, 2) how care will be coordinated by and between Health Net and the LMHP, 3) the process for information exchange between Health Net and the LMHP, and 4) shared financial accountability strategies.

V. DEFINITIONS

Behavioral Health Services (or “Behavioral Health”)

Mental Health Services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations and any mental health benefits and substance abuse available under the Medicare Program.

Behavioral Health Care Management Team (“BHCMT”)

Multidisciplinary team that provides care management and care coordination for Medicare and Medi-Cal Behavioral Health Services, and authorization for Medicare services to Beneficiaries enrolled in the Demonstration Project. The BHCMT is composed of representatives from the LMHP, Health Net and/or MHN and SAPC.

Behavioral Health Care Plan

The care plan developed by a Beneficiary and the Beneficiary’s BHCMT that describes the authorized Behavioral Health Services to be provided to the Beneficiary.

Beneficiary

An individual who is eligible for both Medicare and Medi-Cal benefits and who is enrolled in the Cal MediConnect Program and who receives covered services through Health Net.

Care Coordination

The management of physical, LTSS and Behavioral Health Services for Beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

Coordinated Care Initiative (“CCI”)

California’s coordinated care model that intends seamless access to the full continuum of medical, social, LTSS and Behavioral Health Services to Beneficiaries.

Confidentiality of Medical Information Act

A State law, California Civil Code Section 56 et. seq., which governs the confidentiality of medical information, as defined therein; this law specifies when medical information is required and permitted to be disclosed by health care providers and others.

Cal MediConnect Program or Demonstration Project

The three-year CCI demonstration project involving an agreement or agreements between the Demonstration Health Plans, DHCS and CMS for coverage of individuals with eligibility for both Medicare and Medi-Cal.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, Public Law 104-191 and its implementing regulations, including Standards for the Privacy of Individually Identifiable Health Information and the Health Insurance Reform: Security Standards at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), including its implementing regulations, which provide federal protections for individually identifiable health information held by covered entities, as defined therein.

Interdisciplinary Care Team (ICT)

A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of Beneficiaries. The ICT also includes a representative from the BHCMT.

Local Mental Health Plan (“LMHP”)

The Los Angeles County Department of Mental Health which is the local county agency that has responsibility for administering public and Specialty Mental Health Services.

Local Mental Health Plan Providers

Specialty Mental Health Providers who deliver mental health services through the LMHP.

Long Term Services and Supports (“LTSS”)

Those services and supports described in Welfare and Institutions Code Section 141861, subdivision (b).

Medi-Cal

California's Medicaid health care program of medical assistance benefits under Title XIX of the Social Security Act.

Medicare

Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (“ESRD”) or Amyotrophic Lateral Sclerosis (“ALS”).

Managed Health Network, Inc., (“MHN”)

Managed Health Network, Inc., together with its subsidiaries, is the behavioral healthcare affiliate of Health Net that assists Health Net in meeting the behavioral and care coordination needs of certain Beneficiaries covered through the Demonstration Project.

Primary Care Provider (“PCP”)

A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary through the Cal MediConnect Program.

Program Administration Team (“PAT”)

A team composed of staff from the MHN and/or Health Net, LMHP, and SAPC that provides program oversight of the BHCMT.

Protected Health Information (“PHI”)

Individually identifiable health information as defined by 45 C.F.R. Section 160.103.

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Specialty Mental Health Services

Services provided through the LMHP as defined by Title 9, California Code of Regulations (CCR) Section 1810.247 and in accordance with Chapter 11 of Title 9.

State Department of Health Care Services (DHCS)

The State department that has responsibility for administering health care services funded Medi-Cal.

Welfare and Institutions Code Section 5328 et. seq.

The State laws governing the confidentiality of information and records of the LMHP and LMHP Providers; this law specifies that all information and records received in the course or providing services are confidential and specifies when such information is required or permitted to be disclosed.

VI. APPLICABLE DOCUMENTS

Addenda I, II, III, and IV are attached to and form a part of this MOU. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or contents or description of task or responsibility between the MOU and the addendum, or between addenda, such conflict or inconsistency shall be resolved in a manner that advances the purpose and intent of this MOU. Addenda to this Agreement are as follows:

Addendum I

Cal Medi-Connect Coordination of Care Policy and Procedures [Behavioral Health] Policy and Procedure. This Policy sets forth the coordination of care procedures that the Parties and their applicable related entities will follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum II

DMH and DPH Authorization and Care Management Flow Charts. Addendum II sets forth the process flows and guidelines that the Parties and their applicable related entities in the Demonstration Project agree to follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum III

Mental Health Benefits in the Duals Demonstration Matrix. Addendum III sets forth a listing of the Behavioral Health Services to be provided to Beneficiaries and the Party that will have financial responsibility for provision of that Service as defined by DHCS for the Demonstration Project.

Addendum IV

Exchange of Information Related to the Cal MediConnect Program Beneficiaries.

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VII. ROLES AND RESPONSIBILITIES

Health Net has primary administrative and program responsibility for care management, care coordination and authorization for reimbursement for Behavioral Health Services covered by Medicare under the Demonstration Project.

A. Behavioral Health Services Administrative Arrangements

Health Net and its affiliate MHN will be providing the Behavioral Health Services and care coordination needs of certain Beneficiaries as required under the Demonstration Project.

Health Net and/or MHN shall:

1. Develop and contract a Behavioral Health Services provider network that includes, but is not limited to, the LMHP and LMHP Providers.
2. Lead and be the focal point for all Behavioral Health Services coordination activities between Health Net, MHN, LMHP and SAPC
3. Lead and/or participate in the BHCMT.
4. Process Medicare Behavioral Health Services claims payment to Behavioral Health Services network providers which include, but are not limited to, LMHP Providers.

B. Care Management Teams

To ensure that Medicare and Medi-Cal Behavioral Health Services are coordinated into a seamless system of care, Health Net, LMHP and SAPC, shall establish three interagency care management teams for Behavioral Health composed of, but not limited to, representatives from each of the entities.

The interagency care management teams are responsible, as described below, for ensuring that health, mental health, substance abuse and LTSS services are easily accessible and coordinated for Beneficiaries.

1. Program Administration Team ("PAT") has the following shared responsibilities:
 - Develop algorithms, and policies and procedures to assist the BHCMT in its day to day operations.
 - Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 - Conduct program evaluation.
 - Resolve disputes between Health Net and the LMHP.
 - Identify and resolve provider relations issues.

2. Behavioral Health Care Management Team (“BHCMT”) led by Health Net and/or MHN has the following shared responsibilities:
 - Authorize covered Behavioral Health Services based upon algorithms developed by PAT. Develop individual Behavioral Health Care Plans.
 - Coordinate care between physical health, Behavioral Health and substance abuse providers.
 - Monitor individual clinical progress.
 - Reassess individual service needs.
 - Refer and link to appropriate services.
 - Serve as the liaison to the Interdisciplinary Care Team for Beneficiaries that also need non Behavioral Health Services.
 - Resolve disputes between Health Net and LMHP.

3. Interdisciplinary Care Team (“ICT”) Health Net is responsible for facilitating ICTs to provide care management services to Beneficiaries, that present with complex and multiple health, mental health, substance abuse conditions and may also need LTSS. The ICT will include, but is not limited to, health care staff, BHCMT, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate and as permitted by law.

For further guidance regarding the role of and processes applicable to the Care Management Teams refer to Addendums I and II to this MOU.

C. Referrals and Criteria

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care for purposes of referring Beneficiaries for Behavioral Health Services, Health Net, LMHP, and SAPC agree to the following protocols, as further described in Addenda I, II and III to this MOU.

1. Referral Process for Behavioral Health Services
 - 1.1 The Cal MediConnect Program shall have a “no wrong door” approach to service access, with multiple entry paths for Beneficiaries to access Behavioral Health Services. Referrals may come from various sources including, but not limited to, Beneficiary self-referrals.
 - 1.2 All incoming referrals or requests for Behavioral Health Services shall be screened and triaged according to procedures established by the BHCMT to determine Behavioral Health need, and to refer and link Beneficiaries to a Behavioral Health

provider and/or to SAPC for substance use disorders treatment and recovery services.

2. Referral Process for non-Behavioral Health Services

2.1 The LMHP shall identify Beneficiaries that need physical health care services and refer these Beneficiaries to the BHCMT in the manner described in Addendum I and Addendum II attached to this MOU.

3. Determination of LMHP Service Criteria

3.1. The criteria for provision of Specialty Mental Health Services are set forth in 9 CCR Sections 1820.205, 1830.205, 1830.210. Criteria for Medi-Cal Specialty Mental Health Services include, but are not limited to:

- One or more of the disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, currently used by DHCS to determine Medi-Cal medical necessity, excepting those disorders specifically excluded by regulation.
- Specific impairments as a result of the mental disorder or probability of deterioration of an important area[s] of life functioning.
- Services that 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.

4. Determination of Medicare Non-Specialty Mental Health Service Criteria

4.1. Health Net shall provide directly or through MHN Behavioral Health Services to Beneficiaries as listed in Addendum III.

4.2. Description of Covered Medi-Cal Specialty Mental Health Services are included in Addendum III.

D. Credentialing

The LMHP has a large network of licensed providers both directly employed by the LMHP or contracted with the LMHP that deliver clinical services at LMHP operated or LMPH contracted provider treatment sites. Credentialing of licensed providers in the LMHP network, if necessary, must be consistent with DMH civil service rules and with the requirements of the relevant accrediting

and regulatory entities that govern and review Health Net's credentialing processes and policies. In the event that the the LMHP providers are required to be credentialed, the following terms apply:

1. Upon determination by Health Net and/or MHN that LMHP's credentialing process meets the required standards, Health Net agrees to delegate to the LMHP the credentialing of those LMHP providers who are directly employed by the LMHP for purposes of becoming Medicare-reimbursable providers in the Cal MediConnect Program.
2. Health Net and/or Health Net through MHN are responsible for contracting and credentialing those providers contracted with the LMHP (i.e., those who are not directly employed by the LMHP), who are Medicare reimbursable, for the purposes of becoming Medicare-reimbursable providers in the Cal MediConnect Program.

All contracted providers in the LMHP network shall be eligible to participate in the credentialing process.

3. The standards for the credentialing of providers shall satisfy the requirements of Health Net, CMS, National Committee on Quality Assurance ("NCQA"), URAC and other applicable regulatory entities or requirements and the three-way agreement to be entered into by and among CMS, the State and Health Net. All LMHP providers must meet the Medicare credentialing requirements and standards to be eligible for reimbursement for Medicare services provided pursuant to the Cal MediConnect Program.
4. As part of any delegation of credentialing to the LMHP, Health Net may perform periodic oversight audits to ensure that the required standards are met on an ongoing basis. Any such audits shall, except as otherwise necessary to satisfy the requirements of CMS, DHCS, DMHC, NCQA, URAC and other applicable regulatory entities, and the three-way agreement to be entered into by and among CMS, the State and Health Net, be conducted in a manner consistent with rules applicable to Los Angeles County employment, which rules shall be communicated by the LMHP to Health Net. Any information obtained from LMPH in conducting such audits shall be considered confidential and shall, except as otherwise required by CMS, NCQA, URAC, or other applicable regulatory entity, not be disclosed by Health Net. Nothing in this section shall be construed to prevent Health Net from disclosing any document if such disclosure is required by law, or by an order issued by a court of competent jurisdiction.

5. Providers and provider sites must be dually credentialed in both LMHP's, Health Net's and MHN's networks at all times in order to provide Medi-Cal reimbursable service to Beneficiaries.
6. Any failure of a provider or provider site to meet the applicable credentialing standards and requirements as determined by Health Net, MHN or LMHP will automatically result in removal of that provider or provider site as a credentialed provider of Behavioral Health Services to Beneficiaries pursuant to the terms and conditions contained in the applicable provider agreement between the parties.
7. Health Net and LMHP will notify each other promptly of any changes in provider or provider site network credentialing status or compliance.

E. Financial Responsibility: Reimbursement Process for Medicare Behavioral Health Services Provided by LMHP Providers

1. Primary financial responsibility of and between the parties for Behavioral Health Services for the Demonstration Project are based on the matrix provided by DHCS as set forth in Addendum III, attached hereto. Further provisions and processes for reimbursement of Behavioral Health Services shall be specified in a separate provider agreement between LMHP and Health Net and/or MHN.

For further information regarding financial responsibility and processes for the provision of Behavioral Health Services to Beneficiaries covered by Medicare, refer to the Addenda attached to this MOU.

F. Beneficiary and Provider Education

1. Health Net will develop, in collaboration with the LMHP, education materials that explain the Behavioral Health and substance abuse components of the Demonstration Project.
2. LMPH will provide Health Net staff with training on LMHP programs, eligibility and assessment criteria, services available, and how to review and understand data made available for coordination of care to Health Net and/or MHN. . Initial trainings will be provided prior to implementation of the Demonstration Project, and on an as-needed basis, but not less than annually.
3. Health Net will provide LMPH staff with opportunities for training on Health Net benefits and procedures. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative, and on an as-needed basis, but not less than annually.

4. The LMHP will train its providers on procedures for filing claims and reimbursement of Medicare services, care coordination and care management requirements established by Health Net.
5. Health Net will train its providers on procedures for Behavioral Health care coordination, care management requirements, referral processes, claims and reimbursement issues.
6. Health Net will develop, in collaboration with the LMHP, a provider manual that addresses the Behavioral Health and substance abuse components of the Demonstration project.
7. Health Net and the LMHP will provide information and education about the Demonstration Project to potential eligible enrollees, their family members, caregivers and to Beneficiaries enrolled in the Demonstration Project to assist them with making informed decisions related to their health care needs.

G. Dispute Resolution Related to Reimbursement for Services

1. First Level Disputes: All disputes “First Level Disputes” shall be submitted to the BHCMT for resolution. First Level Disputes may include, but are not limited to, disagreements regarding authorization for or reimbursement of Medicare and or Medi-Cal services.
2. Second Level Disputes: If the BHCMT cannot resolve a First Level Dispute to the satisfaction of either or both parties, the dispute shall be submitted to the PAT within mutually agreed upon timeframes. The PAT shall inform the BHCMT of its decision (“Second Level Disputes”).
3. Third Level Disputes: If the PAT cannot resolve a Second Level Dispute to the satisfaction of either or both parties, the dispute shall be addressed by executive management from the LMHP and Health Net. The executive management shall review the dispute and inform the PAT of its decision (“Third Level Disputes”).
4. If resolution cannot be reached at the executive management level within agreed upon timeframes, Health Net and LMHP agree to follow the resolution of dispute process in accordance with 9 CCR Sections 1810.370, 1850.505 and 1850.525, and the three way contract between Health Net and DHCS and CMS, as such contract is described in the DHCS/CMS MOU.

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H. Dispute Resolution Related to Provider Relations

1. First Level Disputes: Disputes between Health Net and the LMHP regarding provider relations and contracting shall be submitted to the PAT.
2. Second Level Disputes: If satisfactory resolution of a dispute cannot be reached by the PAT, the dispute shall be addressed and resolved by the executive management staff from Health Net and the LMHP.

VIII. COORDINATION OF CARE

A. Point of Contact for Clinical Issues

1. Health Net contact staff is the Senior Director of Health Services. MHN shall designate a contact staff.
2. The LMHP contact staff is the Medical Director.
3. SAPC contact staff is the designated Program Director.

B. Care Coordination Activities

1. Health Net shall conduct a Health Risk Assessment as required by the Demonstration Project that includes Behavioral Health screenings for all Beneficiaries enrolled with Health Net in the Demonstration Project. Health Net will refer Beneficiaries with specific mental health and substance abuse findings from the screenings to the PCP for potential linkage to a mental health provider and/or substance abuse provider.
2. The ICT or member thereof shall refer Beneficiaries to the BHCMT if the PCP or the Beneficiary believes that mental health services beyond the scope of practice of the PCP are required.
3. The PCP, LMHP provider, Beneficiary and the BHCMT shall collaboratively develop a Behavioral Health Care Plan for the Beneficiary
4. As permitted by HIPAA and applicable privacy laws, the LMHP provider and PCP shall share PHI as needed for the purpose of care coordination in accordance with Addendum IV.
5. LMHP providers shall submit written documentation that contains treatment coordination information to the beneficiary's PCP in accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws.

6. Health Net's PCP shall submit written documentation that contains treatment coordination information to the Beneficiary's mental health provider in accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws.
7. Health Net shall establish a process for reviewing and updating Behavioral Health Care Plans as clinically indicated, such as following a hospitalization, a significant change in health or well-being, in level of care, or a request for change of provider, and for coordinating with the LMHP Provider when necessary.
8. The LMHP, Health Net and SAPC providers may participate in case conferencing and conduct regular meetings to review the care coordination process.
9. Health Net shall coordinate with the LMHP and SAPC to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
10. Health Net shall develop procedures and coordinate direct transfers between inpatient psychiatric services and inpatient medical services and involve the BHCMT for the purpose of care management and care coordination.

C. Case Consultation

In accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws, the LMHP and Health Net shall establish processes that facilitate consultation and coordination of psychiatric and medical treatment and care plans.

1. The LMHP providers may provide information, education, and consultation to Health Net PCPs regarding Behavioral Health related issues to improve coordination of care and care management.
2. Health Net PCPs may provide information, education, and consultation to LMHP providers on medical issues to improve coordination of care and care management.
3. Consultation between Health Net. PCPs and LMHP providers may be facilitated by various means including, but not limited to:
 - Direct consultation
 - Telephonic consultation

- E-mail consultation
- Telepsychiatry/Telemedicine

- Facilitated case conference by BHCMT or ICT concerning care management planning

IX. EXCHANGE OF INFORMATION

- 9.1. 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 as specified under HIPAA. The disclosure of data, including without limitation PHI, from Health Net and/or MHN to LMHP, is for the purposes of Health Net's payment/health care operations and/or the LMHP's treatment, payment or health care operations in their capacity as Covered Entities and/or, to the extent applicable, in their capacity as Health Oversight Agencies (as such capitalized terms are defined in HIPAA).
- 9.2. Each party acknowledges that it may have additional obligations under other State or federal laws that may impose on that party additional restrictions with respect 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 C.F.R. Part 2.
- 9.3. Each party acknowledges that it will comply with consent 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.
- 9.4. Addendum IV sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information, to ensure coordination of physical health, mental health, and substance abuse services.

X. SHARED FINANCIAL ACCOUNTABILITY STRATEGIES

The LMHP, Health Net and SAPC (pursuant to a separate memorandum of understanding entered into with SAPC) agree to comply with the Shared Accountability Performance Metrics and requirements, as specified in the DHCS/CMS MOU and the three-way contract between CMS, DHCS, and Health Net. The goal of Shared Accountability Performance Metrics is to develop

coordination strategies to reduce inappropriate cost shifting between Medicare and Medi-Cal Specialty Mental Health Services and develop a formal financial arrangement strategy for shared cost savings. The strategies build on the performance-based withhold in the capitation rates of 1%, 2% and 3% respectively for years one, two and three of the Cal MediConnect Program. If the specified shared accountability measures are achieved, Health Net shall provide an incentive payment to LMHP and SAPC under mutually agreeable terms and pay a percentage of the recovered funds attributed to that measure to LMHP and SAPC. This payment shall be structured in a way that does not offset Los Angeles County's Certified Public Expenditure (CPE).

Health Net and the LMHP, and Health Net and SAPC agree to modify and update their respective MOUs to incorporate the Behavioral Health Shared Accountability Standards in accordance with the three-way contract by and among, CMS, DHCS and Health Net upon finalization of the three-way contract.

XI. INDEMNIFICATION

Health Net and the LMHP 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 damage whatsoever, including but not limited to death or injury to any person and damage to 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 VIII shall survive termination of this MOU.

XII. 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 sufficient for liabilities which may arise from or relate to this MOU.

XIII. TERM

This MOU is effective _____2013, ("Effective Date") and, unless terminated earlier as provided herein, shall continue in effect so long as necessary to implement the Cal MediConnect Program or for three years from the Effective Date, whichever date is earlier. The term of this MOU may be extended by the parties upon their mutual written agreement.

XIV. 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 effective March 27, 2013; (ii) termination of the three way agreement by and among Health Net, 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

XV. MISCELLANEOUS TERMS

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

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

15.3 Interpretation: Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the requirements of the Cal MediConnect Program.

15.4 Supervening Circumstances. Neither Health Net nor LMHP 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) any 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.

15.5 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 the Cal MediConnect Program shall not require the consent of LMHP and/or SAPC or Health Net and shall be effective immediately on the effective date of the requirement.

15.6 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 party which consent shall not be unreasonably withheld.

15.7 Confidentiality. Health Net and LMHP agree to hold Beneficiary health information and records in accordance with HIPAA and applicable privacy laws. The parties acknowledge that LMHP is governed by the Public Records Act, Government Code Section 6520 et seq (the "PRA"). Pursuant to the PRA, documents provided to LMHP may be deemed "public records" as that term is defined in the PRA and, subject to the exceptions set forth therein, may be subject to public disclosure. Consistent with the provisions of the PRA, LMHP shall not disclose documents provided by Health Net which are excepted from the disclosure requirements of the PRA and which are clearly marked or otherwise identified as confidential by Health Net, including, without limitation, the exceptions applicable to corporate financial records and proprietary information including trade secrets. In the event LMHP is required to defend an action on a PRA request for any document provided by Health Net to LMHP in connection with the subject matter of this Agreement, Health Net agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in any action or liability arising from the defense of such action. Nothing in this section shall be construed to prevent LMHP from disclosing any document if such disclosure is required by law, or by an order issued by a court of competent jurisdiction .

15.8 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 govern.

15.9 Notice. Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Section 15.9 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

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

With a copy to:

Health Net, Inc.
21650 Oxnard Street
Woodland Hills, CA 91367
Attn: General Counsel

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Los Angeles County Department of Mental Health
550 South Vermont 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.

- 15.10 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.
- 15.11 Waiver of Obligations.** The waiver of any obligation 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.
- 15.12 Status as Independent Entities.** None of the provisions of this MOU is intended to create, nor shall be deemed or construed to create any relationship between Health Net and LMHP other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this MOU. Neither Health Net nor LMHP, nor any of their respective agents, employees or representatives, shall be construed to be the agent, employee or representative of the other.
- 15.13 Entire Agreement.** This MOU represents 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.
- 15.14 Counterparts.** This MOU may be executed in counterparts and by facsimile 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 executed this MOU on the date first written.

Health Net Community Solutions, Inc.

By _____

Name:

Title:

Date: _____

Los Angeles County, Department of Mental Health

By _____

Marvin J. Southard, D.S.W.

Director

Date: _____



National Policy Library Document

Policy Name: BEHAVIORAL HEALTH; CAL
MEDI-CONNECT COORDINATION
OF CARE "NO WRONG
DOOR" [LA COUNTY] Policy No.: LR710-122235

Policy Author: Rogelio Lopez Author Title: Public Programs Adminstratr Sr Author Department: 4001-Medi-Cal Public Health 1
Functional Owner: Janice F Milligan Executive Owner: David J Friedman

This Policy is applicable to the following:

Department(s): Public Health Coordination

Business Unit(s): HNCA

Products/LOB's: Dual Eligible

Date Created in NPL:	Date Last Reviewed :	Date Approved:	Version:
07/10/2013	07/15/2013	07/15/2013	1

Policy Statement:

Health Net is responsible for providing beneficiaries seamless access to all medically necessary behavioral health services (mental health and substance use disorder treatment) currently covered by Medicare and Medicaid. Health Net will coordinate with county agencies to ensure enrollees have seamless access to these services. Health Net will ensure coordination of behavioral health with medical care and long-term services and supports.

Policy Purpose:

The purpose of this policy is to describe the coordination of care for assisting members in need of services under the Health Net Cal Medi-Connect program.

Scope/Limitations:

This policy and related procedures apply to all individuals employed, contracted, or otherwise representing Health Net and its subsidiaries who are responsible for providing coordination of care services for members under the Health Net Cal Medi-Connect program.

References:

- California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
- Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
- Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Members, D. Mental Health Services
- MMCD Policy letter 00-01

- E. Title 9, CCR, Chapter 11, Division 1, Section(s): 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205(b)(1); 1830.210; 1850.210(I); 1850.505
- F. Title 22, CCR, Chapter 3, Article 4, Section(s) 51305; 51311; 51313; 51183
- G. Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (I) and the State of California Alcohol and/or Other Drug Program Certification Standards
- H. Welfare and Institutions Code Section 5600.3; and 14016.5
- I. Health Net Model of Care 2013
- J. Memorandum of Understanding Between Health Net and L.A. County Department of Mental Health
- K. Authorization and Care Management Flow Chart "No Wrong Door" February 27, 2013

Definitions:

Addiction is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving. (Authority – Substance Abuse and Mental Health Services Administration, A Treatment Improvement Protocol 54 and the American Society of Addiction Medicine)

BH means Behavioral Health which includes Mental Health and Substance Use Disorder Services

BHCMT means Behavioral Health Care Management Team.

Behavioral Health Care Management Team (BHCMT) Multidisciplinary team that provides care management, care coordination and authorization for reimbursement of Medicare services to beneficiaries enrolled in the Dual Demonstration project. The team is composed of representatives from the Local Mental Health Plan, Health Plans, and the Department of Public Health

Behavioral Health Care Plan The care plan developed by a beneficiary and the beneficiary's Behavioral Health Care Management Team that describes the authorized services to the beneficiary.

BHP means Behavioral Health Providers

Care Coordination The management of services for beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

DMH means County Department of Mental Health.

DPH means County Department of Public Health

Health Plan "The Plan" or "Plan" refers to Health Net

Interdisciplinary Care Team (ICT) A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services for beneficiaries.

LMHP Los Angeles County Department of Mental Health (DMH) which is the local county agency that has responsibility for administering public mental health services.

Managed Health Network means Health Net's Behavioral Health subsidiary.

Primary Care means a basic level of health care usually rendered in ambulatory setting by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. Primary care emphasizes caring for the member's general health needs as opposed to specialist focusing on specific needs. This means providing care for the majority of health care problems, including, but not limited to, preventive services acute and chronic conditions, and psychosocial issues.

Primary Care Provider (PCP) means a person responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

Program Administration Team (PAT) A team composed of staff from the Health Plan, DMH, and SAPC that provides program oversight of the Behavioral Health Care Management Team.

Specialty Mental Health Service means: Medi-Cal specialty mental health services and health plans and counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. These criteria can be summarized as the following:

Diagnosis – one or more of the specified Medi-Cal included diagnosis and Statistical Manual of Mental Disorders;

Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won't progress appropriately;

Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment

Specialty Substance Use Disorder Treatment Services are outpatient, residential, prevention, recovery, and support services which are made available to persons with substance use disorders. Services are directed towards alleviating and/or preventing substance use among individuals. Types of services, as described in Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards, include assessment, screening, evaluation, crisis intervention, individual, group, family counseling, collateral, vocational, detoxification, medication assisted treatment services, aftercare, and education services on tuberculosis and sexually transmitted diseases.

Specialty Substance Use Disorder Treatment Services Provider means an entity / organization contracted with Los Angeles County, Department of Public Health Substance Abuse Prevention and Control and is certified or licensed to provide specialty substance use disorder treatment services. Individuals providing counseling services must be registered, certified or licensed in accordance with the California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000.

Subcontracted Plan means a health maintenance organization or any other health care service plan licensed under the Knox-Keene Act which has entered into a service agreement with Health Net to provide or arrange for health care services to Medi-Cal members, and to perform the other duties and responsibilities as set forth in such Plan Partner's Services Agreement.

Policy/Procedure:

The Demonstration project has a "no wrong door" approach to service access. There will be multiple entry paths for beneficiaries to access behavioral health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling Health Net's and/or Managed Health Network's (MHN) Behavioral Health toll free number that will be available 24 hours, 7 days a week for service authorization and referral. Sources of referrals will also be educated on expeditiously referring behavioral health cases to MHN's Behavioral Health toll free number.

Calls will be screened and triaged to establish eligibility and determine BH needs and refer and link

beneficiaries to BH providers. The assessments will be conducted using guidelines developed by the Program Administration Team (PAT).

1. If the member does not require BH services, he/she is referred to the health plans member services department.
2. If the member does require BH services appropriate authorization and referral will be given.
3. In cases of Crisis, the caller will be appropriately directed to emergency services.

Beneficiaries that are enrolled in the Demonstration project may walk in or present to a BH provider (self refer) without an appointment to obtain services. The BH provider will not be required to secure authorization from the BHCMT prior to rendering reimbursable services. Services will be reviewed retroactively for authorization and claims payment. However, members that are receiving inpatient services will need prior authorization

Initially, the BHCMT will determine if the member is in need of emergent, urgent or routine Behavioral Health Services. Beneficiaries experiencing a BH crisis will be immediately referred to emergency services including psychiatric hospitals.

An emergency (behavioral health) is defined as an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition including symptoms of intoxication or withdrawal .

Emergency behavioral health services will be provided in accordance with the symptoms listed above. The use of 911 services will be incorporated as necessary. If the member is in need of non-urgent BH or additional services, the BHCMT will determine the members' Care Management level based on guidelines developed by PAT. In all cases, coverage under Medicare is primary.

Care Management

Care Management level determination includes the following: (Refer to Attachment 1 "Flow charts")

1. **Low Intensity CM Medicare:** These services include but may not be limited to the following services, as covered by Medicare:

- a. Outpatient services within the scope of primary care which may be completed by behavioral health physician
- b. Outpatient Psychiatric services such as medication management, assessment, individual and group therapy delivered by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office, clinic, or hospital outpatient department.
- c. Psychological / Psychiatric testing / assessment
- d. Institutions for Mental Diseases (Mental Health Rehab Center or Skilled Nursing Facility)

2. **High Intensity CM Medicare:** These services include but may not be limited to the following services as covered by Medicare

- a. Psychiatric Inpatient Hospital services for acute conditions
- b. Partial hospitalization / Intensive Outpatient services
- c. Substance Use Disorder (SUD) detox

3. **Low Intensity CM Medi-Cal/Medicare:**

- a. Mental health services (individual and group therapy, assessment, collateral, plan development)
- b. Medication support services (prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications, including the evaluation of need, clinical effectiveness and side effects; obtaining informed consent; education; collateral and plan development)
- c. Day rehabilitation
- d. Methadone Clinic
- e. Targeted Case Management

4. High Intensity CM Medi-Cal/Medicare:

- a. Intensive Day treatment
- b. Crisis intervention
- c. Psychiatric Emergency Services
- d. Crisis stabilization
- e. Adult Residential Treatment Services

Beneficiaries that do not meet criteria for specialty mental health services will be referred and linked back to HN / MHN provider network by the BHCMT.

Referral Process for non BH Care Services

1. Beneficiaries with co occurring medical conditions or with need for other ancillary or medical services may be referred by the BHCMT to the ICT that is developed by the Health Plan for coordinating all care requirements of the beneficiary.
2. Any BHP may identify behavioral health beneficiaries that need physical health care services and refer the beneficiaries to the BHCMT care manager.
3. Health Net's BHCMT care manager will identify the Primary Care Physician (PCP) assigned to the beneficiary and refer and link the beneficiary to the PCP for health care services as needed.

Structural Considerations for BH Care Coordination:**Care Management Teams**

- Program Administration Team (PAT) will have the following shared responsibilities:
 1. Develop guidelines and policies and procedures to assist the Behavioral Health Care Management Team in its day to day operations.
 2. Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 3. Program evaluation.
 4. Resolve disputes between Health Net and the LMHP.
 5. Identify and resolve issues between Health Net & DMH / DPH provider relations.
- Behavioral Health Care Management Team (BHCMT) will have the following shared responsibilities:
 1. Authorize reimbursement based upon developed guidelines by PAT.
 2. Develop a behavioral health care plan.
 3. Coordinate care between physical health, mental health, substance abuse and LTSS providers through the ICT.
 4. Monitor clinical progress.
 5. Reassess service needs.
 6. Refer and link to appropriate services.
 7. Serve as the liaison to the ICT as needed.

ICT will be facilitated by Health Net / MHN to provide needed care management services to all beneficiaries. The team will include health care staff, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate. The LMHP will provide consultation to the team and ensure mental health needs are addressed.

Care Coordination:**Care Coordination Activities**

1. Health Net and or it's subcontracted plans will conduct a Health Risk Assessment that also includes BH screenings for all beneficiaries enrolled in the Demonstration. Health Net / MHN beneficiaries with specific mental health and substance abuse findings from the screening to a Behavioral Health Provider or PCP for linkage to a mental health provider and/or substance use disorder provider.
2. Health Net's PCP may refer beneficiaries through the toll free BH number to the BHCMT if services required are outside the scope of the PCP or if the beneficiary request services from mental health or

DPH.

3. The BHP and or LMHP provider, beneficiary and the BHCMT will work closely together to develop an individual care plan.
4. If needed DPH provider will secure a signed consent from the beneficiary to share PHI with the BH and or LMHP and the PCP for the purpose of care coordination.
5. BHP and or LMHP providers will submit written documentation that contains treatment coordination information to the BHCMT and beneficiary's primary care physician within 30 days from the initial mental health visit, annually, and when there are significant changes in diagnosis, medications or other aspects of care plans.
6. Health Net PCP will submit written documentation that contains treatment coordination information to the beneficiary's mental health provider within 30 days after the initial primary care visit, annually, and when there are significant changes in diagnosis, medications or other aspects of the care plans.
7. Health Net will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with the BHP and or LMHP provider when necessary.
8. The BHP and or LMHP, Health Net and DPH providers may participate in case conferencing as needed and conduct regular meetings to review the care coordination process.
9. Health Net's BHCMT will coordinate with the BHP and or LMHP and DPH to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
10. Health Net will develop procedures and coordinate direct transfers between psychiatric inpatient hospitals and inpatient medical hospital services and involve the BHCMT for purpose of care management and care coordination.

Exchange of information

Successful Care Coordination is accomplished through exchange of information between providers and entities involved in the care for beneficiaries enrolled in the program. Refer to Policy and Procedure for details on Exchange of Information.

Disclaimer:

Deviations:

Approvers:

Policy Author: Rogelio Lopez - Approved on 07/15/2013

Functional Owner: Janice F Milligan - Approved on 07/15/2013

Executive Owner: David J Friedman - Approved on 07/15/2013

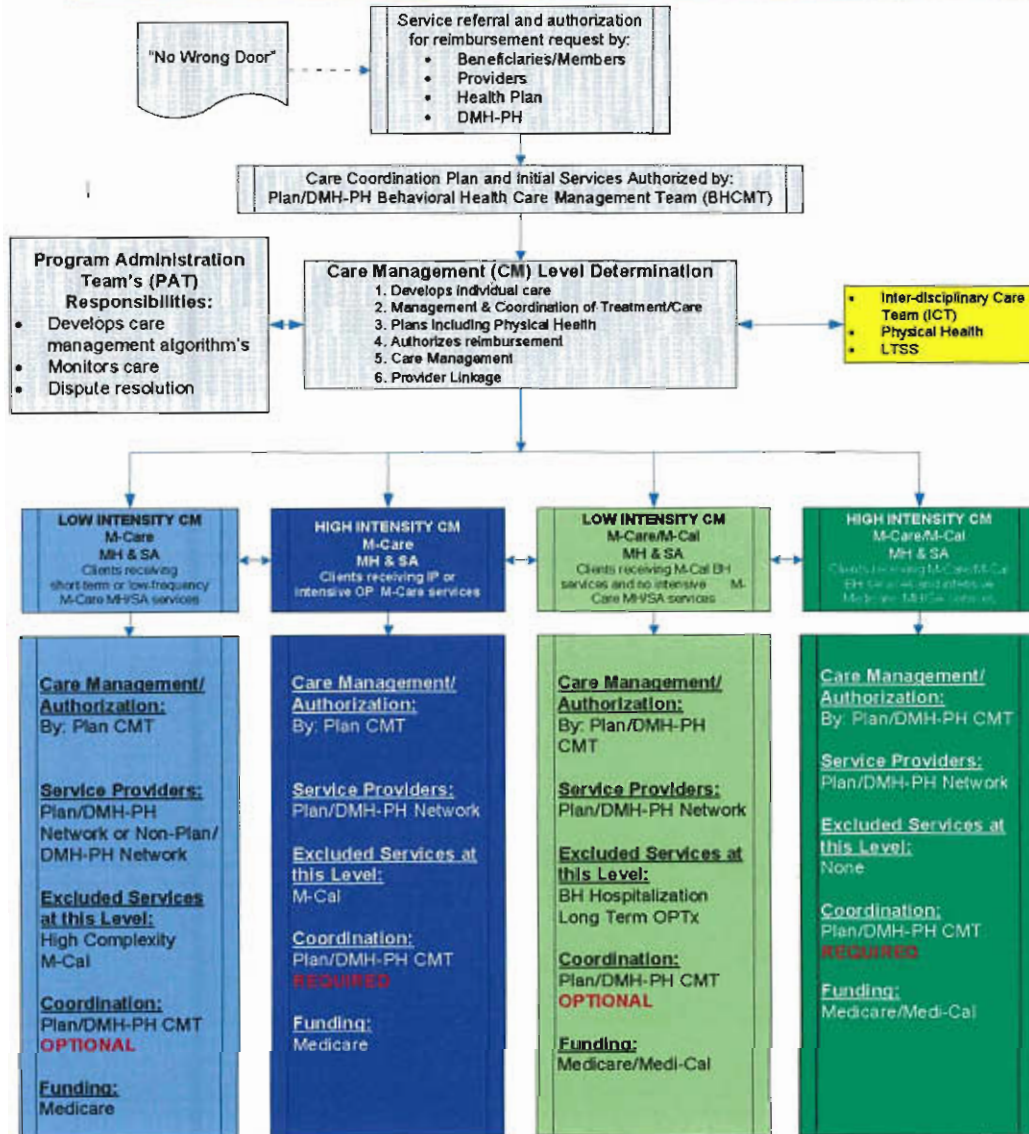
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DMH & DPH

Proposed Authorization and Care Management Flow Chart

Addendum II

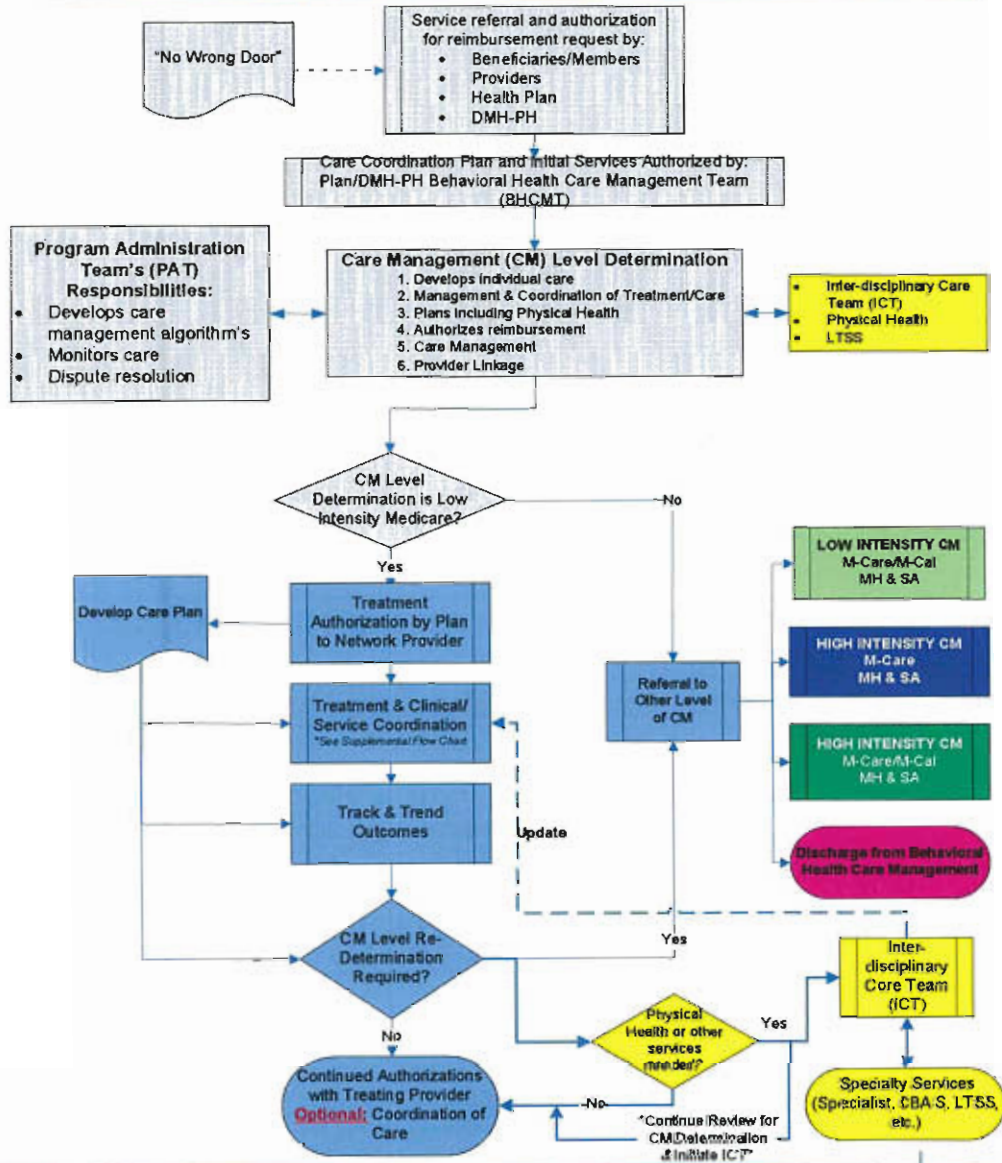
Friday, July 19, 2013



* The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

DMH & DPH Authorization & Care Management Low Intensity Medicare Flow Chart

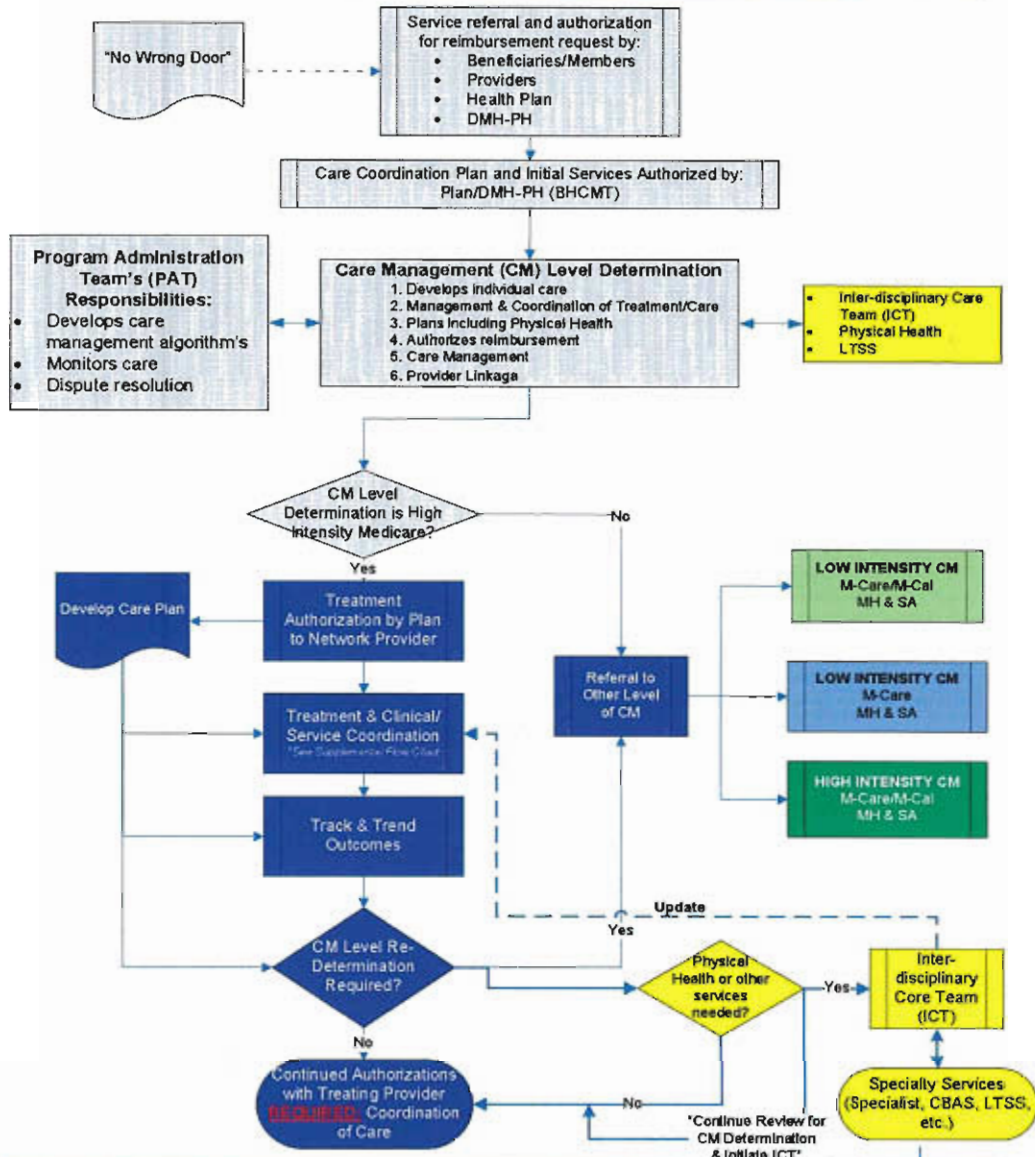
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

**DMH & DPH
Authorization & Care Management High Intensity Medicare Flow Chart**

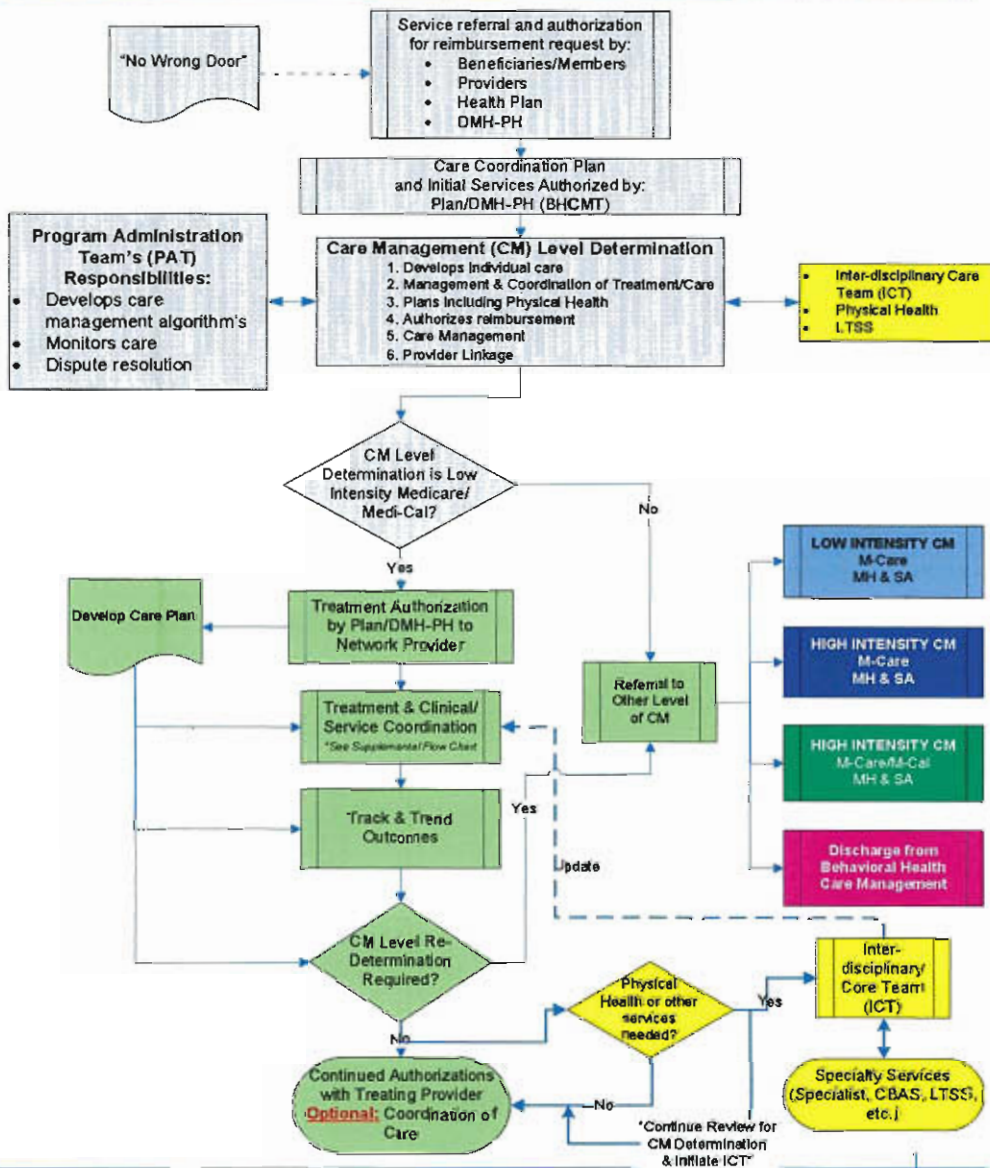
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

DMH & DPH Authorization & Care Management Low Intensity Medicare/Medi-Cal Flow Chart

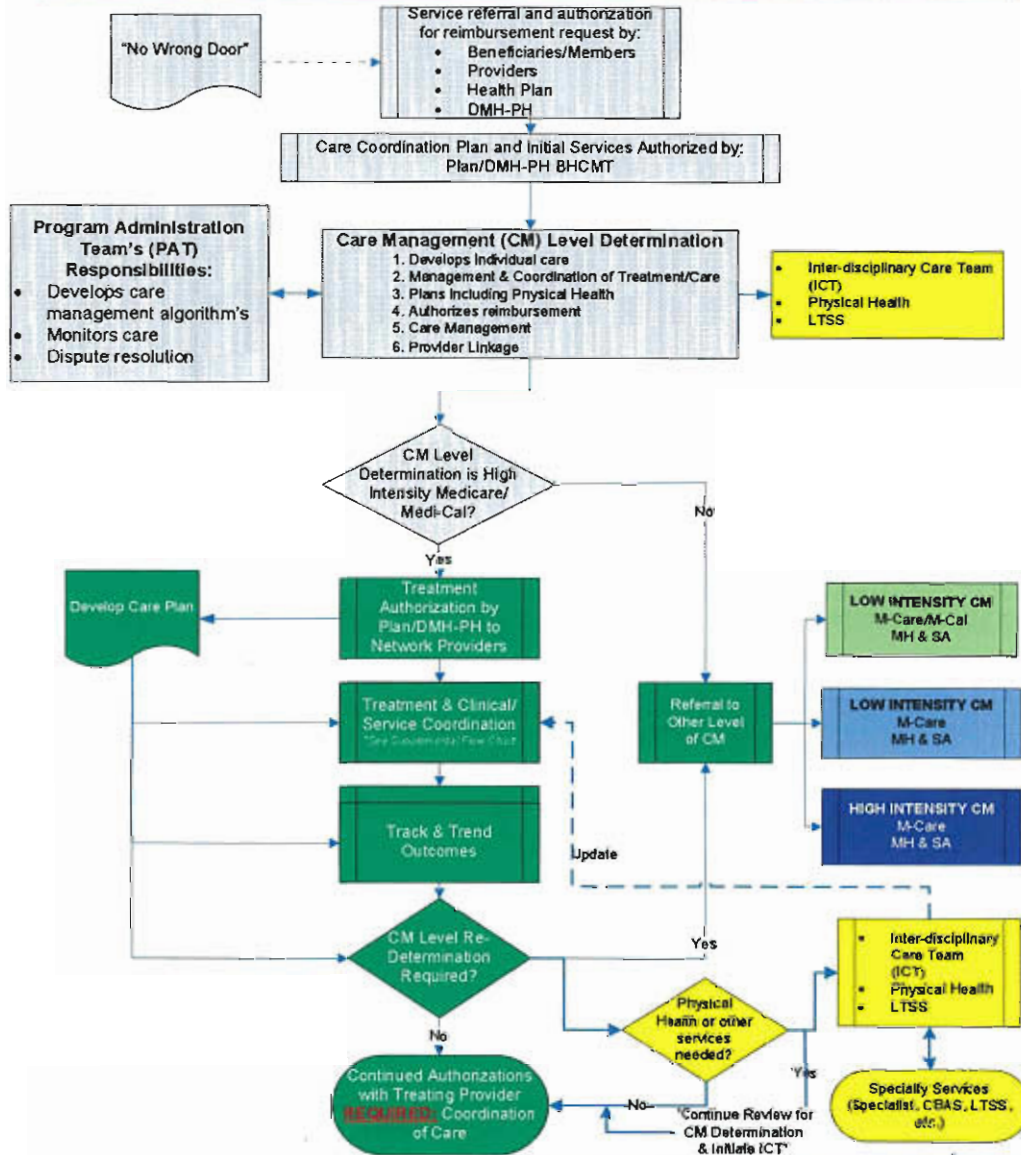
Friday, July 19, 2013



* Complete behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

DMH & DPH Authorization & Care Management High Intensity Medicare/Medi-Cal Flow Chart

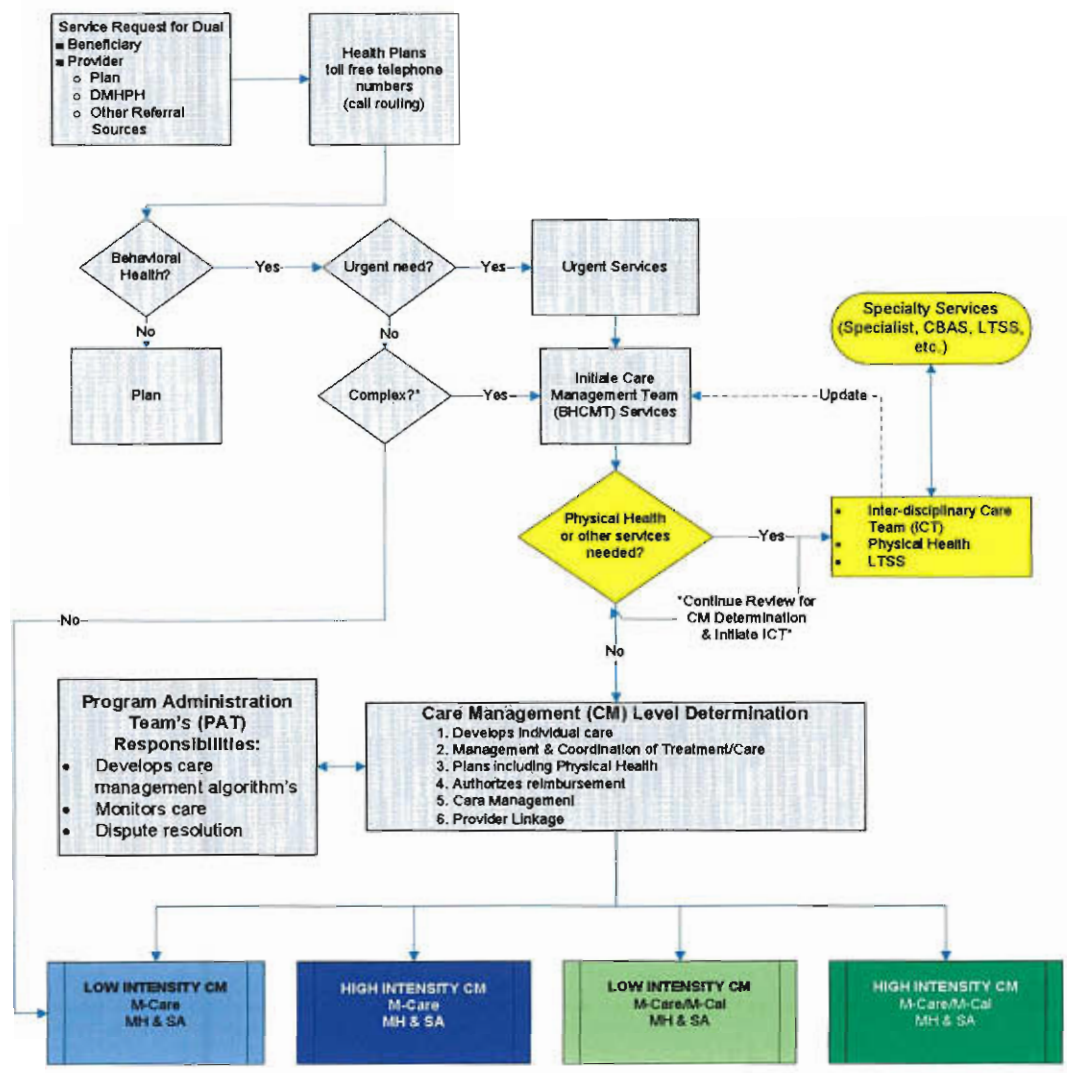
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

DMH & DPH Care Management Level Determination Flow Chart

Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

Behavioral Health Benefits in the Cal MediConnect Program

Coverage Responsibility Matrix

Updated February 27, 2013

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be “carved out”). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1+2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California’s 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

To determine medical necessity for Drug Medi-Cal Substance Abuse Services, health plans and counties will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

Coverage Matrix 1: Mental Health Benefits

Inpatient Services			
	Type of Service	Benefit Coverage	Primary financial responsibility under the Demonstration
Psychiatric inpatient care in a general acute hospital	Facility Charge	Medicare <i>Subject to coverage limitations *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Inpatient care in free-standing psychiatric hospitals (16 beds or fewer)	Facility Charge	Medicare <i>Subject to coverage limitations and depends on facility and license type *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Psychiatric health facilities (PHFs) (16 beds or fewer)	Facility Charge <i>(Most are not Medicare certified)</i>	Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
Emergency Department	Facility Charges	Medicare	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Long-Term Care			
Skilled Nursing Facility	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
SNF-STP (fewer than 50% beds)	Facility Charges	Medicare/Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

Institutes for Mental Disease

	Long-term care	Benefit Coverage	Primary financial responsibility under the Demonstration
SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)[§]	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Not covered by Medicare or Medi-Cal+	County
	Facility Charge ages 65 and older	Medi-Cal	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Mental health rehabilitation centers (MHRCs) (IMD)	Facility Charges	Not covered by Medicare or Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Psychiatric health facilities (PHFs) with more than 16 beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	County	County
	Facility Charge ages 65 and older (<i>most are not Medicare certified</i>)	Medi-Cal*	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Free-standing psychiatric hospital with 16 or more beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Medicare*	Health plan
	Facility Charge ages 65 and older	Medicare	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan

* Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his Medicare psychiatric hospital coverage then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters [02-06](#) and [10-02](#).

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

§ Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act

Outpatient Mental Health Services

		Primary Financial Responsibility	
Type of Service	Benefit Coverage	Patient meets criteria for MHP specialty mental health services [^]	Patient does NOT meet criteria for MHP specialty mental health services
Pharmacy	Medicare	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	Medicare	Health Plan	Health Plan
Outpatient services within the scope of primary care	Medicare	Health Plan	Health Plan
Psychiatric testing/ assessment	Medicare	Health Plan	Health Plan
Mental health services [§] <i>(Individual and group therapy, assessment, collateral)</i>	Medicare	Health plan	Health Plan
Mental health services [§] <i>(Rehabilitation and care plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication support services [§] <i>(Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)</i>	Medicare	Health plan	Health Plan
Medication support services [§] <i>(instruction in the use, risks and benefits of and alternatives for medication; and plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day rehabilitation	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis intervention	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis stabilization	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Adult Residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Targeted Case Management	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria

[^] 1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

[§] Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

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

Coverage Matrix 2: Substance Use Disorder Benefit

	Type of Service	Benefit Coverage	Demonstration Responsibility
Inpatient Acute and Acute Psychiatric Hospitals	Detoxification	Medicare	Health Plan
	Treatment of Drug Abuse ¹ (Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90)	Medicare	Health Plan
Outpatient	Alcohol Misuse Counseling: one alcohol misuse screening (SBIRT) per year. Up to four counseling sessions may be covered if positive screening results. <i>Must be delivered in a primary care setting.</i> ²	Medicare	Health Plan
	Group or individual counseling by a qualified clinician	Medicare	Health Plan
	Subacute detoxification in residential addiction program outpatient	Medicare	Health Plan
	Alcohol and/or drug services in intensive outpatient treatment center	Medicare	Health Plan
	Extended Release Naltrexone (vivitrol) treatment	Medicare	Health Plan
	Methadone maintenance therapy	Drug Medi-Cal	County Drug & Alcohol ³
	Day care rehabilitation	Drug Medi-Cal	County Drug & Alcohol
	Outpatient individual and group counseling (<i>coverage limitations</i>) ⁴	Drug Medi-Cal	County Drug & Alcohol
	Perinatal residential services	Drug Medi-Cal	County Drug & Alcohol

¹ Medicare inpatient detoxification and/or rehabilitation for drug substance abuse when it is medically necessary. Coverage is also available for treatment services provided in the hospital outpatient department to patients who, for example, have been discharged for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. [Click here to learn more.](#)

² Medicare coverage explanation: [Click here to learn more.](#)

³ In San Diego and Orange Counties, county alcohol and drug do not provide these services. Providers have direct contracts with the State.

⁴ Title 22, Section 51341.1 limits DMC individual counseling to the intake, crisis intervention, collateral services and treatment and discharge planning.

Exchange of Information, Including PHI, Related to the Beneficiaries in the Cal MediConnect Program.

1. PURPOSE

This Addendum addresses how LMHP and Health Net will share information to coordinate care of Beneficiaries with severe and persistent mental disorders. Individuals with severe and persistent mental disorders have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their mental health service provider functions as their primary connection to the overall healthcare system.

In order to coordinate care for such Beneficiaries, the parties must identify those Beneficiaries who are enrollees of Health Net and clients of LMHP Providers ("Common Members"). This Addendum documents how the parties will share information to (a) identify Common Members in compliance with the requirements of all applicable Federal and State laws and regulations, and (b) provide coordinated care to the Common Members pursuant to the Cal MediConnect Program.

2. DATA MATCHING

Performing a data match to identify Common Members and transmitting the results to the entities providing services to the Common Members helps achieve two important results:

- a) The matched data can help alert healthcare providers to ongoing mental health needs and interventions in Common Members. These mental health needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and mental health providers that can improve the health status and treatment outcomes of those served.
- b) Results of this match would also provide LMHP with information that would allow LMPH Providers to more efficiently and effectively facilitate access to much needed physical healthcare services for Common Members by identifying available primary care resources.

3. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

3.1 To the extent allowed by HIPAA and applicable State and Federal privacy laws, Health Net shall provide to LMHP the data described in Attachment IV-A, Health Net Beneficiary Data Exchange Protocol ("Protocol"). LMHP shall use this data solely to determine whether Beneficiaries are Common Members.

- a) For those Beneficiaries who are determined to be Common Members, LMHP and Health Net shall use the data for the purposes of coordinating care.
 - b) For those Beneficiaries who are determined not to be Common Members, LMHP shall not use the data for any other purposes, and shall return it to Health Net and remove it from all systems where the data was used or stored.
- 3.2 Health Net and LMHP have reviewed the attached Protocol and agree that the data described in the Protocol complies with HIPAA's minimum necessary standard. **[Note to LMHP: HN is still reviewing the Protocol]**
- 3.3 The parties shall comply with the HIPAA Security Rule in transmitting, receiving and maintaining PHI exchanged in accordance with the Protocol.

4. HIPAA OBLIGATIONS OF THE PARTIES

- 4.1 Health Net and LMPH acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.
- 4.2 Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent unpermitted uses or disclosures of such PHI.

5. BUSINESS ASSOCIATE-OBLIGATIONS

- 5.1 The parties acknowledge that for the purposes of conducting the data matching, LMHP shall be acting in the capacity of a Business Associate of Health Net, with respect to the receipt of PHI for Beneficiaries who are not Common Members.
- 5.2 The parties shall enter into a Business Associate Agreement for the data matching requirements.
- 5.3 Upon completion of the data matching, LMHP shall not retain any PHI for Health Net Beneficiaries who are not Common Members. Such PHI shall be destroyed or returned in accordance with the terms of the Business Associate Agreement.

HEALTH NET BENEFICIARY DATA EXCHANGE PROTOCOL

1. Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty mental health care among Common Members. In the event of an inconsistency between this Protocol and Addendum IV, Addendum IV shall govern.

2. Data Exchange - Data Matching

2.1 Demographic Data. LMHP will provide a secured location for Health Net to place a data file of individuals identified as Beneficiaries, initially in the form of a flat text file, on an interval agreed upon by LMHP and Health Net. Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, referred to as the Dual Eligibles 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
- Health Net Internal MHC Member Number **[kp note to HN internal: Does this field apply to HN?]**
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address

2.2 Match Details. Upon receipt of the Dual Eligibles file, LMHP shall load the data to the Department of Mental Health (“DMH”) Enterprise Data Warehouse. LMHP shall maintain a historical table of dual eligible beneficiaries and their respective eligibility information. LMHP shall conduct a match of concomitant Beneficiaries between Health Net and DMH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or “match” like clients of LMHP and Health Net. The match is performed in “tiers” where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to the next algorithm. This

process continues until a positive match is found or the record has been passed through all tier criteria. For example, records that do not mach 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:

- a) Tier 0:
 - Member CIN weighted at 100%
- b) Tier 1:
 - Member Social Security Number weighted at 100%
 - Member Date of Birth weighted at 100%
- c) Tier 2:
 - Member Social Security Number weighted at 85%
 - Member Full Name weighted at 90%
- d) Tier 3:
 - Member Social Security Number weighted at 85%
 - Member Last Name weighted at 85%
- e) Tier 4:
 - Member Social Security Number weighted at 100%
 - Member Year of birth weighted at 100%
- f) Tier 5:
 - Member Full Name weighted at 90%
 - Member Date of Birth weighted at 100%
 - Member Gender weighted at 100%
- g) 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%

3. Data Exchange – Care Coordination

- 3.1 Health Net Usage. Upon completion of the match, LMHP shall extract and provide (as described below), Common Members who currently have an open and active episode in the DMH Integrated System (IS) or successor

DMH electronic health record (EHR) to Health Net in the form of a flat text file. LMHP will, at a minimum, provide the following elements:

- Admission Data 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
- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

The response data file will be placed on a secured server administered and maintained by the LMHP. Health Net will retrieve the file for the purposes of coordinating Common Members care and for no other purpose by distributing the mental health provider contact information to its Primary Care Providers (PCP) for the purposes of coordinating Common Members care 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

Health Net shall not use or disclose the information for any other purpose.

3.2 LMHP Usage. In addition to the demographic data provided pursuant to Section 2.1, Health Net will provide the following data elements for Common Members to LMHP in the form of a flat text file:

- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

After processing the Beneficiary data, LMHP will upload the PCP and other pertinent information for Common Members to the DMH IS or successor DMH EHR. LMHP 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.

MEMORANDUM OF UNDERSTANDING

By and Between

L.A. CARE HEALTH PLAN
and the

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

For

IMPLEMENTATION OF THE

CAL MEDI-CONNECT PROJECT (Referred to herein as
The Dual Eligibles Demonstration Program)

FOR MEDICARE-MEDI-CAL BENEFICIARIES

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IMPLEMENTATION OF THE

CAL MEDI-CONNECT PROJECT (Referred to herein as
The Dual Eligibles Demonstration Program)

FOR MEDICARE-MEDI-CAL BENEFICIARIES

This Memorandum of Understanding (“MOU”) is made and entered into on the _____ day of _____, 2013 by and between L.A. Care Health Plan (“L.A. Care”), and the County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control, as the county alcohol and drug program administration in Los Angeles County for the purpose of providing access to all medically necessary Behavioral Health Services currently covered by Medicare and Medi-Cal to Beneficiaries enrolled in the Dual Eligibles Demonstration Project.

I. RECITALS

Whereas, California’s Coordinated Care Initiative was created through a public process involving stakeholders and health care consumers and enacted through SB 1008 (Chapter 22, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012);

Whereas, a component of the Coordinated Care Initiative includes a three-year demonstration program which will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a health plan for eligible Medicare and Medi-Cal Beneficiaries;

Whereas, L.A. Care has been selected by the State Department of Health Care Services (“DHCS”) as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County;

Whereas, health plans participating in the Dual Eligibles Demonstration Project (“**Demonstration Health Plans**”) will provide eligible beneficiaries with all mental health and substance use services, generally collectively referred to as “Behavioral Health

Services”, currently covered by Medicare and Medi-Cal; except that county administered Specialty Mental Health Services and county administered Drug Medi-Cal substance use treatment services will not be included in the Demonstration Health Plans’ capitation payments from DHCS, and such Specialty Mental Health Services and Drug Medi-Cal substance use treatment services shall continue to be financed and administered by the counties;

Whereas, in Los Angeles County, the agencies that administer Specialty Mental Health Services and Drug Medi-Cal substance use treatment services are, respectively, the County of Los Angeles Department of Mental Health as the Local Mental Health Plan (“**LMHP**”) and the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (“**SAPC**”);

Whereas, Demonstration Health Plans and county agencies are required to have written agreements outlining how they will coordinate services;

Whereas, the Coordinated Care Initiative provides State authority for the Dual Eligibles Demonstration Project;

Whereas, the DHCS has finalized a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (“**CMS**”) for the Dual Eligibles Demonstration Project; and

Whereas, further, the DHCS, CMS, and L.A. Care have entered into a three-way agreement for the Dual Eligibles Demonstration Project: and

Whereas, in anticipation of federal approval and the finalizing of all required agreements, L.A. Care and SAPC have entered into this MOU for purposes of implementing the Dual Eligibles Demonstration Project.

II. PARTIES

L.A. Care, a licensed California health care service plan under the Knox Keene Act, has been selected by the DHCS as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County. As a component of the Dual Eligibles Demonstration Project, L.A. Care is required to provide physical health services and certain Behavioral Health Services, and to coordinate care for the needs of Beneficiaries.

The SAPC is the county alcohol and drug program administrator responsible for providing medically necessary Drug Medi-Cal substance use treatment services for Medi-Cal eligible beneficiaries of Los Angeles County. Under the Dual Eligibles Demonstration Project, the SAPC will provide Drug Medi-Cal substance use treatment services for Beneficiaries who meet Drug Medi-Cal medical necessity criteria, and, with L.A. Care, will coordinate Medicare and Medi-Cal services.

III. BACKGROUND

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for beneficiaries of both the Medicare and Medi-Cal programs, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including Los Angeles County, were selected by the State to implement a three-year demonstration project for Medicare and Medi-Cal beneficiaries, referred to as the Dual Eligibles Demonstration Project. L.A. Care is one of two local managed care health plans selected by the DHCS and DMH in Los Angeles County to provide health, mental health, substance abuse, and Long Term Services and Supports (“LTSS”) services to Beneficiaries enrolled in the Dual Eligibles Demonstration Project (or “Demonstration Project”).

Under the Demonstration Project, all Medicare and non-specialty Medi-Cal substance use services are the responsibility of L.A. Care and included in its capitation payment for the Demonstration Project. Drug Medi-Cal substance use services not covered by Medicare benefits will not be included in L.A. Care’s capitation payment. L.A. Care and SAPC will collaborate to ensure Beneficiaries have access to coordinated Medicare and Medi-Cal services. Drug Medi-Cal substance abuse treatment services will continue to be provided or arranged for by SAPC, and will be the financial responsibility of SAPC, for Beneficiaries that meet Medi-Cal medical necessity criteria.

IV. PURPOSE

This MOU sets forth the Parties’ mutual understandings, commitments, and protocols regarding how Drug Medi-Cal substance use treatment services funded by Medicare and Medi-Cal will be coordinated and managed by SAPC and L.A. Care for Beneficiaries. Among other things, the MOU addresses: 1) the roles and responsibilities of L.A. Care and SAPC, 2) how care will be coordinated by and between L.A. Care and SAPC, 3) the process for information exchange between L.A. Care and SAPC, and 4) shared financial accountability strategies.

V. DEFINITIONS

Beacon Health Strategies

Beacon Health Strategies, together with its subsidiaries, is the behavioral healthcare affiliate of L.A. Care that assists L.A. Care in meeting the behavioral and care coordination needs of certain Beneficiaries covered through the Demonstration Project.

Behavioral Health Services (or “Behavioral Health”)

Mental Health Services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to

Section 51341.1 of Title 22 of the California Code of Regulations and any mental health benefits and substance abuse available under the Medicare Program.

Behavioral Health Care Management Team (“BHCMT”)

Multidisciplinary team that provides care management and care coordination for Medicare and Medi-Cal services, and authorization for Medicare services to Beneficiaries enrolled in the Demonstration Project. The BHCMT is composed of representatives from the LMHP, L.A. Care and/or Beacon Health Strategies, and SAPC.

Behavioral Health Care Plan

The care plan developed by a Beneficiary and the Beneficiary’s BHCMT that describes the authorized Behavioral Health Services to be provided the Beneficiary.

Beneficiary

An individual who is eligible for both Medicare and Medi-Cal benefits and who is enrolled in the Dual Eligibles Demonstration Project and who receives covered services through L.A. Care.

Care Coordination

The management of physical, LTSS, and Behavioral Health Services for Beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

Coordinated Care Initiative (“CCI”)

California’s coordinated care model that intends seamless access to the full continuum of medical, social, LTSS, and Behavioral Health Services to Beneficiaries.

Confidentiality of Medical Information Act

A State law, California Civil Code Section 56 et. seq., which governs the confidentiality of medical information, as defined therein; this law specifies when medical information is required and permitted to be disclosed by health care providers and others.

Dual Eligibles Demonstration Project or Demonstration Project

The three-year CCI demonstration project involving an agreement or agreements between the Demonstration Health Plans, DHCS, and CMS for coverage of individuals with eligibility for both Medicare and Medi-Cal.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, Public Law 104-191 and its implementing regulations, including Standards for the Privacy of Individually Identifiable Health Information and the Health Insurance Reform: Security Standards at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act, (HITECH Act), including its implementing regulations, which provide federal protections for individually identifiable health information held by covered entities, as defined therein.

Interdisciplinary Care Team (ICT)

A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of Beneficiaries. The ICT also includes a representative from the BHCMT.

Local Mental Health Plan (“LMHP”)

The Los Angeles County Department of Mental Health which is the local county agency that has responsibility for administering public and Specialty Mental Health Services.

Long Term Services and Supports (“LTSS”)

Those services and supports described in Welfare and Institutions Code section 141861, subdivision (b).

Medi-Cal

California's Medicaid health care program of medical assistance benefits under Title XIX of the Social Security Act.

Medicare

Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (“ESRD”) or Amyotrophic Lateral Sclerosis (“ALS”).

Primary Care Provider (“PCP”)

A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary through the Dual Eligibles Demonstration Project.

Program Administration Team (“PAT”)

A team composed of staff from Beacon Health Strategies and/or L.A. Care, LMHP, and SAPC that provides program oversight of the BHCMT.

Protected Health Information (“PHI”)

Individually identifiable health information as defined by 45 C.F.R. Section 160.103.

Specialty Mental Health Services

Services provided through the LMHP as defined by Title 9, California Code of Regulations (CCR) Section 1810.247 and in accordance with Chapter 11 of Title 9.

State Department of Health Care Services (DHCS)

The State department that has responsibility for administering health care services funded Medi-Cal.

Welfare and Institutions Code Section 5328 et. seq.

The State laws governing the confidentiality of information and records of the LMPH and LMPH Providers; this law specifies that all information and records received in the

course or providing services are confidential and specifies when such information is required or permitted to be disclosed.

42 Code of Federal Regulations, Part II

The provisions of federal law which govern the confidentiality of patient alcohol and drug abuse treatment records. Any information which could reasonably be used to identify individuals who are receiving, or who have received, such treatment, is protected by this law. Such information may not be released unless doing so would fall within one of the specific exceptions provided under these provisions. When release of such protected information is contemplated by any of the parties to this MOU, the party in possession of this information should consult this provision to determine whether it may proceed with release.

VI. APPLICABLE DOCUMENTS

Addenda I, II, III, and IV are attached to and form a part of this MOU. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or contents or description of task or responsibility between the MOU and the addendum, or between addenda, such conflict or inconsistency shall be resolved in a manner that advances the purpose and intent of this MOU. Addenda to this Agreement are as follows:

Addendum I

Cal MediConnect Coordination of Care Policy and Procedures [Behavioral Health] Policy and Procedure. This Policy sets forth the coordination of care procedures that the Parties and their applicable related entities will follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum II

DMH and DPH Authorization and Care Management Flow Charts. Addendum II sets forth the process flows and guidelines that the Parties and their applicable related entities in the Demonstration Project agree to follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum III

Mental Health and Substance Abuse Benefits in the Duals Demonstration Matrix. Addendum III sets forth a listing of the Behavioral Health Services to be provided to Beneficiaries and the Party that will have financial responsibility for provision of that Service as defined by DHCS.

Addendum IV

Exchange of Information, Including PHI, Related to the Beneficiaries.

VII. ROLES AND RESPONSIBILITIES

L.A. Care has primary administrative and program responsibility for care management, care coordination, and authorization for reimbursement for Behavioral Health Services covered by Medicare under the Demonstration Project.

A. Behavioral Health Services Administrative Arrangements

L.A. Care and its affiliate Beacon Health Strategies will be providing the Behavioral Health Services and care coordination needs of certain Beneficiaries as required under the Demonstration Project.

L.A. Care and/or Beacon Health Strategies shall:

1. Develop and contract a Behavioral Health Services provider network that includes, but is not limited to, SAPC providers.
2. Lead and be the focal point for all Behavioral Health Services coordination activities between L.A. Care, Beacon Health Strategies, LMHP, and SAPC.
3. Lead and participate in the BHCMTs.
4. Process Medicare Behavioral Health Services claims payment to Behavioral Health Services network providers which include, but are not limited to, SAPC Providers.

B. Care Management Teams

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care, L.A. Care, LMHP, and SAPC, shall establish three interagency care management teams for behavioral health composed of, but not limited to, representatives from each of the entities.

The interagency care management teams are responsible, as described below, for ensuring that health, mental health, substance abuse, and LTSS services are easily accessible and coordinated for Beneficiaries:

1. Program Administration Team (“PAT”) has the following shared responsibilities:
 - Develop algorithms, and policies and procedures to assist the BHCMT in its day to day operations.
 - Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 - Conduct program evaluation.
 - Resolve disputes between L.A. Care and SAPC.
 - Identify and resolve provider relations issues.

2. Behavioral Health Care Management Team (“BHCMT”) led by L.A. Care and/or Beacon Health Strategies
 - Authorize covered Behavioral Health Services based upon algorithms developed by PAT. Develop individual behavioral health care plans.
 - Coordinate care between physical health, mental health, and substance abuse providers.
 - Monitor individual clinical progress.
 - Reassess individual service needs.
 - Refer and link to appropriate services.
 - Serve as the liaison to the Interdisciplinary Care Team for Beneficiaries that also need non-behavioral health services.
 - Resolve disputes between L.A. Care and SAPC.
3. Interdisciplinary Care Team (“ICT”). L.A. Care is responsible for facilitating ICTs to provide care management services to Beneficiaries, that present with complex and multiple health, mental health, substance abuse conditions, and may also need LTSS. The ICT will include, but is not limited to, health care staff, BHCMT, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate and as permitted by law.

For further guidance regarding the role of and processes applicable to the Care Management Teams refer to Addendums I and II to this MOU.

C. Referrals and Criteria

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care for purposes of referring Beneficiaries for Behavioral Health Services, L.A. Care, LMHP, and SAPC agree to the following protocols, as further described in Addenda I, II and III to this MOU.

1. Referral Process for Behavioral Health Services

1.1 The Dual Eligibles Demonstration Project shall have a “no wrong door” approach to service access, with multiple entry paths for Beneficiaries to access Behavioral Health Services. Referrals may come from various sources including, but not limited to, Beneficiary self-referrals.

1.2 All incoming referrals or requests for Behavioral Health Services shall be screened and triaged according to procedures established by the BHCMT to determine Behavioral Health need, and to refer and link Beneficiaries to a Behavioral Health provider and/or to SAPC for substance use disorders treatment and recovery services.

2. Referral Process for non-Behavioral Health Services

2.1 SAPC shall identify Beneficiaries that need physical health care services and refer these Beneficiaries to the BHCMT in the manner described in the Addendum I and Addendum II attached to this MOU.

3. Determination of SAPC Service Criteria

3.1. The criteria for provision of Drug Medi-Cal substance use treatment services are set forth in Section 51341.1 of Title 22 of the California Code of Regulations.

4. Determination of Medicare Non-Specialty Substance Abuse Service Criteria

4.1. L.A. Care shall provide Behavioral Health Services to Beneficiaries as listed in Addendum III.

4.2. Description of Covered Drug Medi-Cal substance use treatment services are included in Addendum III.

D. Credentialing

The SAPC has a large network of licensed providers contracted with the SAPC that deliver clinical services at SAPC owned or SAPC provider treatment sites.

1. L.A. Care and/or L.A. Care through Beacon Health Strategies are responsible for contracting with and credentialing those providers contracted with the SAPC who are Medicare reimbursable, for the purposes of becoming Medicare-reimbursable providers in the Demonstration Project for certain delegated health plans.
2. The standards for the credentialing of providers shall satisfy the requirements of L.A. Care, CMS, National Committee on Quality Assurance (“NCQA”), URAC and other necessary regulatory entities or requirements. SAPC providers must meet the Medicare credentialing requirements and standards to be eligible for reimbursement for Medicare services provided pursuant to the Dual Eligibles Demonstration Project.
3. As part of any delegation of credentialing to SAPC, L.A. Care may perform periodic oversight audits to ensure that the required standards are met on an ongoing basis.
4. Providers and provider sites must be credentialed in both SAPC and L.A. Care and Beacon Health Strategies networks at all times in order to provide Drug Medi-Cal reimbursable services to Beneficiaries.
5. Any failure of a provider or provider site to meet the applicable credentialing standards and requirements as determined by L.A. Care, Beacon Health

Strategies, or SAPC will automatically result in removal of that provider or provider site as a credentialed provider of Behavioral Health Services to Beneficiaries pursuant to the terms and conditions contained in the applicable provider agreement between the parties.

6. L.A. Care and SAPC will notify each other at the time of any changes in provider or provider site network credentialing status or compliance.

E. Financial Responsibility: Reimbursement Process for Medicare Behavioral Health Services Provided by L.A. Care Providers

Primary financial responsibility of and between the parties for Behavioral Health Services for the Demonstration Project are based on the matrix provided by DHCS as set forth in Addendum III, attached hereto. Further provisions and processes for reimbursement of Behavioral Health Services shall be specified in a separate provider agreement between SAPC and L.A. Care or Beacon Health Strategies.

For further information regarding financial responsibility and processes for the provision of Behavioral Health Services to Beneficiaries covered by Medicare, refer to the Addenda III attached to this MOU.

F. Beneficiary and Provider Education

1. L.A. Care will develop, in collaboration with the LMHP and SAPC, education materials that explain the Behavioral Health and substance abuse components of the Demonstration Project.
2. The LMHP and SAPC will provide L.A. Care staff with training on their programs, eligibility and assessment criteria, services available, and how to review and understand data made available for coordination of care to L.A. Care and/or Beacon Health Strategies. Initial trainings will be provided prior to implementation of the Demonstration Project, and on an as-needed basis, but not less than annually.
3. L.A. Care will provide the LMHP and SAPC staff with opportunities for training on L.A. Care benefits and procedures. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative, and on an as-needed basis, but not less than annually.
4. L.A. Care will train its providers on procedures for Behavioral Health care coordination, care management requirements, referral processes, claims and reimbursement issues.
5. L.A. Care will develop, in collaboration with the LMHP and SAPC, a provider manual that addresses the Behavioral Health and substance abuse components of the Demonstration project.

6. L.A. Care, the LMHP, and SAPC will provide information and education about the Demonstration Project to potential eligible enrollees, their family members, caregivers and to Beneficiaries enrolled in the Demonstration Project to assist them with making informed decisions related to their health care needs.

G. Dispute Resolution Related to Reimbursement for Services

1. First Level Disputes: All disputes “First Level Disputes” shall be submitted to the BHCMT for resolution. First Level Disputes may include, but are not limited to, disagreements regarding authorization for or reimbursement of Medicare and/or Medi-Cal services.
2. Second Level Disputes: If the BHCMT cannot resolve a First Level Dispute to the satisfaction of either or both parties, the dispute shall be submitted to the PAT within mutually agreed upon timeframes. The PAT shall inform the BHCMT of its decision. (“Second Level Disputes”)
3. Third Level Disputes: If the PAT cannot resolve a Second Level Dispute to the satisfaction of either or both parties, the dispute shall be addressed by executive management from the LMHP, SAPC, and L.A. Care. The executive management shall review the dispute and inform the PAT of its decision. (“Third Level Disputes”)
4. If resolution cannot be reached at the executive management level within agreed upon timeframes, L.A. Care and SAPC agree to follow the resolution of dispute process in accordance with 9, CCR Sections 1810.370, 1850.505 and 1850.525, the three way contract by and among L.A. Care, DHCS, and CMS, as such contract is described in the DHCS/CMS MOU.

H. Dispute Resolution Related to Provider Relations

1. First Level Disputes: Disputes between L.A. Care and SAPC regarding provider relations and contracting shall be submitted to the PAT.
2. Second Level Disputes: If satisfactory resolution of a dispute cannot be reached by the PAT, the dispute shall be addressed and resolved by the executive management staff from L.A. Care and SAPC.

VIII. COORDINATION OF CARE

A. Point of Contact for Clinical Issues

1. L.A. Care contact staff is the Senior Director of Health Services.
 - a. Beacon Health Strategies shall designate a contact staff.

2. The LMHP contact staff is the Medical Director.
3. SAPC contact staff is the designated Program Director.

B. Care Coordination Activities

1. L.A. Care shall conduct a Health Risk Assessment that includes Behavioral Health screenings for all Beneficiaries enrolled with L.A. Care in the Demonstration Project. L.A. Care will refer Beneficiaries with specific mental health and substance abuse findings from the screenings to the PCP for potential linkage to a mental health provider and/or substance abuse provider.
2. The ICT or member thereof shall refer Beneficiaries to the BHCMT if the PCP or the Beneficiary believes that mental health and/or substance abuse services beyond the scope of practice of the PCP are required.
3. The PCP, SAPC provider, Beneficiary, and the BHCMT shall collaboratively develop a Behavioral Health Care Plan for the Beneficiary.
4. As permitted by HIPAA and other applicable privacy laws, the SAPC provider and PCP shall share PHI as needed for the purpose of care coordination in accordance with Addendum IV.
5. SAPC providers shall submit written documentation that contains treatment coordination information to the beneficiary's PCP in accordance with Addendum IV to the extent permitted by HIPAA and other applicable privacy laws.
6. L.A. Care's PCP shall submit written documentation that contains treatment coordination information to the Beneficiary's mental health provider in accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws.
7. L.A. Care shall establish a process for reviewing and updating the Behavioral Health Care Plan as clinically indicated, such as following a hospitalization, a significant change in health or well-being, in level of care, or a request for change of provider, and for coordinating with the SAPC provider when necessary.
8. The SAPC and L.A. Care providers may participate in case conferencing and conduct regular meetings to review the care coordination process.
9. L.A. Care shall coordinate with the LMHP and SAPC to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

10. L.A. Care shall develop procedures and coordinate direct transfers between inpatient psychiatric services and inpatient medical services and involve the BHCMT for the purpose of care management and care coordination.

C. Case Consultation

In accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws, L.A. Care and SAPC shall establish processes that facilitate consultation and coordination of psychiatric and medical treatment and care plans.

1. SAPC providers may provide information, education, and consultation to L.A. Care PCP regarding substance use related issues to improve coordination of care and care management.
2. L.A. Care PCP may provide information, education, and consultation to SAPC providers on medical issues to improve coordination of care and care management.
3. Consultation between L.A. Care PCP and SAPC providers may be facilitated by various means including, but not limited to:
 - Direct consultation
 - Telephonic consultation
 - Email consultation
 - Telepsychiatry/Telemedicine
 - Facilitated case conference by BHCMT or ICT concerning care management planning

IX. EXCHANGE OF INFORMATION

9.1 The parties understand and agree that each party has obligations under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (“HIPAA”), as amended by subtitle D, Privacy, of the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, as further implemented by the Omnibus HIPAA Rule, 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 as specified under HIPAA. The disclosure of data, including without limitation PHI, from L.A. Care and/or - Health Strategies to SAPC, are for the purposes of L.A. Care's payment/health care operations and/or the SAPC's treatment, payment, or health care operations in their capacity as Covered Entities and/or to the extent applicable in their capacity as Health Oversight Agencies (as such capitalized terms are defined in HIPAA).

9.2 Each party acknowledges that it may have additional obligations under other State or federal laws that may impose on that party additional restrictions with respect 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 C.F.R. Part 2.

9.3 Each party acknowledges that it will comply with consent 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.

9.4 Addendum IV sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information to ensure coordination of physical health, mental health services, and substance abuse services.

X. SHARED FINANCIAL ACCOUNTABILITY STRATEGIES

L.A. Care, the LMHP (pursuant to a separate memorandum of understanding entered into with the LMHP), and SAPC agree to comply with the Shared Accountability Performance Metrics and requirements, as specified in the DHCS/CMS MOU and the three-way contract between CMS, DHCS, and L.A. Care. The goal of Shared Accountability Performance Metrics is to develop coordination strategies to reduce inappropriate cost shifting between Medicare, Medi-Cal Specialty Mental Health Services and Drug Medi-Cal Substance Abuse Services, and develop a formal financial arrangement strategy for shared cost savings. The strategies build on the performance-based withhold in the capitation rates of 1%, 2%, and 3% respectively for years one, two, and three of the Dual Eligibles Demonstration Project. If the specified shared accountability measures are achieved, L.A. Care shall provide an incentive payment to LMHP and SAPC under mutually agreeable terms and pay a percentage of the recovered funds attributed to that measure to the LMHP and SAPC. This payment shall be structured in a way that does not offset Los Angeles County's Certified Public Expenditure (CPE).

L.A. Care and the LMHP, and L.A. Care and the SAPC agree to modify and update this MOU to incorporate the Behavioral Health Shared Accountability Standards in accordance with the three-way contract by and among L.A. Care, DHCS, and CMS upon finalization of the three-way contract.

XI. INDEMNIFICATION

L.A. Care and the SAPC shall indemnify, defend and hold harmless each other, their elected and appointed directors, officers, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any damage whatsoever, including but not limited to death or injury to any person and damage to any property, resulting from the misconduct,

negligent acts, errors or omissions by the other party or any of its directors, officers, 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 shall survive termination of this MOU.

XII. 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 sufficient for liabilities which may arise from or relate to this MOU.

XIII. TERM

This MOU is effective _____ 2013 (“Effective Date”) and shall continue in effect so long as necessary to implement the Dual Eligibles Demonstration Project or for three years from the Effective Date, whichever date is earlier. The term of this MOU may be extended by the parties upon their mutual written agreement.

XIV. 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 effective March 27, 2013; (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.

XV. MISCELLANEOUS TERMS

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

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

15.3 Interpretation: Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the requirements of the Dual Eligibles Demonstration Project.

15.4 Supervening Circumstances: Neither L.A. Care nor SAPC 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) any 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.

15.5 **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 the Dual Eligibles Demonstration Project shall not require the consent of LMHP and/or SAPC or L.A. Care and shall be effective immediately on the effective date of the requirement.

15.6 **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 party which consent shall not be unreasonably withheld.

15.7 **Confidentiality**: L.A. Care and SAPC 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 SAPC each agree to keep the foregoing strictly confidential. L.A. Care and SAPC agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. L.A. Care and SAPC 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 only 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 consultant 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. Notwithstanding 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 SAPC is required to defend an action under either of the foregoing acts, L.A. Care agrees to defend and indemnify SAPC 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.

15.8 **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 govern.

15.9 **Notice:** Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Section 15.9 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

LA Care Health Plan

1055 West 7th Street
Los Angeles, California 90017
Attn: Dr. Trudi Carter, Chief Medical Officer

Substance Abuse Prevention and Control

Los Angeles County Department of Public Health
1000 South Fremont Avenue, A9 East, 3rd Floor
Alhambra, California 91803
Attn: John Viernes, Jr., Director

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

15.10 **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.

15.11 **Waiver of Obligations.** The waiver of any obligation 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.

15.12 **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, SAPC, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee, or representative of the other.

15.13 **Entire Agreement.** This MOU represents 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.

15.14 **Counterparts.** This MOU may be executed in counterparts and by facsimile or PDF signature, all of which taken together constitute a single agreement

between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.

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


By _____ Date: _____

Name:
Title:
L.A. Care Health Plan

By _____ Date: _____

Jonathan E. Fielding, M.D., M.P.H., Director and Health Officer
Los Angeles County, Department of Public Health

ADDENDUM I

 <p>TITLE: CAL MEDI-CONNECT COORDINATION OF CARE POLICIES AND PROCEDURES “NO WRONG DOOR”</p> <p>SERVICE AREA: BEHAVIORAL HEALTH</p> <p>DEPARTMENT: HEALTH SERVICES</p>	Policy and Procedure Number		BH01			
	Total No. of Pages		7			
	Dates					
	Effective Date					
	Review/Revision Date					
	Review Date					
	Supersedes Policy Number					
	PPSA/Mandated		YES		NO	
	Administrative		YES		NO	X
	Applies to:					
	D SNP Medicare		YES		NO	
	Cal Medi-Connect		YES	X	NO	

1.0 POLICY:

- 1.1 L.A. Care health plan is responsible for providing beneficiaries seamless access to all medically necessary behavioral health services (mental health and substance use disorder treatment) currently covered by Medicare and Medicaid.
- 1.2 L.A. Care will coordinate with county agencies to ensure enrollees have seamless access to these services.
- 1.3 L.A. Care will ensure coordination of behavioral health with medical care and long-term services and supports

2.0 DEFINITION(S):

- 2.1 **Addiction** is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving. (Authority – Substance Abuse and Mental Health Services Administration, A Treatment Improvement Protocol 54 and the American Society of Addiction Medicine)
- 2.2 **BH** means Behavioral Health which includes Mental Health and Substance Use Disorder Services
- 2.3 **BHCMT** means Behavioral Health Care Management Team.
- 2.4 **Behavioral Health Care Management Team (BHCMT)** Multidisciplinary team that provides care management, care coordination and authorization for reimbursement of Medicare services to beneficiaries enrolled in the Demonstration project. The team is composed of representatives from the Local Mental Health Plan, Health Plans, and the Department of Public Health
- 2.5 **Behavioral Health Care Plan** The care plan developed by a beneficiary and the beneficiary’s Behavioral Health Care Management Team that describes the authorized services to the beneficiary.

- 2.6 BHP** means Behavioral Health Providers
- 2.7 Care Coordination** The management of services for beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.
- 2.8 DMH** means County Department of Mental Health.
- 2.9 DPH** means County Department of Public Health
- 2.10 Health Plan “The Plan” or “Plan”** refers to LA Care
- 2.11 Interdisciplinary Care Team (ICT)** A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of beneficiaries with complex needs.
- 2.12 LMHP** Los Angeles County Department of Mental Health (DMH) which is the local county agency that has responsibility for administering public mental health services.
- 2.13 Primary Care** means a basic level of health care usually rendered in ambulatory setting by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. Primary care emphasizes caring for the member’s general health needs as opposed to specialist focusing on specific needs. This means providing care for the majority of health care problems, including, but not limited to, preventive services acute and chronic conditions, and psychosocial issues.
- 2.14 Primary Care Provider (PCP)** means a person responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).
- 2.15 Program Administration Team (PAT)** A team composed of staff from the Health Plan, DMH, and SAPC that provides program oversight of the Behavioral Health Care Management Team.
- 2.16 Specialty Mental Health Service** means: Medi-Cal specialty mental health services and health plans and counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. These criteria can be summarized as the following:
- 2.16.1** Diagnosis – one or more of the specified MediCal included diagnosis and Statistical Manual of Mental Disorders;
- 2.16.2** Impairment – significant impairment or probability of deterioration of an

important area of life functioning, or for children a probability the child won't progress appropriately;

2.16.3 Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment

2.17 **Specialty Substance Use Disorder Treatment Services** are outpatient, residential, prevention, recovery, and support services which are made available to persons with substance use disorders. Services are directed towards alleviating and/or preventing substance use among individuals. Types of services, as described in Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards, include assessment, screening, evaluation, crisis intervention, individual, group, family counseling, collateral, vocational, detoxification, medication assisted treatment services, aftercare, and education services on tuberculosis and sexually transmitted diseases.

2.18 **Specialty Substance Use Disorder Treatment Services Provider** means an entity / organization contracted with Los Angeles County, Department of Public Health Substance Abuse Prevention and Control and is certified or licensed to provide specialty substance use disorder treatment services. Individuals providing counseling services must be registered, certified or licensed in accordance with the California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000.

2.19 **Subcontracted Plan** means a health maintenance organization or any other health care service plan licensed under the Knox -Keene Act which has entered into a service agreement with the Local Initiative of L.A. County (LA Care) to provide or arrange for health care services to Medi-Cal members, and to perform the other duties and responsibilities as set forth in such Plan Partner's Services Agreement with the Local Initiative.

3.0 PROCEDURE:

3.1 The Demonstration project has a "no wrong door" approach to service access. There will be multiple entry paths for beneficiaries to access behavioral health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling L.A. Care's Behavioral Health toll free number that will be available 24 hours, 7 days a week for service authorization and referral. Sources of referrals will also be educated on expeditiously referring Behavioral Health cases to L.A. Care's Behavioral Health toll free number.

3.2 Calls will be screened and triaged to establish eligibility and determine BH needs. and refer and link beneficiaries to BH providers. The assessments will be conducted using guidelines developed by the Program Administration Team (PAT).

3.2.1 If the member does not require BH services, he/she is referred to the health plans member services department.

3.2.2 If the member does require BH services appropriate authorization and referral will be given.

3.2.3 In cases of Crisis, the caller will be appropriately directed to emergency services.

3.3 Beneficiaries that are enrolled in the Demonstration project may walk in or present to a BH provider without an appointment to obtain services. The BH provider will be required to secure authorization from the BHCMT via the toll free number prior to rendering reimbursable services, with the exception of psychiatric crisis or emergency.

3.3.1 Initially the BHCMT will determine if the member is in need of emergent, urgent or routine Behavioral Health Services. Beneficiaries experiencing a BH crisis will be immediately referred to emergency services including psychiatric hospitals.

3.3.1.1 An emergency (behavioral health) is defined as an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition including symptoms of intoxication or withdrawal .

3.3.1.2 Emergency behavioral health services will be provided in accordance with the symptoms listed above.

3.3.1.3 The use of 911 services will be incorporated as necessary.

3.3.2 If the member is in need of non urgent BH or additional services, the BHCMT will determine the members' Care Management level based on guidelines developed by PAT. In all cases, coverage under Medicare is primary.

3.4 Care Management level determination includes the following:

3.4.1 Low Intensity CM Medicare: These services include but may not be limited to the following services, as covered by Medicare:

3.4.1.1 Outpatient services within the scope of primary care which may be completed by behavioral health physician

3.4.1.2 Outpatient Psychiatric services such as medication management, assessment, individual and group therapy delivered by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office, clinic, or hospital outpatient department.

3.4.1.3 Psychological / Psychiatric testing / assessment

3.4.1.4 Institutions for Mental Diseases (Mental Health Rehab Center or Skilled Nursing Facility)

3.4.2 High Intensity CM Medicare: These services include but may not be limited to the following services as covered by Medicare

3.4.2.1.1 Psychiatric Inpatient Hospital services for acute conditions

3.4.2.1.2 Partial hospitalization / Intensive Outpatient services

3.4.2.1.3 Substance Use Disorder (SUD) detox

3.4.3 Low Intensity CM Medi-Cal/Medicare:

3.4.3.1.1 Mental health services (individual and group therapy, assessment, collateral, plan development)

3.4.3.1.2 Medication support services (prescribing, administering, dispensing and monitoring drug interactions and

contraindications of psychiatric medications, including the evaluation of need, clinical effectiveness and side effects; obtaining informed consent; education; collateral and plan development)

3.4.3.1.3 Day rehabilitation

3.4.3.1.4 Methadone Clinic

3.4.3.1.5 Targeted Case Management

3.4.4 High Intensity CM Medi-Cal/Medicare:

3.4.4.1.1 Intensive Day treatment

3.4.4.1.2 Crisis intervention

3.4.4.1.3 Psychiatric Emergency Services

3.4.4.1.4 Crisis stabilization

3.4.4.1.5 Adult Residential Treatment Services

3.4.5 Beneficiaries that do not meet criteria for specialty mental health services will be referred and linked back to L.A. Care provider network by the BHCMT.

3.5 Referral Process for non BH Care Services

3.5.1 Beneficiaries with co occurring medical conditions or with need for other ancillary or medical services may be referred by the BHCMT to the ICT that is developed by the Health Plan for coordinating all care requirements of the beneficiary

3.5.2 Any BHP may identify behavioral health beneficiaries that need physical health care services and refer the beneficiaries to the BHCMT care manager.

3.5.3 L.A. Care's BHCMT care manager will identify the Primary Care Physician (PCP) assigned to the beneficiary and refer and link the beneficiary to the PCP for health care services as needed.

4.0 STRUCTURAL CONSIDERATIONS FOR BH CARE COORDINATION:

4.1 Care Management Teams

4.1.1 Program Administration Team (PAT) will have the following shared responsibilities:

4.1.1.1 Develop guidelines and policies and procedures to assist the Behavioral Health Care Management Team in its day to day operations.

4.1.1.2 Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.

4.1.1.3 Program evaluation.

4.1.1.4 Resolve disputes between L.A. Care and the LMHP.

4.1.1.5 Identify and resolve issues between LA Care & DMH / DPH provider relations.

4.1.2 Behavioral Health Care Management Team (BHCMT) will have the following shared responsibilities:

4.1.2.1 Authorize reimbursement based upon developed guidelines by PAT.

4.1.2.2 Develop a behavioral health care plan.

4.1.2.3 Coordinate care between physical health, mental health, substance abuse and LTSS providers through the ICT.

4.1.2.4 Monitor clinical progress.

4.1.2.5 Reassess service needs.

4.1.2.6 Refer and link to appropriate services.

4.1.2.7 Serve as the liaison to the ICT as needed.

4.1.3 ICT will be facilitated by L.A. Care to provide needed care management services to all beneficiaries. The team will include health care staff, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate. The LMHP will provide consultation to the team and ensure mental health needs are addressed.

5.0 CARE COORDINATION:

5.1 Care Coordination Activities

- 5.1.1 L.A. Care will conduct a Health Risk Assessment for all beneficiaries enrolled in the Demonstration project that also includes BH screenings. L.A. Care will refer beneficiaries with specific mental health and substance abuse findings from the screening to the PCP for linkage to a mental health provider and/or substance use disorder provider.
- 5.1.2 L.A. Care's PCP will refer beneficiaries through the toll free BH number to the BHCMT if services required are outside the scope of the PCP or if the beneficiary request services from mental health or DPH.
- 5.1.3 The BHP and or LMHP provider, beneficiary and the BHCMT will work closely together to develop an individual care plan.
- 5.1.4 If needed DPH provider will secure a signed consent from the beneficiary to share PHI with the BH and or LMHP and the PCP for the purpose of care coordination.
- 5.1.5 BHP and or LMHP providers will submit written documentation that contains treatment coordination information to the beneficiary's primary care physician within 30 days from the initial mental health visit, annually, and when there are significant changes in diagnosis, medications or other aspects of care plans.
- 5.1.6 L.A. Care PCP will submit written documentation that contains treatment coordination information to the beneficiary's mental health provider within 30 days after the initial primary care visit, annually, and when there are significant changes in diagnosis, medications or other aspects of the care plans.
- 5.1.7 L.A. Care will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with the BHP and or LMHP provider when necessary.
- 5.1.8 The BHP and or LMHP, L.A Care and DPH providers may participate in case conferencing as needed and conduct regular meetings to review the care coordination process.
- 5.1.9 L.A. Care's BHCMT will coordinate with the BHP and or LMHP and DPH to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
- 5.1.10 L.A. Care will develop procedures and coordinate direct transfers between psychiatric inpatient hospitals and inpatient medical hospital services and involve the BHCMT for purpose of care management and care coordination.

5.2 Exchange of information

- 5.2.1 Successful Care Coordination is accomplished through exchange of information between providers and entities involved in the care for beneficiaries enrolled in the

program. Refer to Policy and Procedure XXXXX for details on Exchange of Information.

6.0 AUTHORITY:

- 6.1 California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
- 6.2 Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
- 6.3 Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Members, D. Mental Health Services
- 6.4 MMCD Policy letter 00-01
- 6.5 Title 9, CCR, Chapter 11, Division 1, Section(s): 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205(b)(1); 1830.210; 1850.210(I); 1850.505
- 6.6 Title 22, CCR, Chapter 3, Article 4, Section(s) 51305; 51311; 51313; 51183
- 6.7 Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards
- 6.8 Welfare and Institutions Code Section 5600.3; and 14016.5

7.0 REFERENCE(S):

- 7.1 L.A. Care Health Plan Model of Care 2013
- 7.2 Memorandum of Understanding Between L.A. Care and L.A. County Department of Mental Health
- 7.3 Authorization and Care Management Flow Chart “No Wrong Door” February 27, 2013

Accountability Matrix	
Responsible Department(s)	Policy Section #

ELECTRONICALLY APPROVED BY THE FOLLOWING			
	Officer	Director	Regulatory Affairs &

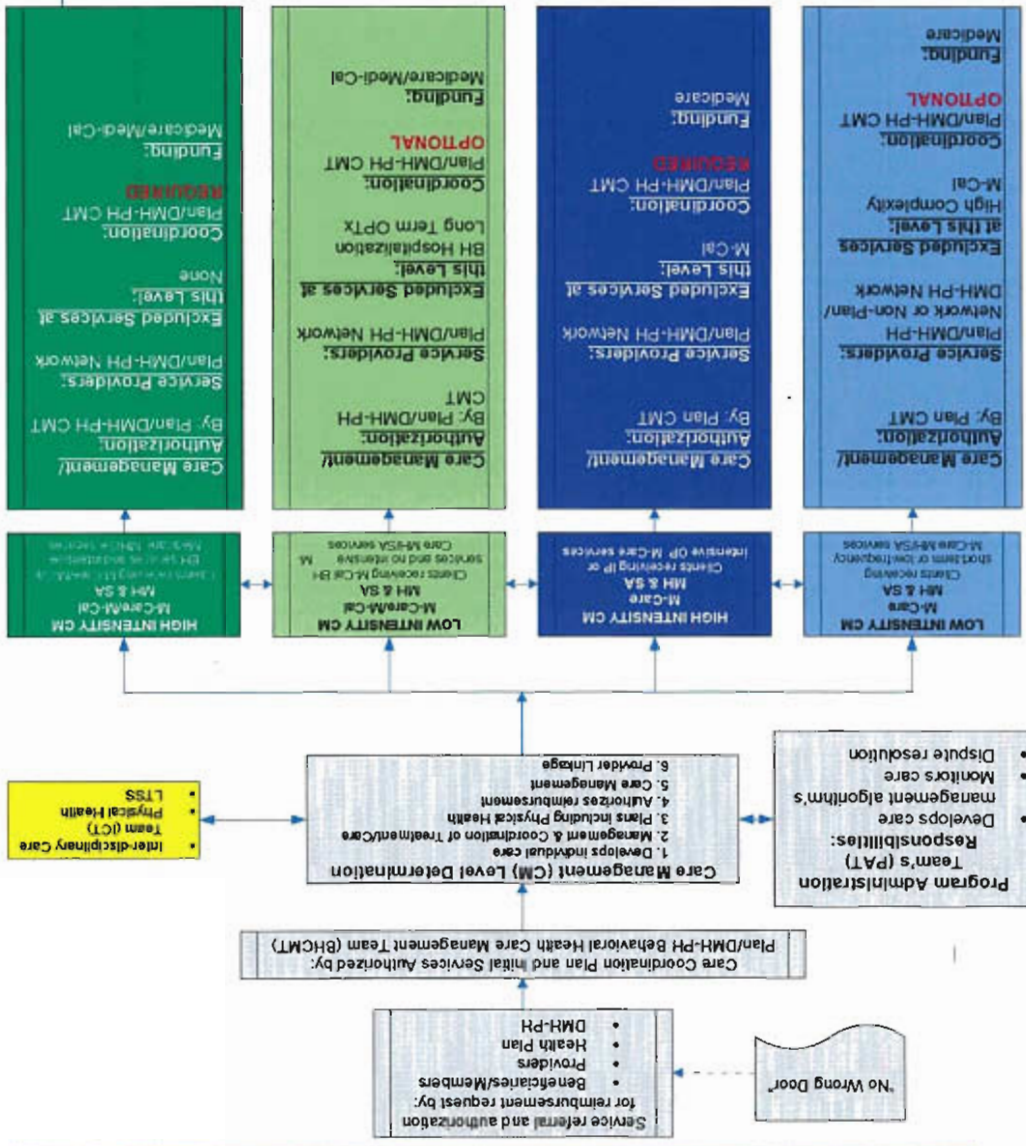
			Compliance
Name			
Department			
Title			
IF APPLICABLE			
Board of Governors		Motion Number:	

*Note: Please write "N/A" for the Name, Department, and Title of the Director if this approval is not applicable.

Policy History				
Date	Department	Policy or Section #	Comment(s)	Next or Annual Review Date

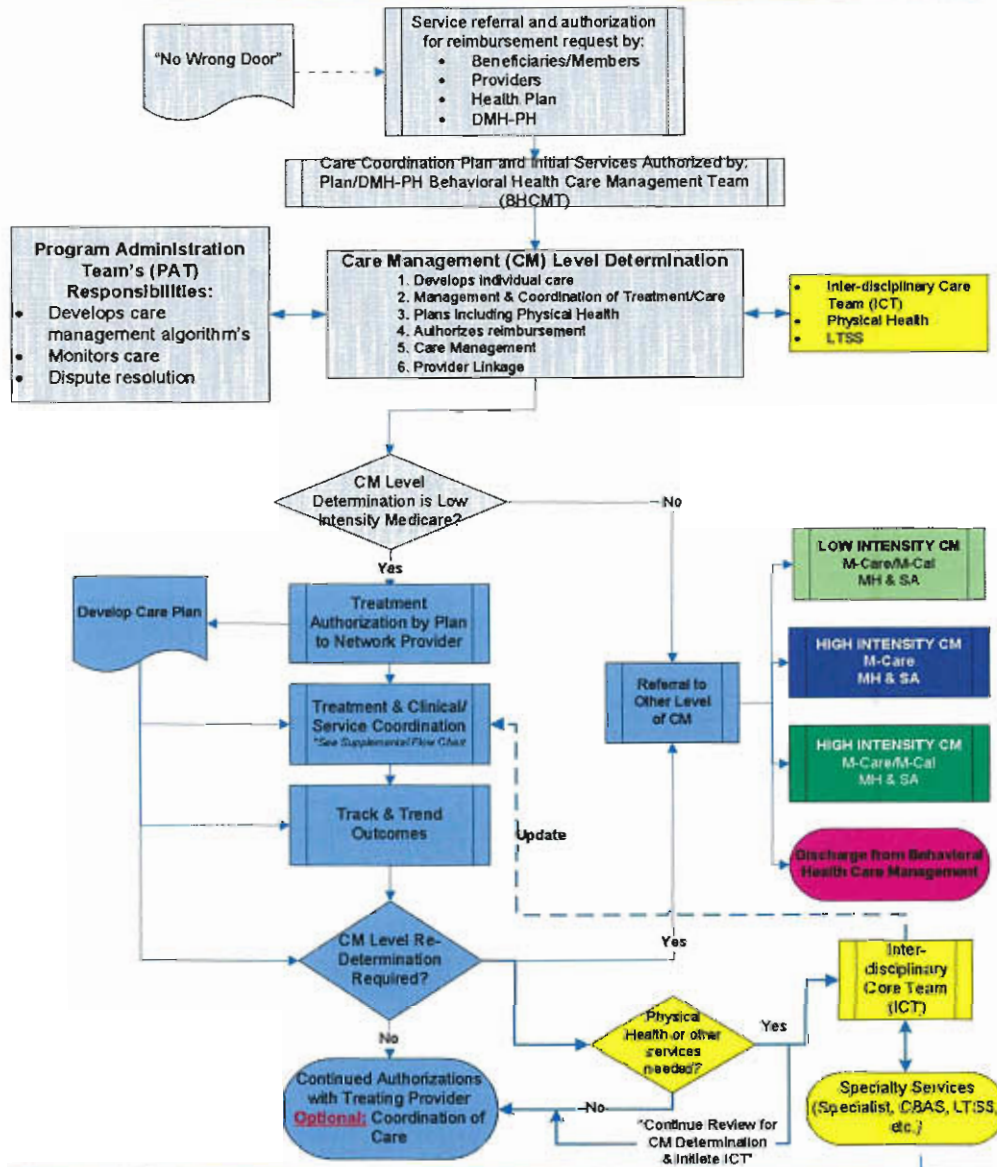
Proposed Authorization and Care Management Flow Chart

Friday, July 19, 2013



**DMH & DPH
Authorization & Care Management Low Intensity Medicare Flow Chart**

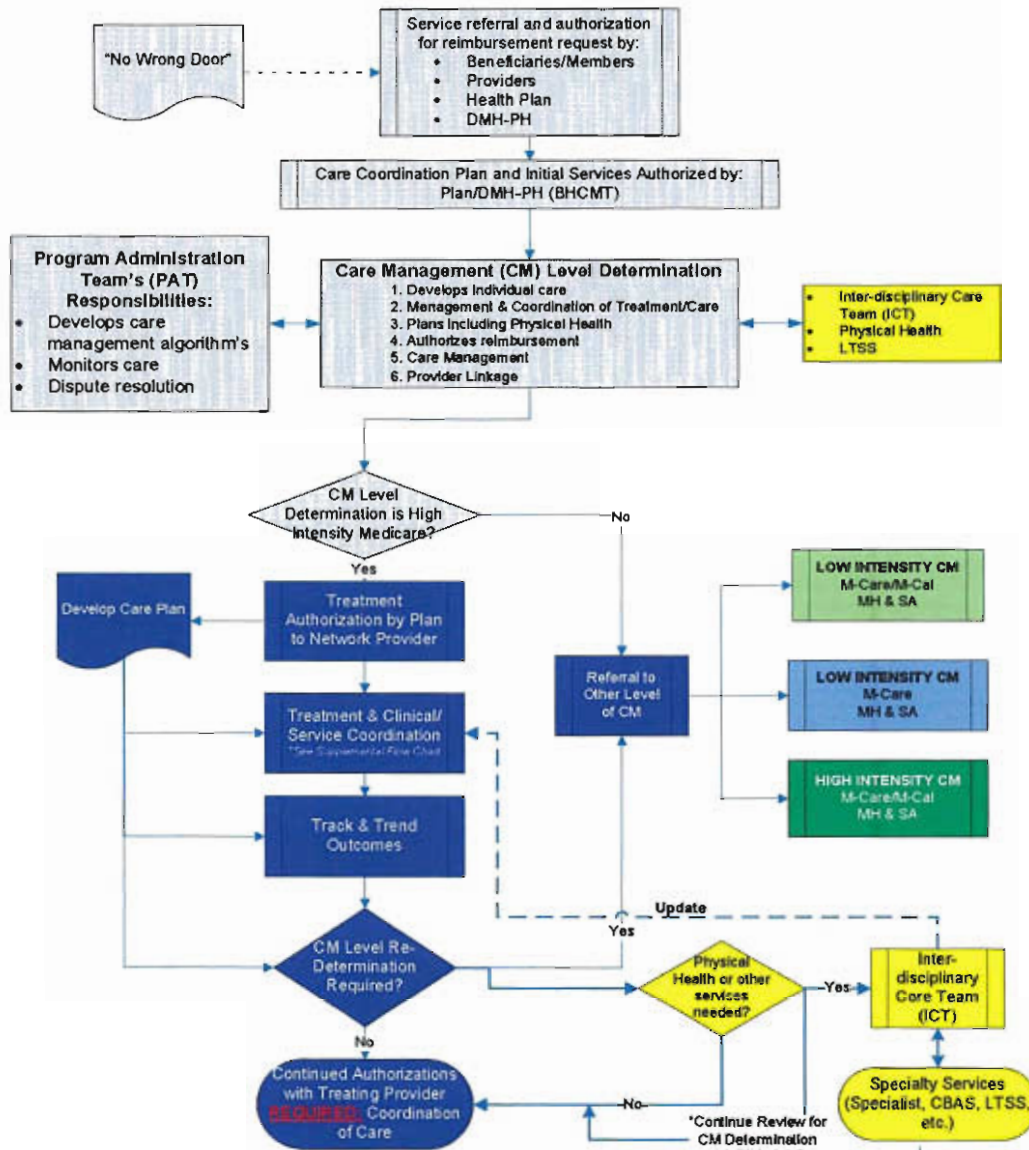
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal

DMH & DPH Authorization & Care Management High Intensity Medicare Flow Chart

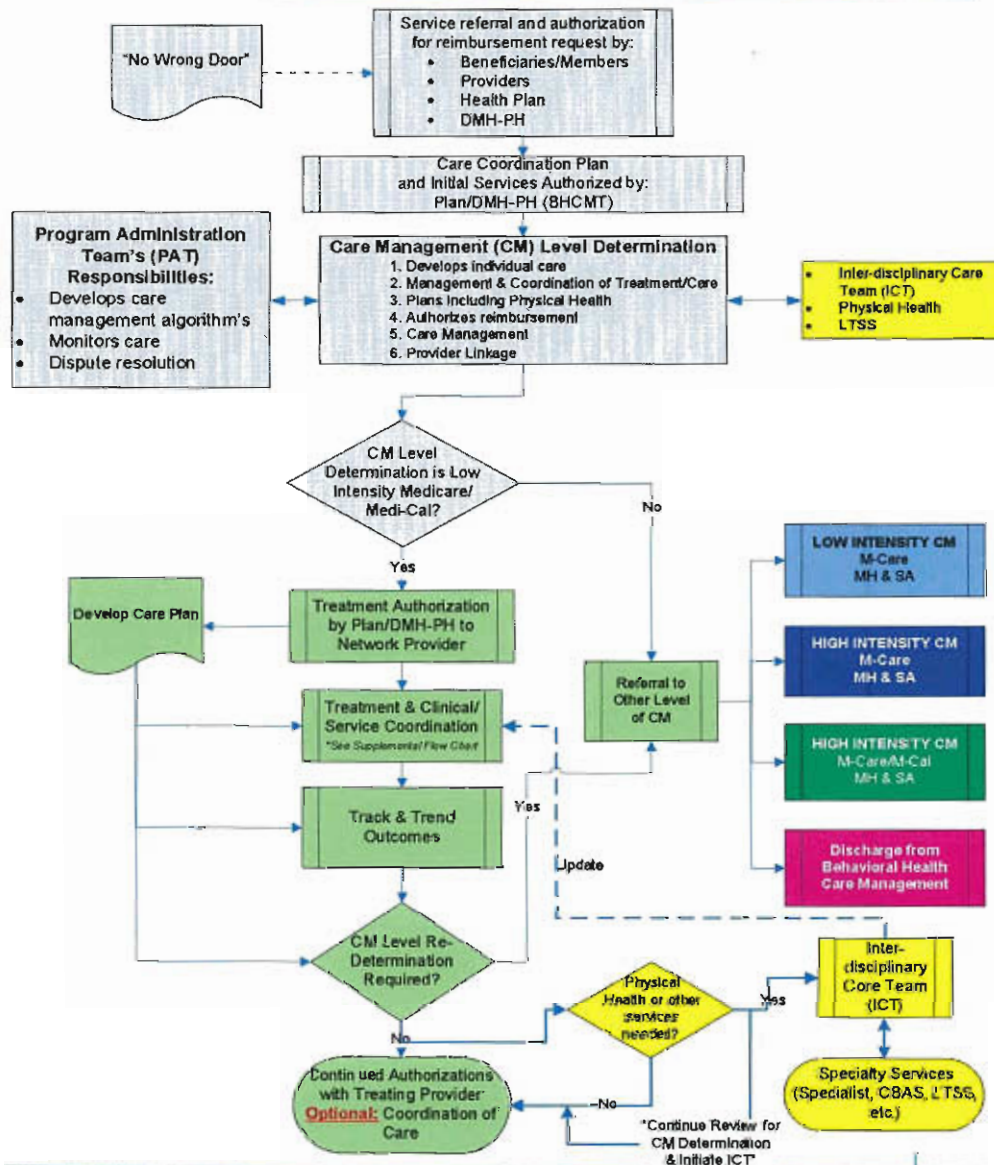
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

DMH & DPH Authorization & Care Management Low Intensity Medicare/Medi-Cal Flow Chart

Friday, July 19, 2013

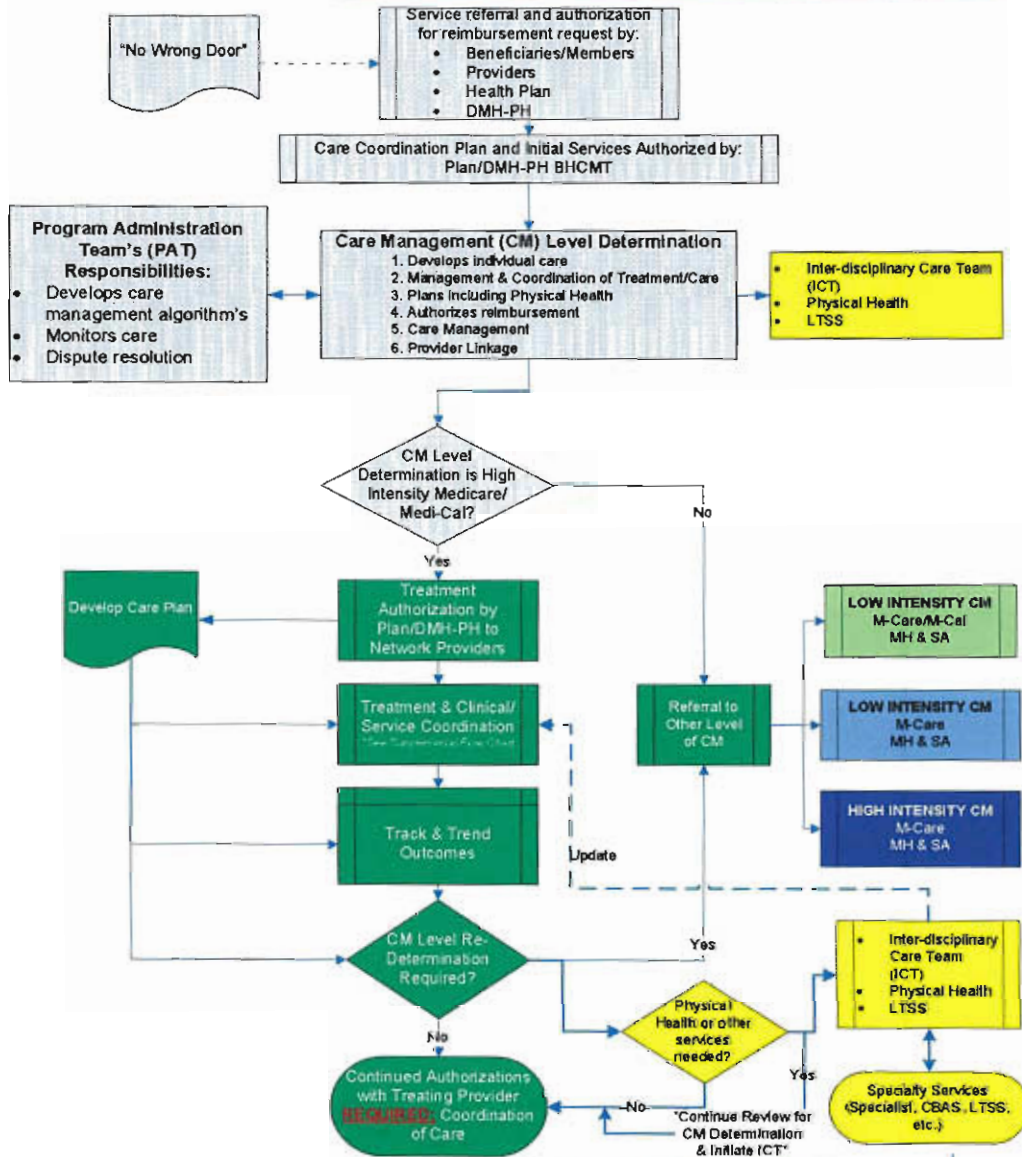


* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal



DMH & DPH Authorization & Care Management High Intensity Medicare/Medi-Cal Flow Chart

Friday, July 19, 2013

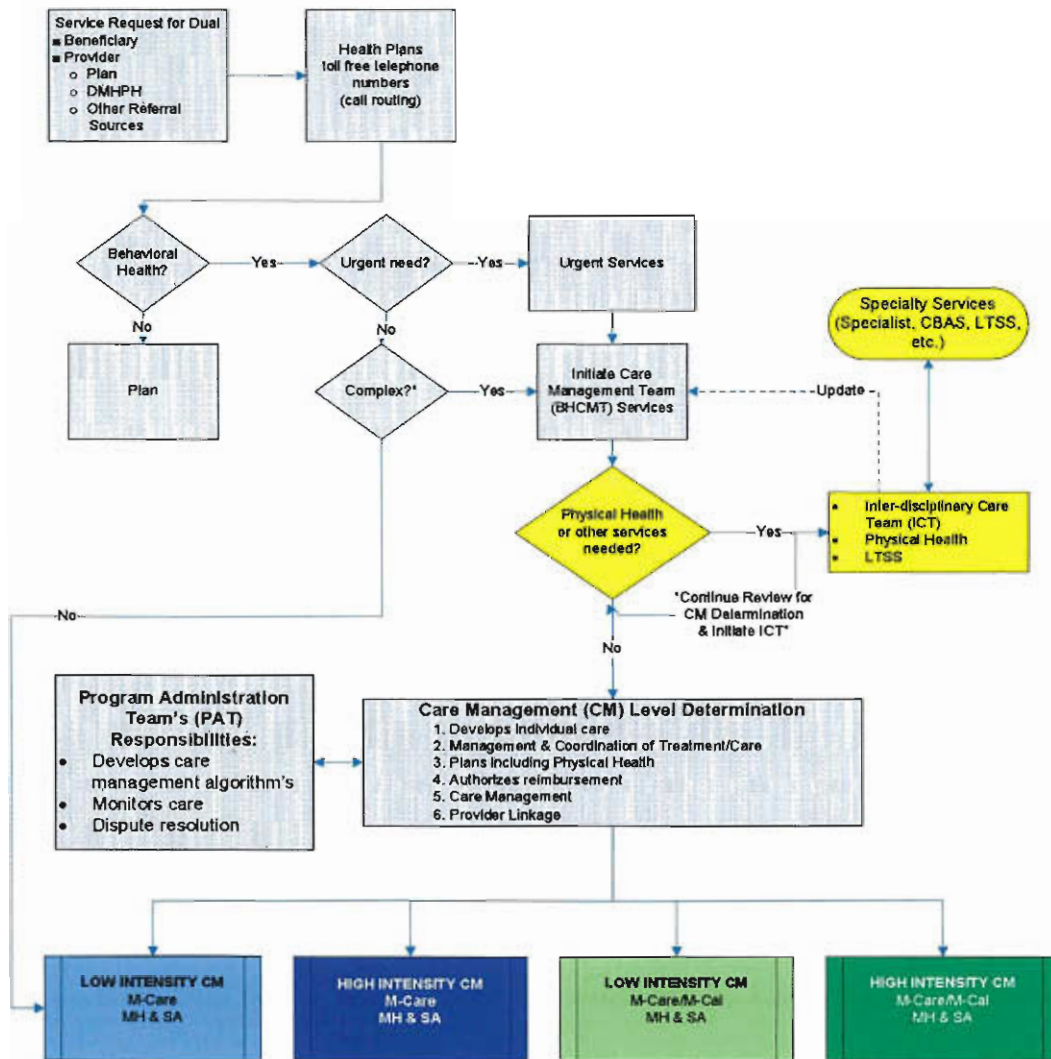


* Complex behavioral health care cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Medi-Cal



DMH & DPH Care Management Level Determination Flow Chart

Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

Behavioral Health Benefits in the Cal MediConnect Program

Coverage Responsibility Matrix

Updated February 27, 2013

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be “carved out”). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1+2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California’s 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

To determine medical necessity for Drug Medi-Cal Substance Abuse Services, health plans and counties will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

Coverage Matrix 1: Mental Health Benefits

Inpatient Services			
	Type of Service	Benefit Coverage	Primary financial responsibility under the Demonstration
Psychiatric inpatient care in a general acute hospital	Facility Charge	Medicare <i>Subject to coverage limitations *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Inpatient care in free-standing psychiatric hospitals (16 beds or fewer)	Facility Charge	Medicare <i>Subject to coverage limitations and depends on facility and license type *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Psychiatric health facilities (PHFs) (16 beds or fewer)	Facility Charge <i>(Most are not Medicare certified)</i>	Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
Emergency Department	Facility Charges	Medicare	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Long-Term Care			
Skilled Nursing Facility	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
SNF-STP (fewer than 50% beds)	Facility Charges	Medicare/Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

Institutes for Mental Disease

	Long-term care	Benefit Coverage	Primary financial responsibility under the Demonstration
SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)[§]	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Not covered by Medicare or Medi-Cal+	County
	Facility Charge ages 65 and older	Medi-Cal	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Mental health rehabilitation centers (MHRCs) (IMD)	Facility Charges	Not covered by Medicare or Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Psychiatric health facilities (PHFs) with more than 16 beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	County	County
	Facility Charge ages 65 and older (<i>most are not Medicare certified</i>)	Medi-Cal*	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Free-standing psychiatric hospital with 16 or more beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Medicare*	Health plan
	Facility Charge ages 65 and older	Medicare	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan

* Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his Medicare psychiatric hospital coverage then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters [02-06](#) and [10-02](#).

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

§ Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act

Outpatient Mental Health Services

		Primary Financial Responsibility	
Type of Service	Benefit Coverage	Patient meets criteria for MHP specialty mental health services [^]	Patient does NOT meet criteria for MHP specialty mental health services
Pharmacy	Medicare	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	Medicare	Health Plan	Health Plan
Outpatient services within the scope of primary care	Medicare	Health Plan	Health Plan
Psychiatric testing/ assessment	Medicare	Health Plan	Health Plan
Mental health services [§] <i>(Individual and group therapy, assessment, collateral)</i>	Medicare	Health plan	Health Plan
Mental health services [§] <i>(Rehabilitation and care plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication support services [§] <i>(Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)</i>	Medicare	Health plan	Health Plan
Medication support services [§] <i>(instruction in the use, risks and benefits of and alternatives for medication; and plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day rehabilitation	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis intervention	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis stabilization	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Adult Residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Targeted Case Management	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria

[^] 1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

[§] Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

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

Coverage Matrix 2: Substance Use Disorder Benefit

	Type of Service	Benefit Coverage	Demonstration Responsibility
Inpatient Acute and Acute Psychiatric Hospitals	Detoxification	Medicare	Health Plan
	Treatment of Drug Abuse ¹ (Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90)	Medicare	Health Plan
Outpatient	Alcohol Misuse Counseling: one alcohol misuse screening (SBIRT) per year. Up to four counseling sessions may be covered if positive screening results. <i>Must be delivered in a primary care setting.</i> ²	Medicare	Health Plan
	Group or individual counseling by a qualified clinician	Medicare	Health Plan
	Subacute detoxification in residential addiction program outpatient	Medicare	Health Plan
	Alcohol and/or drug services in intensive outpatient treatment center	Medicare	Health Plan
	Extended Release Naltrexone (vivitrol) treatment	Medicare	Health Plan
	Methadone maintenance therapy	Drug Medi-Cal	County Drug & Alcohol ³
	Day care rehabilitation	Drug Medi-Cal	County Drug & Alcohol
	Outpatient individual and group counseling (<i>coverage limitations</i>) ⁴	Drug Medi-Cal	County Drug & Alcohol
	Perinatal residential services	Drug Medi-Cal	County Drug & Alcohol

¹ Medicare inpatient detoxification and/or rehabilitation for drug substance abuse when it is medically necessary. Coverage is also available for treatment services provided in the hospital outpatient department to patients who, for example, have been discharged for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. [Click here to learn more.](#)

² Medicare coverage explanation: [Click here to learn more.](#)

³ In San Diego and Orange Counties, county alcohol and drug do not provide these services. Providers have direct contracts with the State.

⁴ Title 22, Section 51341.1 limits DMC individual counseling to the intake, crisis intervention, collateral services and treatment and discharge planning.

Exchange of Information, Including PHI, Related to the Beneficiaries in the Demonstration Project

1. PURPOSE

This Addendum addresses how SAPC and L.A.Care will share information to coordinate care of Beneficiaries with severe and persistent substance use disorder (SUD). Individuals with severe and persistent SUD have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their SUD service provider functions as their primary connection to the overall healthcare system.

In order to coordinate care for such Beneficiaries, the parties must identify those Beneficiaries who are enrollees of L.A.Care and clients of SAPC Providers ("Common Members"). This Addendum documents how the parties will share information to (a) identify Common Members in compliance with the requirements of all applicable federal and State laws and regulations, and (b) provide coordinated care to the Common Members pursuant to the Demonstration Project.

2. DATA MATCHING

Performing a data match to identify Common Members and transmitting the results to the entities providing services to the Common Members helps achieve two important results:

- a) The matched data can help alert healthcare providers to ongoing SUD needs and interventions in Common Members. These SUD needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and SUD providers that can improve the health status and treatment outcomes of those served.
- b) Results of this match would also provide SAPC with information that would allow SAPC Providers to more efficiently and effectively facilitate access to much needed physical healthcare services for Common Members by identifying available primary care resources.

3. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

3.1 To the extent allowed by HIPAA and applicable State and federal privacy laws, L.A. Care shall provide to SAPC the data described in Attachment IV-A, L.A. Care Beneficiary Data Exchange Protocol ("Protocol"). SAPC shall use this data solely to determine whether Beneficiaries are Common Members.

- a) For those Beneficiaries who are determined to be Common Members, SAPC and L.A. Care shall use the data for the purposes of coordinating care.

- b) For those Beneficiaries who are determined not to be Common Members, SAPC shall not use the data for any other purposes, and shall return it to L.A. Care and remove it from all systems where the data was used or stored.

3.2 L.A. Care and SAPC have reviewed the attached Protocol and agree that the data described in the Protocol complies with HIPAA's minimum necessary standard.

[Note to SAPC: HN is still reviewing the Protocol]

3.3 The parties shall comply with the HIPAA Security Rule in transmitting, receiving, and maintaining PHI exchanged in accordance with the Protocol.

4. HIPAA OBLIGATIONS OF THE PARTIES

5. L.A. Care and SAPC acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.

5.1 Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent unpermitted uses or disclosures of such PHI.

6. BUSINESS ASSOCIATE-OBLIGATIONS

6.1 The parties acknowledge that for the purposes of conducting the data matching, SAPC shall be acting in the capacity of a Business Associate of L.A. Care, with respect to the receipt of PHI for Beneficiaries who are not Common Members.

6.2 The parties shall enter into a Business Associate Agreement for the data matching requirements.

6.3 Upon completion of the data matching, SAPC shall not retain any PHI for L.A. Care Beneficiaries who are not Common Members. Such PHI shall be destroyed or returned in accordance with the terms of the Business Associate Agreement.

Attachment IV-A
L.A. CARE BENEFICIARY DATA EXCHANGE PROTOCOL

1. Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty substance use disorder care among Common Members. In the event of an inconsistency between this Protocol and Addendum IV, Addendum IV shall govern.

2. Data Exchange - Data Matching

2.1 Demographic Data. SAPC will provide a secured location for L.A. Care to place a data file of individuals identified as Beneficiaries, initially in the form of a flat text file, on an interval agreed upon by SAPC 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, referred to as the Dual Eligibles 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 [kp note to HN internal: Does this field apply to HN?]
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address

2.2 Match Details. Upon receipt of the Dual Eligibles file, SAPC shall load the data to the Department of Public Health ("DPH") Enterprise Data Warehouse. SAPC shall maintain a historical table of dual eligible beneficiaries and their respective eligibility information. SAPC shall conduct a match of concomitant Beneficiaries between L.A. Care and DPH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or "match" like clients of SAPC 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:

- a) Tier 0:
 - Member CIN weighted at 100%
- b) Tier 1:
 - Member Social Security Number weighted at 100%
 - Member Date of Birth weighted at 100%
- c) Tier 2:
 - Member Social Security Number weighted at 85%
 - Member Full Name weighted at 90%
- d) Tier 3:
 - Member Social Security Number weighted at 85%
 - Member Last Name weighted at 85%
- e) Tier 4:
 - Member Social Security Number weighted at 100%
 - Member Year of birth weighted at 100%
- f) Tier 5:
 - Member Full Name weighted at 90%
 - Member Date of Birth weighted at 100%
 - Member Gender weighted at 100%
- g) 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%

3. Data Exchange – Care Coordination

- 4. L.A. Care Usage. Upon completion of the match, SAPC shall extract and provide (as described below), Common Members who currently have an open and active episode in the DPH Integrated System (IS) or successor DPH electronic health**

record (EHR) to L.A. Care in the form of a flat text file. SAPC will, at a minimum, provide the following elements:

- Admission Data of Episode
- Last SUD Contact Date
- SAPC Provider ID
- SAPC Provider Name
- SAPC Provider Address
- SAPC Provider Contact Phone Number
- SAPC Provider Primary Contact Name
- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

The response data file will be placed on a secured server administered and maintained by the SAPC. L.A. Care will retrieve the file for the purposes of coordinating Common Members care and for no other purpose by distributing the SUD provider contact information to its Primary Care Providers (PCP) for the purposes of coordinating Common Members care 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
- L.A. Care shall not use or disclose the information for any other purpose

4.1 SAPC Usage. In addition to the demographic data provided pursuant to Section 2.1, L.A. Care will provide the following data elements for Common Members to SAPC in the form of a flat text file:

- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

After processing the Beneficiary data, SAPC will upload the PCP and other pertinent information for Common Members to the DPH IS or successor DPH EHR. SAPC Providers will then be able to access the data via the IS or successor DPH 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 DPH EHR is controlled via user credentials.

MEMORANDUM OF UNDERSTANDING

By and Between

HEALTH NET COMMUNITY SOLUTIONS, INC.
and theCOUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

For

IMPLEMENTATION OF THE

CAL MEDI-CONNECT PROJECT (Referred to herein as
The Dual Eligibles Demonstration Program)

FOR MEDICARE-MEDI-CAL BENEFICIARIES

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IMPLEMENTATION OF THE

CAL MEDI-CONNECT PROJECT (Referred to herein as
The Dual Eligibles Demonstration Program)

FOR MEDICARE-MEDI-CAL BENEFICIARIES

This Memorandum of Understanding (“MOU”) is made and entered into on the _____ day of _____, 2013 by and between Health Net Community Solutions, Inc. (“Health Net”), and the County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control, as the county alcohol and drug program administration in Los Angeles County for the purpose of providing access to all medically necessary Behavioral Health Services currently covered by Medicare and Medi-Cal to Beneficiaries enrolled in the Dual Eligibles Demonstration Project.

I. RECITALS

Whereas, California’s Coordinated Care Initiative was created through a public process involving stakeholders and health care consumers and enacted through SB 1008 (Chapter 22, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012);

Whereas, a component of the Coordinated Care Initiative includes a three-year demonstration program which will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a health plan for eligible Medicare and Medi-Cal Beneficiaries;

Whereas, Health Net has been selected by the State Department of Health Care Services (“DHCS”) as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County;

Whereas, health plans participating in the Dual Eligibles Demonstration Project (“**Demonstration Health Plans**”) will provide eligible beneficiaries with all mental health and substance use services, generally collectively referred to as “Behavioral Health

Services”, currently covered by Medicare and Medi-Cal; except that county administered Specialty Mental Health Services and county administered Drug Medi-Cal substance use treatment services will not be included in the Demonstration Health Plans’ capitation payments from DHCS, and such Specialty Mental Health Services and Drug Medi-Cal substance use treatment services shall continue to be financed and administered by the counties;

Whereas, in Los Angeles County, the agencies that administer Specialty Mental Health Services and Drug Medi-Cal substance use treatment services are, respectively, the County of Los Angeles Department of Mental Health as the Local Mental Health Plan (“**LMHP**”) and the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (“**SAPC**”);

Whereas, Demonstration Health Plans and county agencies are required to have written agreements outlining how they will coordinate services;

Whereas, the Coordinated Care Initiative provides State authority for the Dual Eligibles Demonstration Project;

Whereas, the DHCS has finalized a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (“**CMS**”) for the Dual Eligibles Demonstration Project;

Whereas, further, the DHCS, CMS, and Health Net have entered into a three-way agreement for the Dual Eligibles Demonstration Project: and

Whereas, in anticipation of federal approval and the finalizing of all required agreements, Health Net and SAPC have entered into this MOU for purposes of implementing the Dual Eligibles Demonstration Project.

II. PARTIES

Health Net, a licensed California health care service plan under the Knox Keene Act, has been selected by the DHCS as one of the health plans to administer the Dual Eligibles Demonstration Project in Los Angeles County. As a component of the Dual Eligibles Demonstration Project, Health Net is required to provide physical health services and certain Behavioral Health Services, and to coordinate care for the needs of Beneficiaries.

The SAPC is the county alcohol and drug program administrator responsible for providing medically necessary Drug Medi-Cal substance use treatment services for Medi-Cal eligible beneficiaries of Los Angeles County. Under the Dual Eligibles Demonstration Project, the SAPC will provide Drug Medi-Cal substance use treatment services for Beneficiaries who meet Drug Medi-Cal medical necessity criteria, and, with Health Net, will coordinate Medicare and Medi-Cal services.

III. BACKGROUND

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for beneficiaries of both the Medicare and Medi-Cal programs, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including Los Angeles County, were selected by the State to implement a three-year demonstration project for Medicare and Medi-Cal beneficiaries, referred to as the Dual Eligibles Demonstration Project. Health Net is one of two local managed care health plans selected by the DHCS and DMH in Los Angeles County to provide health, mental health, substance abuse, and Long Term Services and Supports (“LTSS”) services to Beneficiaries enrolled in the Dual Eligibles Demonstration Project (or “Demonstration Project”).

Under the Demonstration Project, all Medicare and non-specialty Medi-Cal substance use services are the responsibility of Health Net and included in its capitation payment for the Demonstration Project. Drug Medi-Cal substance use services not covered by Medicare benefits will not be included in Health Net’s capitation payment. Health Net and SAPC will collaborate to ensure Beneficiaries have access to coordinated Medicare and Medi-Cal services. Drug Medi-Cal substance abuse treatment services will continue to be provided or arranged for by SAPC, and will be the financial responsibility of SAPC, for Beneficiaries that meet Medi-Cal medical necessity criteria.

IV. PURPOSE

This MOU sets forth the Parties’ mutual understandings, commitments, and protocols regarding how Drug Medi-Cal substance use treatment services funded by Medicare and Medi-Cal will be coordinated and managed by SAPC and Health Net for Beneficiaries. Among other things, the MOU addresses: 1) the roles and responsibilities of Health Net and SAPC, 2) how care will be coordinated by and between Health Net and SAPC, 3) the process for information exchange between Health Net and SAPC, and 4) shared financial accountability strategies.

V. DEFINITIONS

Behavioral Health Services (or “Behavioral Health”)

Mental Health Services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations and any mental health benefits and substance abuse available under the Medicare Program.

Behavioral Health Care Management Team (“BHCMT”)

Multidisciplinary team that provides care management and care coordination for Medicare and Medi-Cal services, and authorization for Medicare services to Beneficiaries

enrolled in the Demonstration Project. The BHCMT is composed of representatives from the LMHP, Health Net and/or MHN, and SAPC.

Behavioral Health Care Plan

The care plan developed by a Beneficiary and the Beneficiary's BHCMT that describes the authorized Behavioral Health Services to be provided the Beneficiary.

Beneficiary

An individual who is eligible for both Medicare and Medi-Cal benefits and who is enrolled in the Dual Eligibles Demonstration Project and who receives covered services through Health Net.

Care Coordination

The management of physical, LTSS and Behavioral Health Services for Beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

Coordinated Care Initiative ("CCI")

California's coordinated care model that intends seamless access to the full continuum of medical, social, LTSS and Behavioral Health Services to Beneficiaries.

Confidentiality of Medical Information Act

A State law, California Civil Code Section 56 et. seq., which governs the confidentiality of medical information, as defined therein; this law specifies when medical information is required and permitted to be disclosed by health care providers and others.

Dual Eligibles Demonstration Project or Demonstration Project

The three-year CCI demonstration project involving an agreement or agreements between the Demonstration Health Plans, DHCS and CMS for coverage of individuals with eligibility for both Medicare and Medi-Cal.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, Public Law 104-191 and its implementing regulations, including Standards for the Privacy of Individually Identifiable Health Information and the Health Insurance Reform: Security Standards at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act, (HITECH Act), including its implementing regulations, which provide federal protections for individually identifiable health information held by covered entities, as defined therein.

Interdisciplinary Care Team (ICT)

A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of Beneficiaries. The ICT also includes a representative from the BHCMT.

Local Mental Health Plan (“LMHP”)

The Los Angeles County Department of Mental Health which is the local county agency that has responsibility for administering public and Specialty Mental Health Services.

Long Term Services and Supports (“LTSS”)

Those services and supports described in Welfare and Institutions Code section 141861, subdivision (b).

Medi-Cal

California's Medicaid health care program of medical assistance benefits under Title XIX of the Social Security Act.

Medicare

Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (“ESRD”) or Amyotrophic Lateral Sclerosis (“ALS”).

Managed Health Network, Inc. (“MHN”)

Managed Health Network, Inc., together with its subsidiaries, is the behavioral healthcare affiliate of Health Net that assists Health Net in meeting the behavioral and care coordination needs of certain Beneficiaries covered through the Demonstration Project.

Primary Care Provider (“PCP”)

A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary through the Dual Eligibles Demonstration Project.

Program Administration Team (“PAT”)

A team composed of staff from MHN and/or Health Net, LMHP, and SAPC that provides program oversight of the BHCMT.

Protected Health Information (“PHI”)

Individually identifiable health information as defined by 45 C.F.R. Section 160.103.

Specialty Mental Health Services

Services provided through the LMHP as defined by Title 9, California Code of Regulations (CCR) Section 1810.247 and in accordance with Chapter 11 of Title 9.

State Department of Health Care Services (DHCS)

The State department that has responsibility for administering health care services funded Medi-Cal.

Welfare and Institutions Code Section 5328 et. seq.

The State laws governing the confidentiality of information and records of the LMPH and LMPH Providers; this law specifies that all information and records received in the course or providing services are confidential and specifies when such information is required or permitted to be disclosed.

42 Code of Federal Regulations, Part II

The provisions of Federal law which govern the confidentiality of patient alcohol and drug abuse treatment records. Any information which could reasonably be used to identify individuals who are receiving, or who have received, such treatment, is protected by this law. Such information may not be released unless doing so would fall within one of the specific exceptions provided under these provisions. When release of such protected information is contemplated by any of the parties to this MOU, the party in possession of this information should consult this provision to determine whether it may proceed with release.

VI. APPLICABLE DOCUMENTS

Addenda I, II, III, and IV are attached to and form a part of this MOU. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or contents or description of task or responsibility between the MOU and the addendum, or between addenda, such conflict or inconsistency shall be resolved in a manner that advances the purpose and intent of this MOU. Addenda to this Agreement are as follows:

Addendum I

Cal Medi-Connect Coordination of Care Policy and Procedures [Behavioral Health] Policy and Procedure. This Policy sets forth the coordination of care procedures that the Parties and their applicable related entities will follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum II

DMH and DPH Authorization and Care Management Flow Charts. Addendum II sets forth the process flows and guidelines that the Parties and their applicable related entities in the Demonstration Project agree to follow for the provision of Behavioral Health Services to Beneficiaries.

Addendum III

Mental Health and Substance Abuse Benefits in the Duals Demonstration Matrix. Addendum III sets forth a listing of the Behavioral Health Services to be provided to Beneficiaries and the Party that will have financial responsibility for provision of that Service as defined by DHCS.

Addendum IV

Exchange of Information, Including PHI, Related to the Beneficiaries.

VII. ROLES AND RESPONSIBILITIES

Health Net has primary administrative and program responsibility for care management, care coordination and authorization for reimbursement for Behavioral Health Services covered by Medicare under the Demonstration Project.

A. Behavioral Health Services Administrative Arrangements

Health Net and its affiliate MHN will be providing the Behavioral Health Services and care coordination needs of certain Beneficiaries as required under the Demonstration Project.

Health Net and/or MHN shall:

1. Develop and contract a Behavioral Health Services provider network that includes, but is not limited to, SAPC providers.
2. Lead and be the focal point for all Behavioral Health Services coordination activities between Health Net, MHN, LMHP, and SAPC.
3. Lead and participate in the BHCMTs.
4. Process Medicare Behavioral Health Services claims payment to Behavioral Health Services network providers which include, but are not limited to, SAPC Providers.

B. Care Management Teams

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care, Health Net, LMHP, and SAPC, shall establish three interagency care management teams for behavioral health composed of, but not limited to, representatives from each of the entities.

The interagency care management teams are responsible, as described below, for ensuring that health, mental health, substance abuse and LTSS services are easily accessible and coordinated for Beneficiaries:

1. Program Administration Team (“PAT”) has the following shared responsibilities:
 - Develop algorithms, and policies and procedures to assist the BHCMT in its day to day operations.
 - Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 - Conduct program evaluation.
 - Resolve disputes between Health Net and SAPC.
 - Identify and resolve provider relations issues.
2. Behavioral Health Care Management Team (“BHCMT”) led by Health Net and/ or MHN
 - Authorize covered Behavioral Health Services based upon algorithms developed by PAT. Develop individual behavioral health care plans.

- Coordinate care between physical health, mental health and substance abuse providers.
 - Monitor individual clinical progress.
 - Reassess individual service needs.
 - Refer and link to appropriate services.
 - Serve as the liaison to the Interdisciplinary Care Team for Beneficiaries that also need non behavioral health services.
 - Resolve disputes between Health Net and SAPC.
3. Interdisciplinary Care Team (“ICT”). Health Net is responsible for facilitating ICTs to provide care management services to Beneficiaries, that present with complex and multiple health, mental health, substance abuse conditions, and may also need LTSS. The ICT will include, but is not limited to, health care staff, BHCMT, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate and as permitted by law.

For further guidance regarding the role of and processes applicable to the Care Management Teams refer to Addendums I and II to this MOU.

C. Referrals and Criteria

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care for purposes of referring Beneficiaries for Behavioral Health Services, Health Net, LMHP, and SAPC agree to the following protocols, as further described in Addenda I, II and III to this MOU.

1. Referral Process for Behavioral Health Services

1.1 The Dual Eligibles Demonstration Project shall have a “no wrong door” approach to service access, with multiple entry paths for Beneficiaries to access Behavioral Health Services. Referrals may come from various sources including, but not limited to, Beneficiary self-referrals.

1.2 All incoming referrals or requests for Behavioral Health Services shall be screened and triaged according to procedures established by the BHCMT to determine Behavioral Health need, and to refer and link Beneficiaries to a Behavioral Health provider and/or to SAPC for substance use disorders treatment and recovery services.

2. Referral Process for non-Behavioral Health Services

2.1 SAPC shall identify Beneficiaries that need physical health care services and refer these Beneficiaries to the BHCMT in the manner described in the Addendum I and Addendum II attached to this MOU.

3. Determination of SAPC Service Criteria

3.1. The criteria for provision of Drug Medi-Cal substance use treatment services are set forth in Section 51341.1 of Title 22 of the California Code of Regulations.

4. Determination of Medicare Non-Specialty Substance Abuse Service Criteria

4.1. Health Net shall provide Behavioral Health Services to Beneficiaries as listed in Addendum III.

4.2. Description of Covered Drug Medi-Cal substance use treatment services are included in Addendum III.

D. Credentialing

The SAPC has a large network of licensed providers contracted with the SAPC that deliver clinical services at SAPC owned or SAPC provider treatment sites.

1. Health Net and/or Health Net through MHN are responsible for contracting with and credentialing those providers contracted with the SAPC who are Medicare reimbursable, for the purposes of becoming Medicare-reimbursable providers in the Demonstration Project for certain delegated health plans.
2. The standards for the credentialing of providers shall satisfy the requirements of Health Net, CMS, National Committee on Quality Assurance (“NCQA”), URAC, and other necessary regulatory entities or requirements. SAPC providers must meet the Medicare credentialing requirements and standards to be eligible for reimbursement for Medicare services provided pursuant to the Dual Eligibles Demonstration Project.
3. As part of any delegation of credentialing to SAPC, Health Net may perform periodic oversight audits to ensure that the required standards are met on an ongoing basis.
4. Providers and provider sites must be credentialed in both SAPC and Health Net and MHN’s networks at all times in order to provide Drug Medi-Cal reimbursable services to Beneficiaries.
5. Any failure of a provider or provider site to meet the applicable credentialing standards and requirements as determined by Health Net, MHN, or SAPC will automatically result in removal of that provider or provider site as a credentialed provider of Behavioral Health Services to Beneficiaries pursuant to the terms and conditions contained in the applicable provider agreement between the parties.

6. Health Net and SAPC will notify each other at the time of any changes in provider or provider site network credentialing status or compliance.

E. Financial Responsibility: Reimbursement Process for Medicare Behavioral Health Services Provided by Health Net Providers

Primary financial responsibility of and between the parties for Behavioral Health Services for the Demonstration Project are based on the matrix provided by DHCS as set forth in Addendum III, attached hereto. Further provisions and processes for reimbursement of Behavioral Health Services shall be specified in a separate provider agreement between SAPC and Health Net or MHN.

For further information regarding financial responsibility and processes for the provision of Behavioral Health Services to Beneficiaries covered by Medicare, refer to the Addenda III attached to this MOU.

F. Beneficiary and Provider Education

1. Health Net will develop, in collaboration with the LMHP and SAPC, education materials that explain the Behavioral Health and substance abuse components of the Demonstration Project.
2. The LMHP and SAPC will provide Health Net staff with training on their programs, eligibility and assessment criteria, services available, and how to review and understand data made available for coordination of care to Health Net and/or MHN. Initial trainings will be provided prior to implementation of the Demonstration Project, and on an as-needed basis, but not less than annually.
3. Health Net will provide the LMHP and SAPC staff with opportunities for training on Health Net benefits and procedures. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative, and on an as-needed basis, but not less than annually.
4. Health Net will train its providers on procedures for Behavioral Health care coordination, care management requirements, referral processes, claims and reimbursement issues.
5. Health Net will develop, in collaboration with the LMHP and SAPC, a provider manual that addresses the Behavioral Health and substance abuse components of the Demonstration project.
6. Health Net, the LMHP and SAPC will provide information and education about the Demonstration Project to potential eligible enrollees, their family members, caregivers and to Beneficiaries enrolled in the Demonstration Project to assist them with making informed decisions related to their health care needs.

G. Dispute Resolution Related to Reimbursement for Services

1. First Level Disputes: All disputes “First Level Disputes” shall be submitted to the BHCMT for resolution. First Level Disputes may include, but are not limited to, disagreements regarding authorization for or reimbursement of Medicare and or Medi-Cal services.
2. Second Level Disputes: If the BHCMT cannot resolve a First Level Dispute to the satisfaction of either or both parties, the dispute shall be submitted to the PAT within mutually agreed upon timeframes. The PAT shall inform the BHCMT of its decision. (“Second Level Disputes”)
3. Third Level Disputes: If the PAT cannot resolve a Second Level Dispute to the satisfaction of either or both parties, the dispute shall be addressed by executive management from the LMHP, SAPC, and Health Net. The executive management shall review the dispute and inform the PAT of its decision. (“Third Level Disputes”)
4. If resolution cannot be reached at the executive management level within agreed upon timeframes, Health Net and SAPC agree to follow the resolution of dispute process in accordance with 9, CCR Sections 1810.370, 1850.505 and 1850.525, the three way contract by and among Health Net, DHCS and CMS, as such contract is described in the DHCS/CMS MOU.

H. Dispute Resolution Related to Provider Relations

1. First Level Disputes: Disputes between Health Net and SAPC regarding provider relations and contracting shall be submitted to the PAT.
2. Second Level Disputes: If satisfactory resolution of a dispute cannot be reached by the PAT, the dispute shall be addressed and resolved by the executive management staff from Health Net and SAPC.

VIII. COORDINATION OF CARE

A. Point of Contact for Clinical Issues

1. Health Net contact staff is the Senior Director of Health Services.
 - a. MHN shall designate a contact staff.
2. The LMHP contact staff is the Medical Director.
3. SAPC contact staff is the designated Program Director.

B. Care Coordination Activities

1. Health Net shall conduct a Health Risk Assessment that includes Behavioral Health screenings for all Beneficiaries enrolled with Health Net in the Demonstration Project. Health Net will refer Beneficiaries with specific mental health and substance abuse findings from the screenings to the PCP for potential linkage to a mental health provider and/or substance abuse provider.
2. The ICT or member thereof shall refer Beneficiaries to the BHCMT if the PCP or the Beneficiary believes that mental health and/or substance abuse services beyond the scope of practice of the PCP are required.
3. The PCP, SACP provider, Beneficiary, and the BHCMT shall collaboratively develop a Behavioral Health Care Plan for the Beneficiary.
4. As permitted by HIPAA and other applicable privacy laws, the SACP provider and PCP shall share PHI as needed for the purpose of care coordination in accordance with Addendum IV.
5. SACP providers shall submit written documentation that contains treatment coordination information to the beneficiary's PCP in accordance with Addendum IV to the extent permitted by HIPAA and other applicable privacy laws.
6. Health Net's PCP shall submit written documentation that contains treatment coordination information to the Beneficiary's mental health provider in accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws.
7. Health Net shall establish a process for reviewing and updating the Behavioral Health Care Plan as clinically indicated, such as following a hospitalization, a significant change in health or well-being, in level of care, or a request for change of provider, and for coordinating with the SACP provider when necessary.
8. The SACP and Health Net providers may participate in case conferencing and conduct regular meetings to review the care coordination process.
9. Health Net shall coordinate with the LMHP and SACP to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
10. Health Net shall develop procedures and coordinate direct transfers between inpatient psychiatric services and inpatient medical services and involve the BHCMT for the purpose of care management and care coordination.

C. Case Consultation

In accordance with Addendum IV and to the extent permitted by HIPAA and other applicable privacy laws, SAPC and Health Net shall establish processes that facilitate consultation and coordination of psychiatric and medical treatment and care plans.

1. SAPC providers may provide information, education and consultation to Health Net PCP regarding substance use related issues to improve coordination of care and care management.
2. Health Net PCP may provide information, education and consultation to SAPC providers on medical issues to improve coordination of care and care management.
3. Consultation between Health Net PCP and SAPC providers may be facilitated by various means including, but not limited to:
 - Direct consultation
 - Telephonic consultation
 - Email consultation
 - Telepsychiatry/Telemedicine
 - Facilitated case conference by BHCMT or ICT concerning care management planning

IX. EXCHANGE OF INFORMATION

9.1 The parties understand and agree that each party has obligations under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (“HIPAA”), as amended by subtitle D, Privacy, of the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, as further implemented by the Omnibus HIPAA Rule, 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 as specified under HIPAA. The disclosure of data, including without limitation PHI, from Health Net and/or MHN to SAPC, are for the purposes of Health Net's payment/health care operations and/or the SAPC's treatment, payment or health care operations in their capacity as Covered Entities and/or to the extent applicable in their capacity as Health Oversight Agencies (as such capitalized terms are defined in HIPAA).

9.2 Each party acknowledges that it may have additional obligations under other State or federal laws that may impose on that party additional restrictions with respect 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 C.F.R. Part 2.

9.3 Each party acknowledges that it will comply with consent 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.

9.4 Addendum IV sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information to ensure coordination of physical health, mental health services, and substance abuse services.

X. SHARED FINANCIAL ACCOUNTABILITY STRATEGIES

Health Net, the LMHP (pursuant to a separate memorandum of understanding entered into with the LMHP), and SAPC agree to comply with the Shared Accountability Performance Metrics and requirements, as specified in the DHCS/CMS MOU and the three-way contract between CMS, DHCS, and Health Net. The goal of Shared Accountability Performance Metrics is to develop coordination strategies to reduce inappropriate cost shifting between Medicare, Medi-Cal Specialty Mental Health Services and Drug Medi-Cal Substance Abuse Services, and develop a formal financial arrangement strategy for shared cost savings. The strategies build on the performance-based withhold in the capitation rates of 1%, 2% and 3% respectively for years one, two and three of the Dual Eligibles Demonstration Project. If the specified shared accountability measures are achieved Health Net shall provide an incentive payment to LMHP and SAPC under mutually agreeable terms and pay a percentage of the recovered funds attributed to that measure to the LMHP and SAPC. This payment shall be structured in a way that does not offset Los Angeles County's Certified Public Expenditure (CPE).

Health Net and the LMHP, and Health Net and the SAPC agree to modify and update this MOU to incorporate the Behavioral Health Shared Accountability Standards in accordance with the three-way contract by and among Health Net, DHCS and CMS upon finalization of the three-way contract.

XI. INDEMNIFICATION

Health Net and the SAPC shall indemnify, defend and hold harmless each other, their elected and appointed directors, officers, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any damage whatsoever, including but not limited to death or injury to any person and damage to any property, resulting from the misconduct, negligent acts, errors or omissions by the other party or any of its directors, officers, 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 shall survive termination of this MOU.

XII. 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 sufficient for liabilities which may arise from or relate to this MOU.

XIII. TERM

This MOU is effective _____ 2013 (“Effective Date”) and shall continue in effect so long as necessary to implement the Dual Eligibles Demonstration Project or for three years from the Effective Date, whichever date is earlier. The term of this MOU may be extended by the parties upon their mutual written agreement.

XIV. 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 effective March 27, 2013; (ii) termination of the three way agreement by and among Health Net, 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

XV. MISCELLANEOUS TERMS

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

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

15.3 Interpretation: Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the requirements of the Dual Eligibles Demonstration Project.

15.4 Supervening Circumstances: Neither Health Net nor SAPC 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) any 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.

15.5 **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 the Dual Eligibles Demonstration Project shall not require the consent of LMHP and/or SAPC or Health Net and shall be effective immediately on the effective date of the requirement.

15.6 **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 party which consent shall not be unreasonably withheld.

15.7 **Confidentiality**: Health Net and SAPC agree to hold Beneficiary health information and records in accordance with HIPAA and applicable privacy laws. The parties acknowledge that SAPC is governed by the Public Records Act, Government Code Section 6520 et seq (the "PRA"). Pursuant to the PRA, documents provided to SAPC may be deemed "public records" as that term is defined in the PRA and, subject to the exceptions set forth therein, may be subject to public disclosure. Consistent with the provisions of the PRA, SAPC shall not disclose documents provided by Health Net which are excepted from the disclosure requirements of the PRA and which are clearly marked or otherwise identified as confidential by Health Net, including, without limitation, the exceptions applicable to corporate financial records and proprietary information including trade secrets. In the event SAPC is required to defend an action on a PRA request for any document provided by Health Net to SAPC in connection with the subject matter of this Agreement, Health Net agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in any action or liability arising from the defense of such action. Nothing in this section shall be construed to prevent SAPC from disclosing any document if such disclosure is required by law, or by an order issued by a court of competent jurisdiction.

15.8 **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 govern.

15.9 **Notice**: Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Section 15.9 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

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

With a copy to:

Health Net, Inc.
21650 Oxnard Street
Woodland Hills, California 91367
Attn: General Counsel

Substance Abuse Prevention and Control
Los Angeles County Department of Public Health
1000 South Fremont Avenue, A9 East 3rd Floor
Alhambra, California 91803
Attn: John Viernes, Jr., Director

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

15.10 **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.

15.11 **Waiver of Obligations.** The waiver of any obligation 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.

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

15.13 **Entire Agreement.** This MOU represents 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.

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

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

By _____ Date: _____

Name:
Title:
Health Net Community Services, Inc.

By _____ Date: _____

Jonathan E. Fielding, M.D., M.P.H., Director and Health Officer
Los Angeles County, Department of Public Health



National Policy Library Document

Policy Name: BEHAVIORAL HEALTH; CAL
MEDI-CONNECT COORDINATION
OF CARE "NO WRONG
DOOR" [LA COUNTY] Policy No.: LR710-122235

Policy Author: Rogelio Lopez Author Title: Public Programs Adminstratr Sr Author Department: 4001-Medi-Cal Public Health 1
Functional Owner: Janice F Milligan Executive Owner: David J Friedman

This Policy is applicable to the following:

Department(s): Public Health Coordination

Business Unit(s): HNCA

Products/LOB's: Dual Eligible

Date Created in NPL: 07/10/2013 Date Last Reviewed : 07/15/2013 Date Approved: 07/15/2013 Version: 1

Policy Statement:

Health Net is responsible for providing beneficiaries seamless access to all medically necessary behavioral health services (mental health and substance use disorder treatment) currently covered by Medicare and Medicaid. Health Net will coordinate with county agencies to ensure enrollees have seamless access to these services. Health Net will ensure coordination of behavioral health with medical care and long-term services and supports.

Policy Purpose:

The purpose of this policy is to describe the coordination of care for assisting members in need of services under the Health Net Cal Medi-Connect program.

Scope/Limitations:

This policy and related procedures apply to all individuals employed, contracted, or otherwise representing Health Net and its subsidiaries who are responsible for providing coordination of care services for members under the Health Net Cal Medi-Connect program.

References:

- A. California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
- B. Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
- C. Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Members, D. Mental Health Services
- D. MMCD Policy letter 00-01

- E. Title 9, CCR, Chapter 11, Division 1, Section(s): 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205(b)(1); 1830.210; 1850.210(I); 1850.505
- F. Title 22, CCR, Chapter 3, Article 4, Section(s) 51305; 51311; 51313; 51183
- G. Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (I) and the State of California Alcohol and/or Other Drug Program Certification Standards
- H. Welfare and Institutions Code Section 5600.3; and 14016.5
- I. Health Net Model of Care 2013
- J. Memorandum of Understanding Between Health Net and L.A. County Department of Mental Health
- K. Authorization and Care Management Flow Chart "No Wrong Door" February 27, 2013

Definitions:

Addiction is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving. (Authority – Substance Abuse and Mental Health Services Administration, A Treatment Improvement Protocol 54 and the American Society of Addiction Medicine)

BH means Behavioral Health which includes Mental Health and Substance Use Disorder Services

BHCMT means Behavioral Health Care Management Team.

Behavioral Health Care Management Team (BHCMT) Multidisciplinary team that provides care management, care coordination and authorization for reimbursement of Medicare services to beneficiaries enrolled in the Dual Demonstration project. The team is composed of representatives from the Local Mental Health Plan, Health Plans, and the Department of Public Health

Behavioral Health Care Plan The care plan developed by a beneficiary and the beneficiary's Behavioral Health Care Management Team that describes the authorized services to the beneficiary.

BHP means Behavioral Health Providers

Care Coordination The management of services for beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

DMH means County Department of Mental Health.

DPH means County Department of Public Health

Health Plan "The Plan" or "Plan" refers to Health Net

Interdisciplinary Care Team (ICT) A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services for beneficiaries.

LMHP Los Angeles County Department of Mental Health (DMH) which is the local county agency that has responsibility for administering public mental health services.

Managed Health Network means Health Net's Behavioral Health subsidiary.

Primary Care means a basic level of health care usually rendered in ambulatory setting by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. Primary care emphasizes caring for the member's general health needs as opposed to specialist focusing on specific needs. This means providing care for the majority of health care problems, including, but not limited to, preventive services acute and chronic conditions, and psychosocial issues.

Primary Care Provider (PCP) means a person responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

Program Administration Team (PAT) A team composed of staff from the Health Plan, DMH, and SAPC that provides program oversight of the Behavioral Health Care Management Team.

Specialty Mental Health Service means: Medi-Cal specialty mental health services and health plans and counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. These criteria can be summarized as the following:

Diagnosis – one or more of the specified Medi-Cal included diagnosis and Statistical Manual of Mental Disorders;

Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won't progress appropriately;

Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment

Specialty Substance Use Disorder Treatment Services are outpatient, residential, prevention, recovery, and support services which are made available to persons with substance use disorders. Services are directed towards alleviating and/or preventing substance use among individuals. Types of services, as described in Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards, include assessment, screening, evaluation, crisis intervention, individual, group, family counseling, collateral, vocational, detoxification, medication assisted treatment services, aftercare, and education services on tuberculosis and sexually transmitted diseases.

Specialty Substance Use Disorder Treatment Services Provider means an entity / organization contracted with Los Angeles County, Department of Public Health Substance Abuse Prevention and Control and is certified or licensed to provide specialty substance use disorder treatment services. Individuals providing counseling services must be registered, certified or licensed in accordance with the California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000.

Subcontracted Plan means a health maintenance organization or any other health care service plan licensed under the Knox-Keene Act which has entered into a service agreement with Health Net to provide or arrange for health care services to Medi-Cal members, and to perform the other duties and responsibilities as set forth in such Plan Partner's Services Agreement.

Policy/Procedure:

The Demonstration project has a "no wrong door" approach to service access. There will be multiple entry paths for beneficiaries to access behavioral health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling Health Net's and/or Managed Health Network's (MHN) Behavioral Health toll free number that will be available 24 hours, 7 days a week for service authorization and referral. Sources of referrals will also be educated on expeditiously referring behavioral health cases to MHN's Behavioral Health toll free number.

Calls will be screened and triaged to establish eligibility and determine BH needs and refer and link

beneficiaries to BH providers. The assessments will be conducted using guidelines developed by the Program Administration Team (PAT).

1. If the member does not require BH services, he/she is referred to the health plans member services department.
2. If the member does require BH services appropriate authorization and referral will be given.
3. In cases of Crisis, the caller will be appropriately directed to emergency services.

Beneficiaries that are enrolled in the Demonstration project may walk in or present to a BH provider (self refer) without an appointment to obtain services. The BH provider will not be required to secure authorization from the BHCMT prior to rendering reimbursable services. Services will be reviewed retroactively for authorization and claims payment. However, members that are receiving inpatient services will need prior authorization

Initially, the BHCMT will determine if the member is in need of emergent, urgent or routine Behavioral Health Services. Beneficiaries experiencing a BH crisis will be immediately referred to emergency services including psychiatric hospitals.

An emergency (behavioral health) is defined as an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition including symptoms of intoxication or withdrawal .

Emergency behavioral health services will be provided in accordance with the symptoms listed above. The use of 911 services will be incorporated as necessary. If the member is in need of non-urgent BH or additional services, the BHCMT will determine the members' Care Management level based on guidelines developed by PAT. In all cases, coverage under Medicare is primary.

Care Management

Care Management level determination includes the following: (Refer to Attachment 1 "Flow charts")

1. **Low Intensity CM Medicare:** These services include but may not be limited to the following services, as covered by Medicare:

- a. Outpatient services within the scope of primary care which may be completed by behavioral health physician
- b. Outpatient Psychiatric services such as medication management, assessment, individual and group therapy delivered by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office, clinic, or hospital outpatient department.
- c. Psychological / Psychiatric testing / assessment
- d. Institutions for Mental Diseases (Mental Health Rehab Center or Skilled Nursing Facility)

2. **High Intensity CM Medicare:** These services include but may not be limited to the following services as covered by Medicare

- a. Psychiatric Inpatient Hospital services for acute conditions
- b. Partial hospitalization / Intensive Outpatient services
- c. Substance Use Disorder (SUD) detox

3. **Low Intensity CM Medi-Cal/Medicare:**

- a. Mental health services (individual and group therapy, assessment, collateral, plan development)
- b. Medication support services (prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications, including the evaluation of need, clinical effectiveness and side effects; obtaining informed consent; education; collateral and plan development)
- c. Day rehabilitation
- d. Methadone Clinic
- e. Targeted Case Management

4. High Intensity CM Medi-Cal/Medicare:

- a. Intensive Day treatment
- b. Crisis intervention
- c. Psychiatric Emergency Services
- d. Crisis stabilization
- e. Adult Residential Treatment Services

Beneficiaries that do not meet criteria for specialty mental health services will be referred and linked back to HN / MHN provider network by the BHCMT.

Referral Process for non BH Care Services

1. Beneficiaries with co occurring medical conditions or with need for other ancillary or medical services may be referred by the BHCMT to the ICT that is developed by the Health Plan for coordinating all care requirements of the beneficiary.
2. Any BHP may identify behavioral health beneficiaries that need physical health care services and refer the beneficiaries to the BHCMT care manager.
3. Health Net's BHCMT care manager will identify the Primary Care Physician (PCP) assigned to the beneficiary and refer and link the beneficiary to the PCP for health care services as needed.

Structural Considerations for BH Care Coordination:**Care Management Teams**

- Program Administration Team (PAT) will have the following shared responsibilities:
 1. Develop guidelines and policies and procedures to assist the Behavioral Health Care Management Team in its day to day operations.
 2. Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
 3. Program evaluation.
 4. Resolve disputes between Health Net and the LMHP.
 5. Identify and resolve issues between Health Net & DMH / DPH provider relations.
- Behavioral Health Care Management Team (BHCMT) will have the following shared responsibilities:
 1. Authorize reimbursement based upon developed guidelines by PAT.
 2. Develop a behavioral health care plan.
 3. Coordinate care between physical health, mental health, substance abuse and LTSS providers through the ICT.
 4. Monitor clinical progress.
 5. Reassess service needs.
 6. Refer and link to appropriate services.
 7. Serve as the liaison to the ICT as needed.

ICT will be facilitated by Health Net / MHN to provide needed care management services to all beneficiaries. The team will include health care staff, mental health, substance abuse, LTSS agencies, and other community agencies as appropriate. The LMHP will provide consultation to the team and ensure mental health needs are addressed.

Care Coordination:**Care Coordination Activities**

1. Health Net and or it's subcontracted plans will conduct a Health Risk Assessment that also includes BH screenings for all beneficiaries enrolled in the Demonstration. Health Net / MHN beneficiaries with specific mental health and substance abuse findings from the screening to a Behavioral Health Provider or PCP for linkage to a mental health provider and/or substance use disorder provider.
2. Health Net's PCP may refer beneficiaries through the toll free BH number to the BHCMT if services required are outside the scope of the PCP or if the beneficiary request services from mental health or

DPH.

3. The BHP and or LMHP provider, beneficiary and the BHCMT will work closely together to develop an individual care plan.
4. If needed DPH provider will secure a signed consent from the beneficiary to share PHI with the BH and or LMHP and the PCP for the purpose of care coordination.
5. BHP and or LMHP providers will submit written documentation that contains treatment coordination information to the BHCMT and beneficiary's primary care physician within 30 days from the initial mental health visit, annually, and when there are significant changes in diagnosis, medications or other aspects of care plans.
6. Health Net PCP will submit written documentation that contains treatment coordination information to the beneficiary's mental health provider within 30 days after the initial primary care visit, annually, and when there are significant changes in diagnosis, medications or other aspects of the care plans.
7. Health Net will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with the BHP and or LMHP provider when necessary.
8. The BHP and or LMHP, Health Net and DPH providers may participate in case conferencing as needed and conduct regular meetings to review the care coordination process.
9. Health Net's BHCMT will coordinate with the BHP and or LMHP and DPH to perform an annual review analysis and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.
10. Health Net will develop procedures and coordinate direct transfers between psychiatric inpatient hospitals and inpatient medical hospital services and involve the BHCMT for purpose of care management and care coordination.

Exchange of information

Successful Care Coordination is accomplished through exchange of information between providers and entities involved in the care for beneficiaries enrolled in the program. Refer to Policy and Procedure for details on Exchange of Information.

Disclaimer:

Deviations:

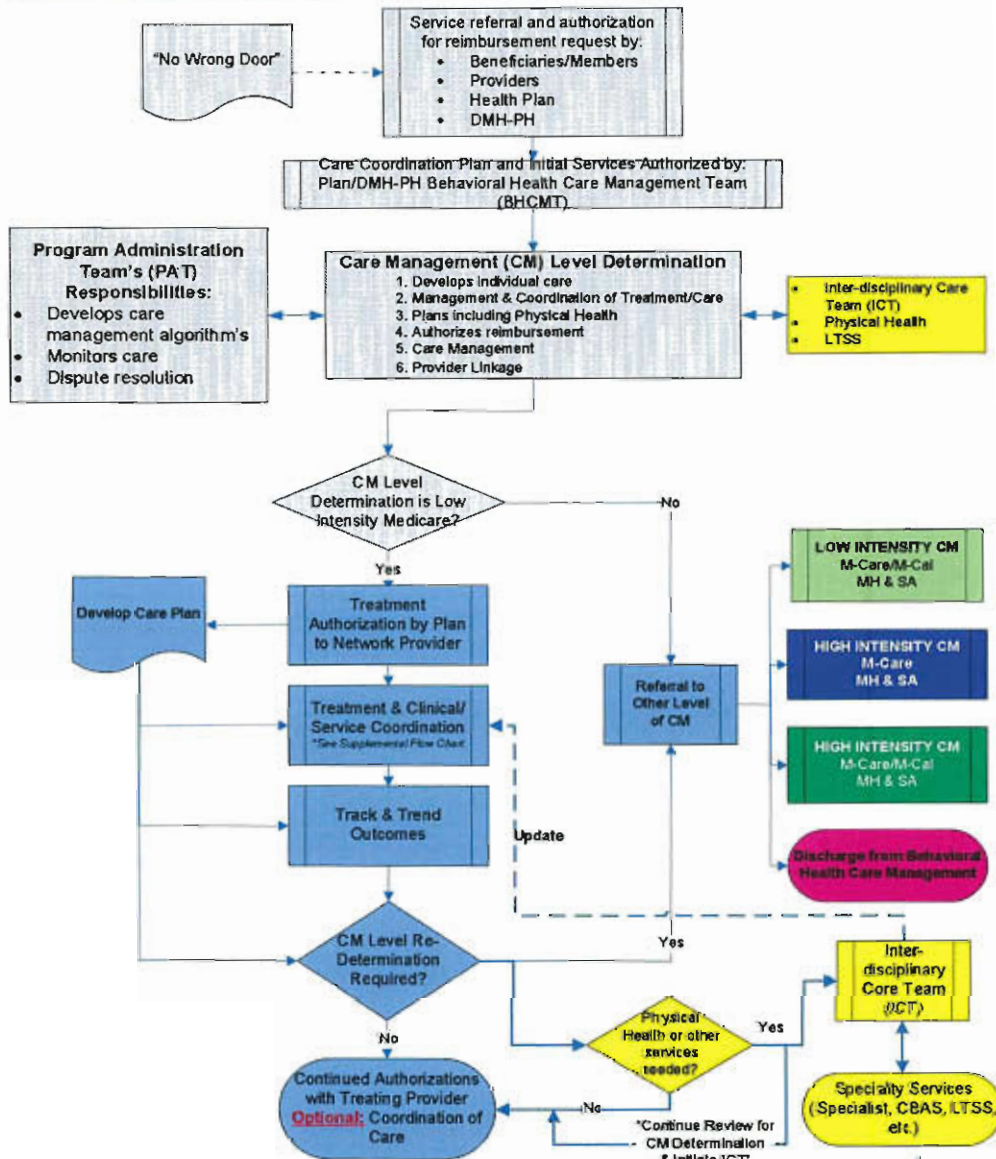
Approvers:

Policy Author: Rogelio Lopez - Approved on 07/15/2013
 Functional Owner: Janice F Milligan - Approved on 07/15/2013
 Executive Owner: David J Friedman - Approved on 07/15/2013

Date Printed: 07/16/2013 10:29:19 AM

**DMH & DPH
Authorization & Care Management Low Intensity Medicare Flow Chart**

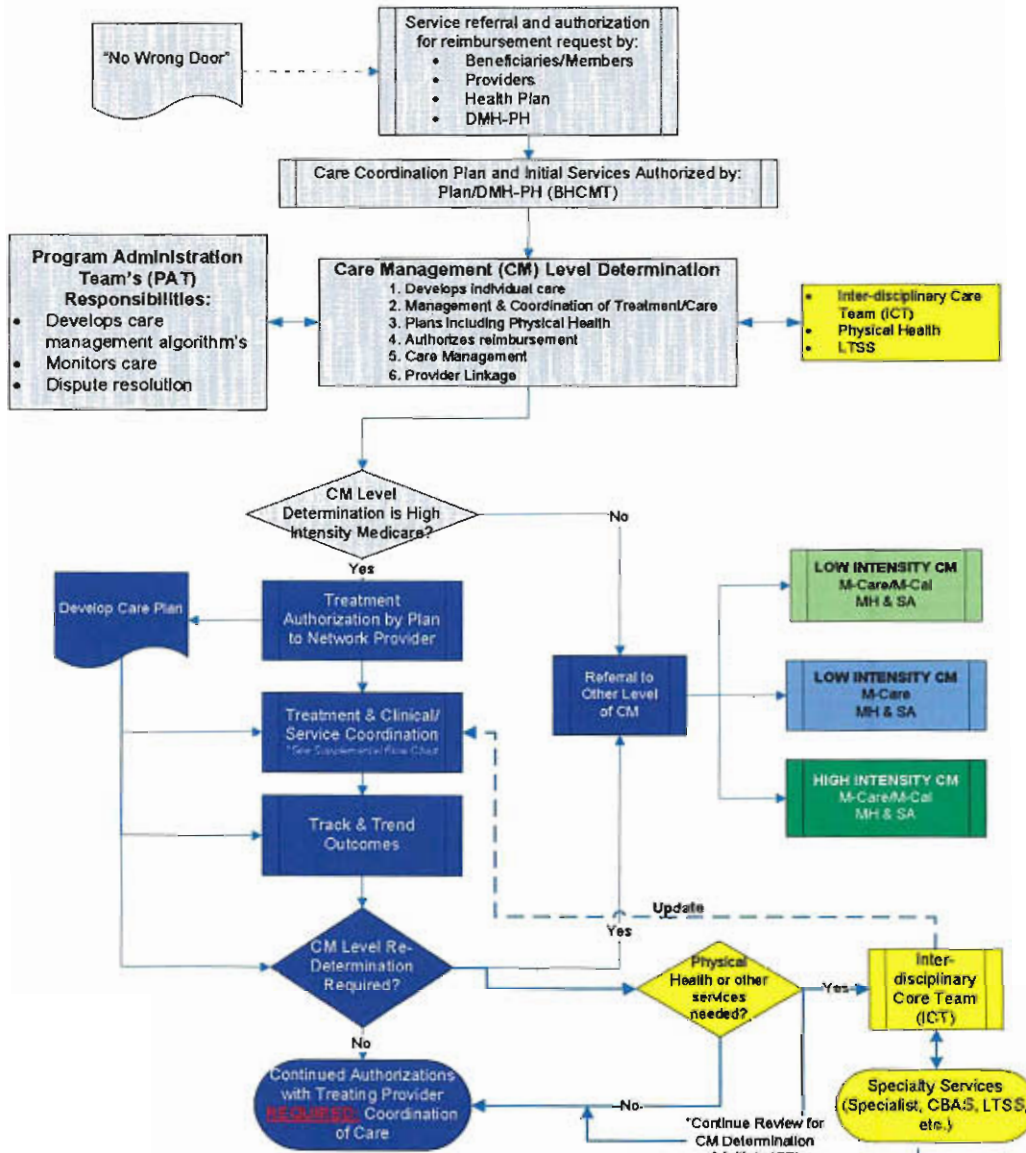
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services, such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

DMH & DPH Authorization & Care Management High Intensity Medicare Flow Chart

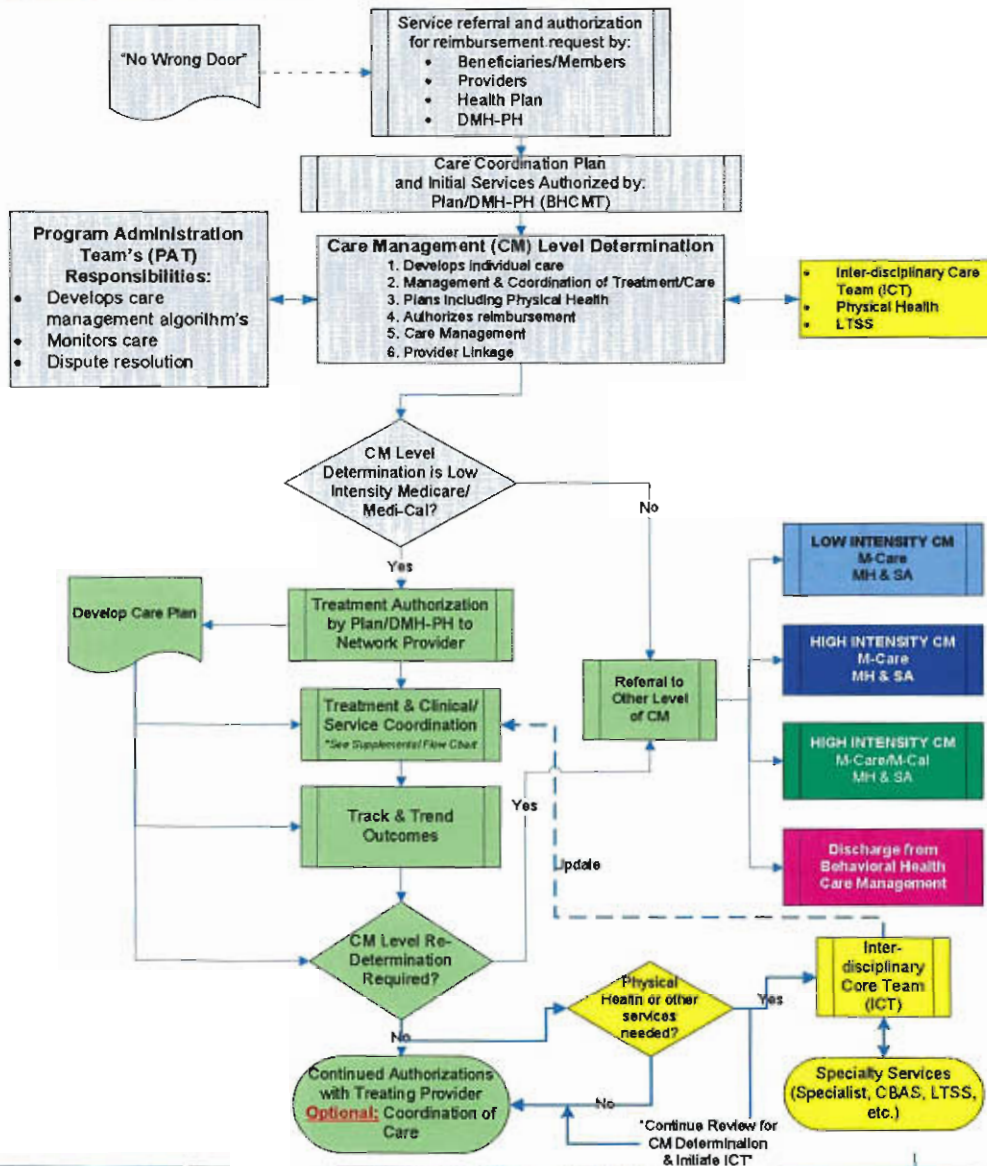
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

DMH & DPH Authorization & Care Management Low Intensity Medicare/Medi-Cal Flow Chart

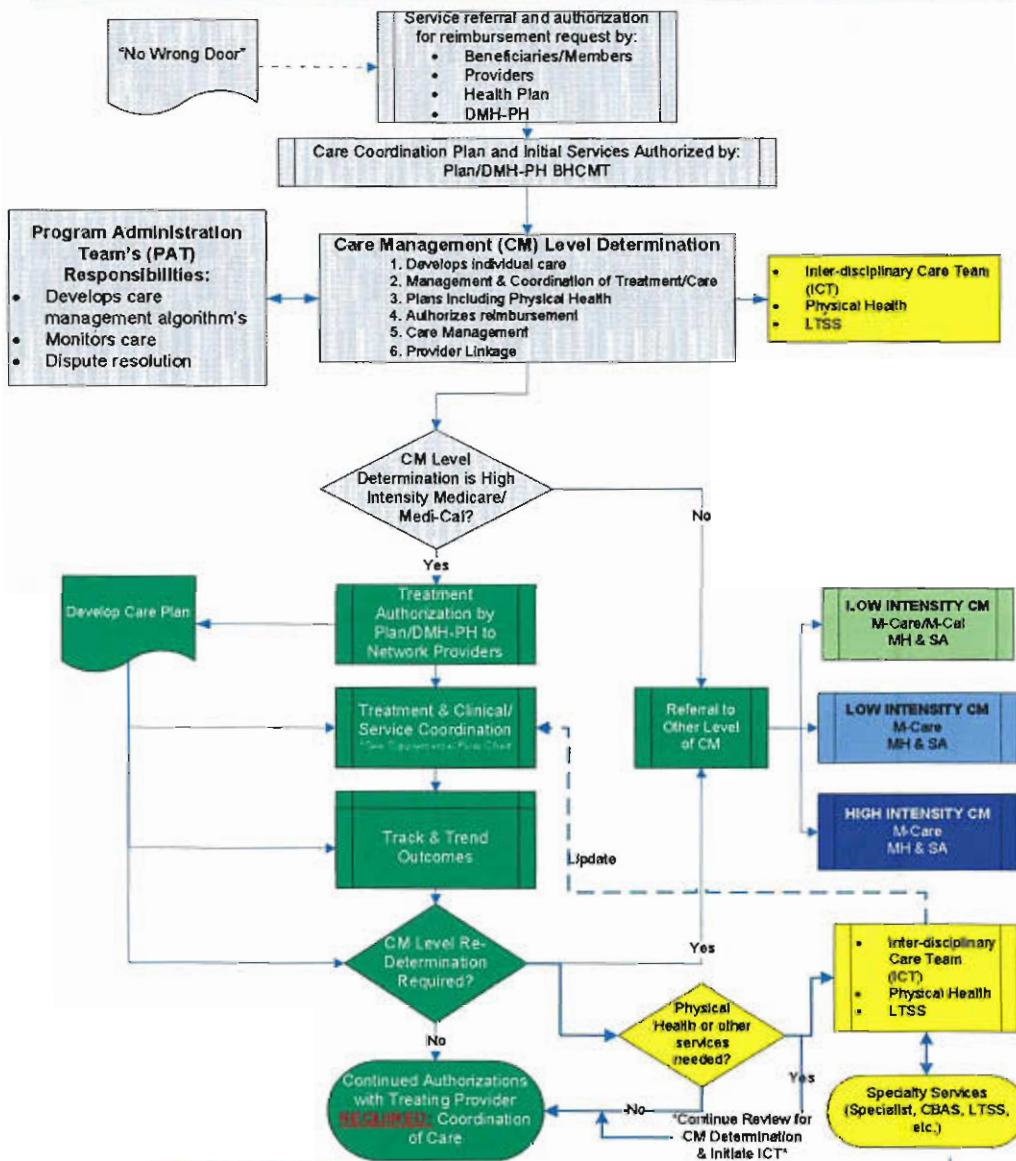
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DMH & DPH Authorization & Care Management High Intensity Medicare/Medi-Cal Flow Chart

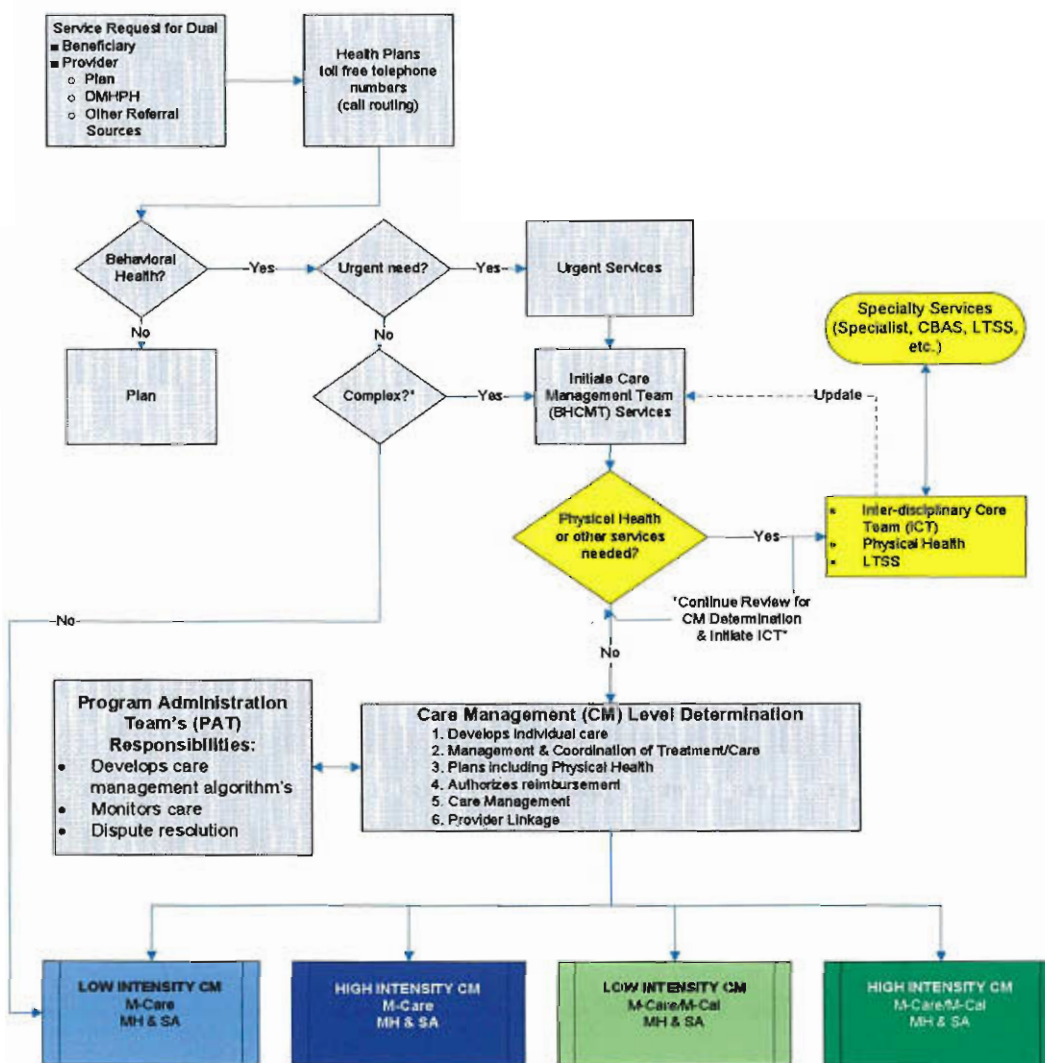
Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
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DMH & DPH Care Management Level Determination Flow Chart

Friday, July 19, 2013



* Complex behavioral healthcare cases that also have physical health needs or needs for other services such as LTSS, CBAS, etc.
 ** The Provider Network consists of Organizations, Facilities, Group Practices and Solo Practitioners who are approved by both Medicare & Med-Cal

Behavioral Health Benefits in the Cal MediConnect Program

Coverage Responsibility Matrix

Updated February 27, 2013

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be “carved out”). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1+2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California’s 1915(b) waiver and State Plan Amendments for targeted case management and expanded services under the Rehabilitation Option, described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

To determine medical necessity for Drug Medi-Cal Substance Abuse Services, health plans and counties will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

Coverage Matrix 1: Mental Health Benefits

Inpatient Services			
	Type of Service	Benefit Coverage	Primary financial responsibility under the Demonstration
Psychiatric inpatient care in a general acute hospital	Facility Charge	Medicare <i>Subject to coverage limitations *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Inpatient care in free-standing psychiatric hospitals (16 beds or fewer)	Facility Charge	Medicare <i>Subject to coverage limitations and depends on facility and license type *</i>	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Psychiatric health facilities (PHFs) (16 beds or fewer)	Facility Charge <i>(Most are not Medicare certified)</i>	Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
Emergency Department	Facility Charges	Medicare	Health Plan
	Psychiatric professional services		
	Medical, pharmacy, ancillary services		
Long-Term Care			
Skilled Nursing Facility	Facility Charges	Medicare/ Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan
SNF-STP (fewer than 50% beds)	Facility Charges	Medicare/Medi-Cal+	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services	Medicare	Health Plan

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

Institutes for Mental Disease

	Long-term care	Benefit Coverage	Primary financial responsibility under the Demonstration
SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)[§]	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Not covered by Medicare or Medi-Cal+	County
	Facility Charge ages 65 and older	Medi-Cal	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Mental health rehabilitation centers (MHRCs) (IMD)	Facility Charges	Not covered by Medicare or Medi-Cal	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Psychiatric health facilities (PHFs) with more than 16 beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	County	County
	Facility Charge ages 65 and older (<i>most are not Medicare certified</i>)	Medi-Cal*	County
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan
Free-standing psychiatric hospital with 16 or more beds	Facility Charges ages 22-64 <i>Subject to IMD Exclusion*</i>	Medicare*	Health plan
	Facility Charge ages 65 and older	Medicare	Health Plan
	Psychiatric professional services	Medicare	Health Plan
	Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements)	Medicare	Health Plan

* Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his Medicare psychiatric hospital coverage then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters [02-06](#) and [10-02](#).

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following acute hospital stay. For long-term care placement, Medi-Cal fee-for-service pays for these costs today.

§ Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act

Outpatient Mental Health Services

		Primary Financial Responsibility	
Type of Service	Benefit Coverage	Patient meets criteria for MHP specialty mental health services [^]	Patient does NOT meet criteria for MHP specialty mental health services
Pharmacy	Medicare	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	Medicare	Health Plan	Health Plan
Outpatient services within the scope of primary care	Medicare	Health Plan	Health Plan
Psychiatric testing/ assessment	Medicare	Health Plan	Health Plan
Mental health services [§] <i>(Individual and group therapy, assessment, collateral)</i>	Medicare	Health plan	Health Plan
Mental health services [§] <i>(Rehabilitation and care plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication support services [§] <i>(Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)</i>	Medicare	Health plan	Health Plan
Medication support services [§] <i>(instruction in the use, risks and benefits of and alternatives for medication; and plan development)</i>	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day rehabilitation	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis intervention	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis stabilization	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Adult Residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Crisis residential treatment services	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Targeted Case Management	Medi-Cal	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria

[^] 1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

[§] Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

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

Coverage Matrix 2: Substance Use Disorder Benefit

	Type of Service	Benefit Coverage	Demonstration Responsibility
Inpatient Acute and Acute Psychiatric Hospitals	Detoxification	Medicare	Health Plan
	Treatment of Drug Abuse ¹ (Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90)	Medicare	Health Plan
Outpatient	Alcohol Misuse Counseling: one alcohol misuse screening (SBIRT) per year. Up to four counseling sessions may be covered if positive screening results. <i>Must be delivered in a primary care setting.</i> ²	Medicare	Health Plan
	Group or individual counseling by a qualified clinician	Medicare	Health Plan
	Subacute detoxification in residential addiction program outpatient	Medicare	Health Plan
	Alcohol and/or drug services in intensive outpatient treatment center	Medicare	Health Plan
	Extended Release Naltrexone (vivitrol) treatment	Medicare	Health Plan
	Methadone maintenance therapy	Drug Medi-Cal	County Drug & Alcohol ³
	Day care rehabilitation	Drug Medi-Cal	County Drug & Alcohol
	Outpatient individual and group counseling (<i>coverage limitations</i>) ⁴	Drug Medi-Cal	County Drug & Alcohol
	Perinatal residential services	Drug Medi-Cal	County Drug & Alcohol

¹ Medicare inpatient detoxification and/or rehabilitation for drug substance abuse when it is medically necessary. Coverage is also available for treatment services provided in the hospital outpatient department to patients who, for example, have been discharged for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. [Click here to learn more.](#)

² Medicare coverage explanation: [Click here to learn more.](#)

³ In San Diego and Orange Counties, county alcohol and drug do not provide these services. Providers have direct contracts with the State.

⁴ Title 22, Section 51341.1 limits DMC individual counseling to the intake, crisis intervention, collateral services and treatment and discharge planning.

ADDENDUM IV
Exchange of Information, Including PHI, Related to the Beneficiaries in the Demonstration Project

1. PURPOSE

This Addendum addresses how SAPC and Health Net will share information to coordinate care of Beneficiaries with substance use disorders (SUD). Individuals with SUD have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their SUD service provider functions as their primary connection to the overall healthcare system.

In order to coordinate care for such Beneficiaries, the parties must identify those Beneficiaries who are enrollees of Health Net and clients of SAPC Providers ("Common Members"). This Addendum documents how the parties will share information to (a) identify Common Members in compliance with the requirements of all applicable federal and State laws and regulations, and (b) provide coordinated care to the Common Members pursuant to the Demonstration Project.

2. DATA MATCHING

Performing a data match to identify Common Members and transmitting the results to the entities providing services to the Common Members helps achieve two important results:

- a) The matched data can help alert healthcare providers to ongoing SUD health needs and interventions in Common Members. These SUD health needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and SUD providers that can improve the health status and treatment outcomes of those served.
- b) Results of this match would also provide SAPC with information that would allow SAPC Providers to more efficiently and effectively facilitate access to much needed physical healthcare services for Common Members by identifying available primary care resources.

3. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

3.1 To the extent allowed by HIPAA and applicable State and federal privacy laws, Health Net shall provide to SAPC the data described in Attachment IV-A, Health Net Beneficiary Data Exchange Protocol ("Protocol"). SAPC shall use this data solely to determine whether Beneficiaries are Common Members.

- a) For those Beneficiaries who are determined to be Common Members, SAPC and Health Net shall use the data for the purposes of coordinating care.

- b) For those Beneficiaries who are determined not to be Common Members, SAPC shall not use the data for any other purposes, and shall return it to Health Net and remove it from all systems where the data was used or stored.

3.2 Health Net and SAPC have reviewed the attached Protocol and agree that the data described in the Protocol complies with HIPAA's minimum necessary standard.

[Note to SAPC: HN is still reviewing the Protocol]

3.3 The parties shall comply with the HIPAA Security Rule in transmitting, receiving, and maintaining PHI exchanged in accordance with the Protocol.

4. HIPAA OBLIGATIONS OF THE PARTIES

5. Health Net and SAPC acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.

5.1 Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent unpermitted uses or disclosures of such PHI.

6. BUSINESS ASSOCIATE-OBLIGATIONS

6.1 The parties acknowledge that for the purposes of conducting the data matching, SAPC shall be acting in the capacity of a Business Associate of Health Net, with respect to the receipt of PHI for Beneficiaries who are not Common Members.

6.2 The parties shall enter into a Business Associate Agreement for the data matching requirements.

6.3 Upon completion of the data matching, SAPC shall not retain any PHI for Health Net Beneficiaries who are not Common Members. Such PHI shall be destroyed or returned in accordance with the terms of the Business Associate Agreement.

Attachment IV-A HEALTH NET BENEFICIARY DATA EXCHANGE PROTOCOL

1. Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty substance use disorder (SUD) care among Common Members. In the event of an inconsistency between this Protocol and Addendum IV, Addendum IV shall govern.

2. Data Exchange - Data Matching

2.1 Demographic Data. SAPC will provide a secured location for Health Net to place a data file of individuals identified as Beneficiaries, initially in the form of a flat text file, on an interval agreed upon by SAPC and Health Net. Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, referred to as the Dual Eligibles 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
- Health Net Internal MHC Member Number [kp note to HN internal: Does this field apply to HN?]
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address

2.2 Match Details. Upon receipt of the Dual Eligibles file, SAPC shall load the data to the Department of Public Health ("DPH") Enterprise Data Warehouse. SAPC shall maintain a historical table of dual eligible beneficiaries and their respective eligibility information. SAPC shall conduct a match of concomitant Beneficiaries between Health Net and DPH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or "match" like clients of SAPC and Health Net. The match is performed in "tiers" where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to

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

- a) Tier 0:
 - Member CIN weighted at 100%
- b) Tier 1:
 - Member Social Security Number weighted at 100%
 - Member Date of Birth weighted at 100%
- c) Tier 2:
 - Member Social Security Number weighted at 85%
 - Member Full Name weighted at 90%
- d) Tier 3:
 - Member Social Security Number weighted at 85%
 - Member Last Name weighted at 85%
- e) Tier 4:
 - Member Social Security Number weighted at 100%
 - Member Year of birth weighted at 100%
- f) Tier 5:
 - Member Full Name weighted at 90%
 - Member Date of Birth weighted at 100%
 - Member Gender weighted at 100%
- g) 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%

3. Data Exchange – Care Coordination

- 4. Health Net Usage. Upon completion of the match, SAPC shall extract and provide (as described below), Common Members who currently have an open and active episode in the DPH Integrated System (IS) or successor DPH electronic health**

record (EHR) to Health Net in the form of a flat text file. SAPC will, at a minimum, provide the following elements:

- Admission Data of Episode
- Last SUD Contact Date
- SAPC Provider ID
- SAPC Provider Name
- SAPC Provider Address
- SAPC Provider Contact Phone Number
- SAPC Provider Primary Contact Name
- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months
- Other SAPC elements

The response data file will be placed on a secured server administered and maintained by the SAPC. Health Net will retrieve the file for the purposes of coordinating Common Members care and for no other purpose by distributing the SUD provider contact information to its Primary Care Providers (PCP) for the purposes of coordinating Common Members care 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
- Health Net shall not use or disclose the information for any other purpose

4.1 SAPC Usage. In addition to the demographic data provided pursuant to Section 2.1, Health Net will provide the following data elements for Common Members to SAPC in the form of a flat text file:

- Current Diagnosis(es) (ICD9-10 or other applicable codes)
- Distinct Procedures (CPT or other applicable codes) for the past six (6) months
- Distinct Medication(s) (NDC codes) and last date filled for the past six (6) months

After processing the Beneficiary data, SAPC will upload the PCP and other pertinent information for Common Members to the DPH IS or successor DPH EHR. SAPC Providers will then be able to access the data via the DPH IS or successor DPH EHR. The information will be displayed as supplemental detail in order to facilitate coordination of care with Primary Care Providers. Access to the DPH IS or successor DPH EHR is controlled via user credentials.

**COORDINATED CARE INITIATIVE
CAL MEDICONECT PROGRAM****MEMORANDUM OF UNDERSTANDING
BETWEEN
the Los Angeles County Department of Public Social Services
AND
L.A. Care Health Plan****I. PURPOSE**

This Memorandum of Understanding (MOU) is entered into by and between the Los Angeles County Department of Public Social Services hereinafter referred to as "COUNTY" and Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan hereinafter referred to as "PLAN", to allow for COUNTY to perform activities to support the provision of In-Home Supportive Services ("IHSS") as a managed care benefit under the Coordinated Care Initiative.

II. TERM

- A. This MOU shall have a term beginning on its execution by COUNTY and PLAN and lasting until notification by the Director of Health Care Services that the enrollment of eligible Medi-Cal beneficiaries described in Welfare and Institutions Code (WIC) Sections 14132.275, 14182.16 and 14182.17 has been completed in the COUNTY, and the California In-Home Supportive Services Authority assumes the responsibilities set forth in Title 23 (commencing with Section 110000) of the Government Code in the COUNTY, unless terminated earlier in accordance with paragraphs B, C or D of this Article.
- B. This MOU may be amended at any time by written, mutual consent of both parties.
- C. Termination without cause: This MOU may be terminated by either party without cause following [180] days written notice.
- D. Termination with cause: This MOU may be terminated by either party after 30 days written notice if the other party is unable to materially fulfill their responsibilities under the MOU. But the party receiving notice will be allowed to correct their compliance with the terms of the MOU in that 30 day period.
- E. This MOU will terminate upon termination of the contract between DHCS and the Plan.
- F. This MOU may be extended, upon both parties agreement in writing, before or after the term expires.

III. SCOPE OF WORK

Welfare and Institutions Code (WIC) section 14186.35(a) requires that IHSS be a Medi-Cal benefit available through managed care health plans in specified counties. WIC section 14186(b)(6) states that it is the intent of the Legislature that in providing IHSS as a managed care benefit "counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining

authorized hours for beneficiaries.” Furthermore, WIC section 14186.35(a) requires that, as a managed care benefit, managed care health plans must administer the program in a specified manner, including entering into an MOU with each county where IHSS is provided as a managed care benefit to allow the county to continue to perform specified functions.

Once a contract with the California Department of Health Care Services is executed, PLAN will be one of the entities responsible for the provision of IHSS as a benefit of managed care in Los Angeles County. COUNTY will perform tasks related to the administration of the IHSS program specified in WIC Section 14186.35(a)(9). This MOU gives the COUNTY the authority to perform these functions under a managed care system.

Additionally, this MOU allows for the sharing of confidential beneficiary information to and from both parties to this MOU to promote shared understanding of the consumer’s needs and ensure appropriate access to IHSS.

This MOU does not contain a funding component. There is no budget for this MOU.

IV. COUNTY RESPONSIBILITIES

- A. COUNTY will assess, approve and authorize each IHSS beneficiary’s initial and continuing need for services pursuant to Article 7 (commencing with Section 12300) of chapter 3 of the Welfare and Institutions Code. Assessments shall be shared with care coordination teams established by PLAN and its designees pursuant to WIC section 14186.35(a)(4). Additional input from the coordination team may be received and considered by COUNTY.
- B. COUNTY shall enroll IHSS providers, conduct provider orientation, and retain enrollment documentation in the manner set forth in WIC section 12301.24 and 12305.81; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- C. COUNTY shall conduct criminal background checks on all potential providers of IHSS and exclude providers consistent with the provisions set forth in WIC sections 12305.81, 12305.86 and 12305.87; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- D. COUNTY shall provide assistance to IHSS recipients in finding eligible providers through the establishment of a registry as well as provide access to training for providers and recipients as set forth in WIC Section 12301.6; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- E. COUNTY shall continue to provide their local public authority with referral information of all IHSS providers for the purposes of wages and benefits until the transition to the California In-Home Supportive Services Authority is complete.
- F. COUNTY shall provide all IHSS providers with information regarding the responsibilities of the California In-Home Supportive Services Authority.
- G. COUNTY shall provide the California In-Home Supportive Services Authority with referral information of all IHSS providers for the purposes of wages and benefits, upon the transition of the county into the California In-Home Supportive Services Authority pursuant to subdivision (a) of WIC section 12300.7.

- H. COUNTY shall pursue overpayment recovery as set forth in WIC section 12305.83.
- I. COUNTY shall perform quality assurance activities including routine case reviews, home visits, and detecting and reporting suspected fraud pursuant to WIC Section 12305.71.
- J. COUNTY shall share with PLAN and its designees confidential data and information necessary to implement the provisions of WIC Section 14186.35.
- K. COUNTY shall participate in administrative fair hearings conducted pursuant to WIC section 10950 et seq. by preparing a county position statement that supports the county action and participating in the hearing as a witness where applicable. COUNTY shall report to PLAN on the resolution of fair hearings requested by PLAN members.
- L. COUNTY will designate a liaison to be responsible for oversight and supervision of the terms of this MOU. COUNTY will immediately notify PLAN in writing of a change in the liaison. PLAN and COUNTY liaisons will meet on a quarterly basis, or as needed, to identify and discuss IHSS-related issues, policy development, program improvements, or other items that could improve health outcomes for IHSS beneficiaries. The liaison at COUNTY will be:

Gail Washington
DPSS/IHSS Program
12900 Crossroads Pkwy, So.
City of Industry, CA 91746
GailWashington@dpss.lacounty.gov
(562) 908-3055

- M. COUNTY liaison will coordinate with PLAN liaison to provide appropriate IHSS staff to participate in interdisciplinary care teams established by PLAN and its designees, when approved by beneficiaries.
- N. COUNTY, in consultation with PLAN, shall establish policies to accept and act on referrals from PLAN and its designees regarding members who may qualify for IHSS services, members who may qualify for IHSS services and need an expedited approval because they are at risk of out-of-home placement, and members who have had a change in condition that may result in the need for a reassessment. Policies shall be in conjunction with current policies regarding assessment and re-assessment procedures.
- O. COUNTY will work with PLAN to develop a conflict resolution process for member issues related to IHSS, excluding appeals. This process will include a requirement for COUNTY to report to PLAN on the outcome of any member issues reported to COUNTY by PLAN.
- P. COUNTY may receive confidential beneficiary information necessary from the PLAN and its designees to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS.
- Q. COUNTY will store confidential information received pursuant to this MOU in a place physically secure from access by unauthorized persons.
- R. COUNTY shall instruct any employee with access to the confidential information received pursuant to this MOU regarding the confidential nature of the information.
- S. County will comply with WIC Sections 12301.3 and 12301.6 as they relate to the

Advisory Committee.

- T. COUNTY will provide PLAN staff with opportunities for training on COUNTY IHSS program, eligibility and assessment criteria, services available, and how to review and understand data made available to the plans (e.g., IHSS case management data.) Initial trainings will be provided prior to implementation of the Coordinated Care Initiative. On-going trainings will be provided on an as-needed basis, but not less than annually.

V. PLAN RESPONSIBILITIES

- A. PLAN shall share confidential beneficiary information with COUNTY, in its capacity as a health oversight agency, as necessary and appropriate, to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS. HIPAA permits the disclosure of PHI to governmental entities or agencies for specified purposes such as in their capacity as a "health oversight agency" or for fraud and abuse purposes.
- B. PLAN will receive from COUNTY confidential beneficiary information necessary to implement the provisions of WIC section 14186.35 and this MOU and will use such data only for such purposes.
- C. PLAN will store confidential information received pursuant to this MOU in a place physically secure from access by unauthorized persons.
- D. PLAN shall instruct any employee with access to the confidential information received pursuant to this MOU regarding the confidential nature of the information.
- E. PLAN, in consultation with COUNTY, shall establish referral processes for members who may qualify for IHSS services, members who may qualify for IHSS services and need an expedited approval because they are at risk of out-of-home placement, and members who have had a change in condition that may result in the need for a reassessment. PLAN will provide assistance in obtaining a completed IHSS Medical Certification Form (SOC 873) when necessary.
- F. PLAN, in consultation with COUNTY, shall establish interdisciplinary care team processes, and other coordination that needs to be established or enhanced to promote the integration of the IHSS Program into managed care.
- G. PLAN will work with COUNTY to develop a conflict resolution process for member issues related to IHSS, excluding appeals. This process will include a requirement for PLAN to report to COUNTY on the outcome of any member issues reported to PLAN by COUNTY.
- H. PLAN will refer beneficiaries who are seeking IHSS appeals to the California Department of Social Services State Hearings Division.
- I. PLAN will provide COUNTY staff with opportunities for training on PLAN benefits, procedures, assessment criteria, services available, and how to review and understand data made available to the COUNTY. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative. On-going trainings will be provided on an as-needed basis, but not less than annually.
- J. PLAN will designate a liaison, with the current employee's name, to be responsible for oversight and supervision of the terms of this MOU. PLAN will immediately notify COUNTY in writing of a change in the liaison. PLAN and COUNTY liaisons will meet on a quarterly basis, or as needed, to identify and

discuss IHSS-related issues, policy development, program improvements, or other items that could improve health outcomes for IHSS beneficiaries. The liaison at PLAN and contact information is:

Beau Hennemann
IHSS Program Manager
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017
bhennemann@lacare.org
213-694-1250 ext. 4632

- K. PLAN liaison will coordinate with COUNTY liaison to arrange for appropriate IHSS staff to participate in interdisciplinary care teams established by PLAN, when approved by beneficiaries.

VI. INDEMNIFICATION

Nothing in this MOU is intended to create an employment relationship between the PLAN and any individual IHSS provider for any purpose including liability due to negligence or intentional torts of the individual provider.. Until the function is taken over by the State of California, the employer of record of each IHSS provider will be the Public Authority (PA) established by the County pursuant to WIC section 12301.6 (b).

VII. DATA SHARING

COUNTY and PLAN will agree to the roles and responsibilities of the sharing of protected health information (PHI) and other confidential beneficiary information for the purposes set forth in WIC sections 14186.35 (a)(8) and (9)(B)(ix).

The COUNTY and PLAN will agree on a secure system of sharing information relating to the dispensation of Fair Hearing cases of IHSS beneficiaries.

VIII. LEGAL SERVICES

In any action at law or in equity, including an action for declaratory relief, brought to enforce or interpret provisions of this MOU, each party shall bear its own costs, including attorney's fees.

IX. GENERAL PROVISIONS

- A. PLAN and COUNTY agree to comply with any applicable provisions of Welfare and Institutions Code section 10850 and any other applicable federal and state laws regarding data security and confidentiality including, but not limited to, the

MOU# _____

Health Insurance Portability and Accountability Act of 1996, as amended, Pub. L. 014-91.

B. This MOU is not effective until signed by both parties.

X. CORRESPONDENCE

All correspondence concerning this MOU should be sent to:

COUNTY:

Department of Public Social Services
IHSS Program Section
12900 Crossroads Parkway South, Suite 100
City of Industry, CA 91746
Attn: Gail Washington

PLAN:

L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017
Attn: Beau Hennemann

This document, consisting of (X) pages, is the full and complete MOU between COUNTY and PLAN.

Date _____ PLAN _____

Chief Executive Officer

Date _____ COUNTY _____

DIRECTOR

Date: _____
(Legal Counsel)COUNTY

Approved as to Legal Form

PLAN

By: _____

Date: _____

**COORDINATED CARE INITIATIVE
CAL MEDICONECT PROGRAM****MEMORANDUM OF UNDERSTANDING
BETWEEN
the Los Angeles County Department of Public Social Services
AND
Health Net, Inc.****I. PURPOSE**

This Memorandum of Understanding (MOU) is entered into by and between the Los Angeles County Department of Public Social Services hereinafter referred to as "COUNTY" and Local Initiative Health Authority for Los Angeles County, a local public agency operating as Health Net Health Plan hereinafter referred to as "PLAN", to allow for COUNTY to perform activities to support the provision of In-Home Supportive Services ("IHSS") as a managed care benefit under the Coordinated Care Initiative.

II. TERM

- A. This MOU shall have a term beginning on its execution by COUNTY and PLAN and lasting until notification by the Director of Health Care Services that the enrollment of eligible Medi-Cal beneficiaries described in Welfare and Institutions Code (WIC) Sections 14132.275, 14182.16 and 14182.17 has been completed in the COUNTY, and the California In-Home Supportive Services Authority assumes the responsibilities set forth in Title 23 (commencing with Section 110000) of the Government Code in the COUNTY, unless terminated earlier in accordance with paragraphs B, C or D of this Article.
- B. This MOU may be amended at any time by written, mutual consent of both parties.
- C. Termination without cause: This MOU may be terminated by either party without cause following [180] days written notice.
- D. Termination with cause: This MOU may be terminated by either party effective thirty (30) days after written notice of a material breach of their obligations under this MOU. The party alleged to have breached the MOU shall have thirty (30) days within which to cure the breach asserted by the other party prior to the effective date of termination for cause.
- E. This MOU will terminate upon termination of the contract between DHCS and the Plan.
- F. This MOU may be extended, upon both parties agreement in writing, before or after the term expires.

III. SCOPE OF WORK

Welfare and Institutions Code (WIC) section 14186.35(a) requires that IHSS be a Medi-Cal benefit available through managed care health plans in specified counties. WIC section 14186(b)(6) states that it is the intent of the Legislature that in providing IHSS as a managed care benefit "counties continue to perform functions necessary for the

administration of the IHSS program, including conducting assessments and determining authorized hours for beneficiaries.” Furthermore, WIC section 14186.35(a) requires that, as a managed care benefit, managed care health plans must administer the program in a specified manner, including entering into an MOU with each county where IHSS is provided as a managed care benefit to allow the county to continue to perform specified functions.

Once a contract with the California Department of Health Care Services is executed, PLAN will be one of the entities responsible for the provision of IHSS as a benefit of managed care in Los Angeles County. COUNTY will perform tasks related to the administration of the IHSS program specified in WIC Section 14186.35(a)(9). This MOU gives the COUNTY the authority to perform these functions under a managed care system.

Additionally, this MOU allows for the sharing of confidential beneficiary information to and from both parties to this MOU to promote shared understanding of the consumer’s needs and ensure appropriate access to IHSS.

This MOU does not contain a funding component. There is no budget for this MOU.

IV. COUNTY RESPONSIBILITIES

- A. COUNTY will assess, approve and authorize each IHSS beneficiary’s initial and continuing need for services pursuant to Article 7 (commencing with Section 12300) of chapter 3 of the Welfare and Institutions Code. Assessments shall be shared with Plan care coordination teams pursuant to WIC section 14186.35(a)(4). Additional input from the coordination team may be received and considered by COUNTY.
- B. COUNTY shall enroll IHSS providers, conduct provider orientation, and retain enrollment documentation in the manner set forth in WIC section 12301.24 and 12305.81; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- C. COUNTY shall conduct criminal background checks on all potential providers of IHSS and exclude providers consistent with the provisions set forth in WIC sections 12305.81, 12305.86 and 12305.87; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- D. COUNTY shall provide assistance to IHSS recipients in finding eligible providers through the establishment of a registry as well as provide access to training for providers and recipients as set forth in WIC Section 12301.6; or may delegate this responsibility to an entity pursuant to WIC section 12300.7.
- E. COUNTY shall continue to provide their local public authority with referral information of all IHSS providers for the purposes of wages and benefits until the transition to the California In-Home Supportive Services Authority is complete.
- F. COUNTY shall provide all IHSS providers with information regarding the responsibilities of the California In-Home Supportive Services Authority.
- G. COUNTY shall provide the California In-Home Supportive Services Authority with referral information of all IHSS providers for the purposes of wages and benefits, upon the transition of the county into the California In-Home Supportive Services

- Authority pursuant to subdivision (a) of WIC section 12300.7.
- H. COUNTY shall pursue overpayment recovery as set forth in WIC section 12305.83.
 - I. COUNTY shall perform quality assurance activities including routine case reviews, home visits, and detecting and reporting suspected fraud pursuant to WIC Section 12305.71.
 - J. County shall share with PLAN confidential data and information necessary to implement the provisions of WIC Section 14186.35.
 - K. COUNTY shall participate in administrative fair hearings conducted pursuant to WIC section 10950 et seq. by preparing a county position statement that supports the county action and participating in the hearing as a witness where applicable. COUNTY shall report to PLAN on the resolution of fair hearings requested by PLAN members.
 - L. COUNTY will designate a liaison to be responsible for oversight and supervision of the terms of this MOU. COUNTY will immediately notify PLAN in writing of a change in the liaison. PLAN and COUNTY liaisons will meet on a quarterly basis, or as needed, to identify and discuss IHSS-related issues, policy development, program improvements, or other items that could improve health outcomes for IHSS beneficiaries. The liaison at COUNTY will be:

Gail Washington
DPSS/IHSS Program
12900 Crossroads Pkwy, So.
City of Industry, CA 91746
GailWashington@dpss.lacounty.gov
(562) 908-3055

- M. COUNTY liaison will coordinate with PLAN liaison to provide appropriate IHSS staff to participate in interdisciplinary care teams established by PLAN, when approved by beneficiaries:
- N. COUNTY, in consultation with PLAN, shall establish policies to accept and act on referrals from PLAN regarding members who may qualify for IHSS services, members who may qualify for IHSS services and need an expedited approval because they are at risk of out-of-home placement, and members who have had a change in condition that may result in the need for a reassessment. Policies shall be in conjunction with current policies regarding assessment and re-assessment procedures.
- O. COUNTY will work with PLAN to develop a conflict resolution process for member issues related to IHSS, excluding appeals. This process will include a requirement for COUNTY to report to PLAN on the outcome of any member issues reported to COUNTY by PLAN
- P. COUNTY may receive confidential beneficiary information necessary from the PLAN to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS.
- Q. COUNTY will store confidential information received pursuant to this MOU in a place physically secure from access by unauthorized persons.
- R. COUNTY shall instruct any employee with access to the confidential information received pursuant to this MOU regarding the confidential nature of the information.

- S. County will comply with WIC Sections 12301.3 and 12301.6 as they relate to the Advisory Committee.
- T. COUNTY will provide PLAN staff with opportunities to attend training on COUNTY IHSS program, eligibility and assessment criteria, services available, and how to review and understand data made available to the plans (e.g., IHSS case management data.) Initial trainings will be provided prior to implementation of the Coordinated Care Initiative. On-going trainings will be provided on an as-needed basis, but not less than annually.

V. PLAN RESPONSIBILITIES

- A. PLAN shall share confidential beneficiary information with COUNTY, in its capacity as a health oversight agency, as necessary and appropriate, to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS. HIPAA permits the disclosure of PHI to governmental entities or agencies for specified purposes such as in their capacity as a "health oversight agency" or for fraud and abuse purposes.
- B. PLAN will receive from COUNTY confidential beneficiary information necessary to implement the provisions of WIC section 14186.35 and this MOU and will use such data only for such purposes.
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- H. PLAN will refer beneficiaries who are seeking IHSS appeals to the California Department of Social Services State Hearings Division.
- I. PLAN will provide COUNTY staff with opportunities for training on PLAN benefits, procedures, assessment criteria, services available, and how to review and understand data made available to the COUNTY. Initial trainings will be provided prior to implementation of the Coordinated Care Initiative. On-going trainings will be provided on an as-needed basis, but not less than annually.
- J. PLAN will designate a liaison, with the current employee's name, to be responsible for oversight and supervision of the terms of this MOU. PLAN will immediately notify COUNTY in writing of a change in the liaison. PLAN and

COUNTY liaisons will meet on a quarterly basis, or as needed, to identify and discuss IHSS-related issues, policy development, program improvements, or other items that could improve health outcomes for IHSS beneficiaries. The liaison at PLAN and contact information is:

Raffie Barsamian
Manager Public Programs
101 N. Brand Blvd. #1500
Glendale, CA 91203
raffie.barsamian@healthnet.com
818-543-9107

- K. PLAN liaison will coordinate with COUNTY liaison to arrange for appropriate IHSS staff to participate in interdisciplinary care teams established by PLAN, when approved by beneficiaries.

VI. INDEMNIFICATION

Nothing in this MOU is intended to create an employment relationship between the PLAN and any individual IHSS provider for any purpose, including liability due to negligence or intentional torts of the individual. Until the function is taken over by the State of California, the employer of record of each IHSS provider will be the Public Authority established by County pursuant to WIC section 12301.6(b).

VII. DATA SHARING

COUNTY and PLAN will agree to the roles and responsibilities of the sharing of protected health information (PHI) and other confidential beneficiary information for the purposes set forth in WIC sections 14186.35 (a)(8) and (9)(B)(ix).

The COUNTY and PLAN will agree on a secure system of sharing information relating to the dispensation of Fair Hearing cases of IHSS beneficiaries.

VIII. LEGAL SERVICES

In any action at law or in equity, including an action for declaratory relief, brought to enforce or interpret provisions of this MOU, each party shall bear its own costs, including attorney's fees.

IX. GENERAL PROVISIONS

- A. PLAN and COUNTY agree to comply with any applicable provisions of Welfare and Institutions Code section 10850 and any other applicable federal and state laws regarding data security and confidentiality including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, Pub. L.

MOU# _____

014-91.

B. This MOU is not effective until signed by both parties.

X. CORRESPONDENCE

All correspondence concerning this MOU should be sent to:

COUNTY:

Department of Public Social Services
IHSS Program Section
12900 Crossroads Parkway South, Suite 100
City of Industry, CA 91746
Attn: Gail Washington

PLAN:

Health Net
101 N. Brand Blvd. #1500
Glendale, CA 91203
Attn: Raffie Barsamian

This document, consisting of (X) pages, is the full and complete MOU between COUNTY and PLAN.

Date _____

PLAN _____

Chief Executive Officer

Date _____

COUNTY _____

DIRECTOR

Date: _____
(Legal Counsel)COUNTY

Approved as to Legal Form

PLAN

By: _____

Date: _____