AGREEMENT

This MEMORANDUM OF UNDERSTANDING (MOU) is made and entered into as of this 10th day of July, 2018 by and between the **COUNTY OF FRESNO,** a Political Subdivision of the State of California, hereinafter referred to as "**COUNTY**" and Blue Cross of California Partnership Plan, Inc., a Medi-Cal Managed Care Health Plan whose address is 3330 W. Mineral King Avenue, Visalia, CA 93291, hereinafter referred to as "ANTHEM", (collectively the "parties").

W I T N E S S E T H:

WHEREAS, COUNTY through its Department of Behavioral Health, is a Mental Health Plan, hereinafter referred to as "MHP", as defined in Title 9 of the California Code of Regulations (CCR), section 1810.226; and

WHEREAS, ANTHEM, is a prepaid full-service health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Knox-Keene Act"), which has entered into an agreement with the California Department of Health Care Services under the Medi-Cal Managed Care Program for the provision of specialty mental health and/or alcohol and other drug services to persons who enroll in the Medi-Cal Plan for Fresno County; and

WHEREAS, COUNTY contracts with the California Department of Health Care Services (DHCS) to provide medically necessary specialty mental health services to the Medi-Cal beneficiaries of Fresno County. The COUNTY and DHCS work collaboratively to ensure timely and effective access to specialty mental health and/or alcohol and other drug services; and

WHEREAS, ANTHEM and COUNTY desire to identify responsibilities and protocols in the delivery of specialty mental health and/or alcohol and other drug services to Medi-Cal Members served by both.

NOW, THEREFORE, in consideration of their mutual covenants and conditions, the parties hereto agree as follows:

1. DEFINITIONS

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

A. ANTHEM Medi-Cal Plan – is the ANTHEM benefit plan covering the provision of

Health Care and Behavioral Health Services to ANTHEM Members pursuant to the Medi-Cal Agreement. The benefits of the ANTHEM Medi-Cal Plan are set forth in the Medi-Cal Agreement.

B. Health Care Services – are all medical, behavioral health and ancillary services, including emergency services, which are covered benefits under the ANTHEM Medi-Cal Plan.

C. Medi-Cal Fee-for Service ("FFS") Rate – is the applicable fee-for-service rate determined by the State Department of Health Services for the service under the Medi-Cal Program. All services to be provided by COUNTY and compensated by ANTHEM pursuant to this Agreement shall be billed by COUNTY, and compensated by ANTHEM, at the then current, applicable Medi-Cal FFS Rate.

D. Member – is a Medi-Cal beneficiary who is eligible and enrolled in the ANTHEM Medi-Cal Plan for Fresno County.

E. Primary Care Physician (PCP) – is either an internist, pediatrician, general practitioner, OB/GYN, or family practitioner contracting with ANTHEM, or one of ANTHEM's contracting medical groups, who has been selected by or assigned to a Member for the purpose of providing and coordinating Health Care Services under the ANTHEM Medi-Cal Plan.

2. RESPONSIBILITIES

A. JOINT RESPONSIBILITIES

1. The parties understand that ANTHEM arranges for the provision of health care for its Members through contracts with independent health care providers ("Contracting Providers"). The parties understand and agree that all references in this Agreement to the provision of Health Care Services by ANTHEM are deemed to refer to services provided by its Contracting Providers.

2. Notwithstanding any provision in this Agreement to the contrary, the parties understand and agree that ANTHEM's responsibilities under this Agreement are subject to, and limited to the requirements under the Medi-Cal Agreement.

3. The parties understand and agree that responsibility for performance of certain services under this Agreement will be shared by the parties as explained in detail in Exhibit A, attached hereto and by this reference incorporated herein.

4. The parties understand and agree to coordinate or arrange for the provision

of specialty mental health services in accordance with MMCD Policy Letter No. 00-01 REV, Exhibit B, attached hereto and by this reference incorporated herein.

5. The parties understand and agree to coordinate or arrange for the provision of substance use disorder services in accordance with ASAM levels of care as described in Exhibit C, attached hereto and by this reference incorporated herein.

B. RESPONSIBILITIES OF ANTHEM

1. ANTHEM shall arrange for the provision of health care for its Members through contracts with Contracting Providers. ANTHEM covers Health Care Services, but it does not provide Health Care Services.

2. ANTHEM shall require that its Contracting Providers comply with all laws requiring the reporting of certain diseases. ANTHEM will disseminate to its Contracting Providers the information provided by the COUNTY regarding local community resources.

3. ANTHEM shall require that its PCP provide behavioral health services limited PCP training and scope of practice.

4. ANTHEM shall promote organized managed care systems that reduce fragmentation in case management and which improve quality of care.

5. ANTHEM shall refer its Members to local agencies and organizations providing health services and health programs for low-income persons where such services are not provided by ANTHEM and its Contracting Providers.

6. ANTHEM shall assist COUNTY to determine the membership status of its Members and to which PCP they have been assigned.

7. ANTHEM shall make every reasonable effort to provide linguistic services for non-English speaking and limited English speaking Members and those who speak Spanish, Hmong, Cambodian, and Lao as their primary language. In the event that a Member seeks services from COUNTY and COUNTY has exhausted all reasonable resources for providing linguistic services to the Member, ANTHEM agrees to provide linguistic services to that Member.

8. In accordance with Exhibit A, all responsibilities of ANTHEM are outlined.

C. RESPONSIBILITIES OF COUNTY

1. COUNTY shall continue to provide such Federal and State mandated public and community programs subject to available funding, as required; and shall further provide such other non-mandated public and community programs subject to available funding, as the COUNTY shall, in its unfettered discretion, determine.

2. Upon request, COUNTY shall maintain and make available to the California Department of Health Care Services and ANTHEM copies of all executed COUNTY subcontracts for the performance of Health Care Services under this Agreement. All COUNTY subcontracts shall be in writing and shall be consistent with the terms and provisions of this Agreement and in compliance with applicable State and Federal Laws. Each COUNTY subcontract shall contain the amount of compensation that the COUNTY subcontractor will receive under the term of the COUNTY subcontract.

3. COUNTY shall require all its specialty mental health and/or alcohol and other drug service providers to assist COUNTY and ANTHEM in the orderly transfer of the medical care of Members in the event of termination of the Medi-Cal Agreement, including, without limitation, making available to the California Department of Health Care Services copies of medical records and any other pertinent information necessary for efficient case management of Members, as determined by the California Department of Health Care Services, subject to compliance with Federal, State and local confidentiality laws.

4. Neither COUNTY nor any of its specialty mental health and/or alcohol and other drug services providers shall in any event, including, without limitation, non-payment by ANTHEM, insolvency of ANTHEM, or breach of this Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive form of payment from any Member for specialty mental health and/or alcohol and other drug services provided pursuant to this Agreement. Neither COUNTY nor any COUNTY specialty mental health and/or alcohol and other drug services provider shall maintain any action at law or equity against a Member to collect sums owed by ANTHEM to COUNTY. However, COUNTY may collect against a person receiving services from the COUNTY who is determined to be ineligible under the Medi-Cal Program at the time of service. In addition, COUNTY may bill the California Department of Health Care Services under the Medi-Cal Fee-For-Services Program for services provided by the COUNTY to a Medi-Cal beneficiary who is determined to not be a Member at the time of service. Upon

notice of any violation of this section, ANTHEM may terminate this Agreement pursuant to Paragraph 4 of this Agreement and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring COUNTY and COUNTY specialty mental health and/or alcohol and other drug services providers to return all sums improperly collected from Members or their representatives. COUNTY and ANTHEM's obligations under this paragraph shall survive the termination of this Agreement with respect to specialty mental health and/or alcohol and other drug services provided during the term of this Agreement without regard to cause of termination of this Agreement.

5. A detailed description of COUNTY's responsibilities is located in Exhibit A.

3. TERM

This Agreement shall become effective upon execution by all parties and shall terminate on the 30th day of June 2019.

This Agreement shall automatically be extended for an unlimited number of one (1) year extensions upon the same terms and conditions herein set forth, unless written notice of non-renewal is given by ANTHEM or COUNTY or COUNTY's DBH Director, or designee, not later than thirty (30) days prior to the close of the current Agreement term.

4. TERMINATION

A. Non-Allocation of Funds - The terms of this MOU, and the services to be provided thereunder, are contingent on the approval of funds by the appropriating government agency. Should sufficient funds not be allocated, the services provided may be modified, or this Agreement terminated at any time by giving ANTHEM thirty (30) days advance written notice.

B. Breach of Contract - COUNTY may immediately suspend or terminate this Agreement in whole or in part, where in the determination of COUNTY there is:

1. An illegal or improper use of funds;
2. A failure to comply with any term of this Agreement;
3. A substantially incorrect or incomplete report submitted to COUNTY;
4. Improperly performed service: and/or
5. Failure by ANTHEM to obtain and maintain a license under the Knox-

Keene Act.

In no event shall any payment by COUNTY constitute a waiver by COUNTY of any breach of this Agreement or any default which may then exist on the part of ANTHEM. Neither shall such payment impair or prejudice any remedy available to COUNTY with respect to the breach or default. COUNTY shall have the right to demand of ANTHEM the repayment to COUNTY of any funds disbursed to ANTHEM under this Agreement, which in the judgment of COUNTY were not expended in accordance with the terms of this Agreement. ANTHEM shall promptly refund any such funds upon demand or, at COUNTY's option; such repayment shall be deducted from future payments owing to ANTHEM under this Agreement.

C. Without Cause - Under circumstances other than those set forth above, this Agreement may be terminated by ANTHEM or COUNTY or COUNTY's DBH Director or designee upon the giving of thirty (30) days advance written notice of an intention to terminate.

5. COMPENSATION

Services pursuant to the terms and conditions of this Agreement shall be performed without the payment of any monetary consideration by ANTHEM or COUNTY, one to the other.

6. INDEPENDENT CONTRACTOR

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

Because of its status as an independent contractor, ANTHEM shall have absolutely no

right to employment rights and benefits available to COUNTY employees. ANTHEM shall be solely liable and responsible for providing to, or on behalf of, its employees all legally-required employee benefits. In addition, ANTHEM shall be solely responsible and save COUNTY harmless from all matters relating to payment of ANTHEM's employees, including compliance with Social Security, withholding, and all other regulations governing such matters. It is acknowledged that during the term of this Agreement, ANTHEM may be providing services to others unrelated to the COUNTY or to this Agreement.

7. MODIFICATION

Any matters of this Agreement may be modified from time to time by the written consent of all the parties without, in any way, affecting the remainder.

8. NON-ASSIGNMENT

Neither party shall assign, transfer or subcontract this Agreement nor their rights or duties under this Agreement without the prior written consent of the other party.

9. HOLD-HARMLESS

ANTHEM agrees to indemnify, save, hold harmless, and at COUNTY's request, defend the COUNTY, its officers, agents and employees from any and all costs and expenses, including attorney fees and court costs, damages, liabilities, claims and losses occurring or resulting to COUNTY in connection with the performance, or failure to perform, by ANTHEM, its officers, agents or employees under this Agreement, and from any and all costs and expenses, including attorney fees and court costs, damages, liabilities, claims and losses occurring or resulting to any person, firm or corporation who may be injured or damaged by the performance, or failure to perform, of ANTHEM, its officers, agents or employees under this Agreement.

10. CONFIDENTIALITY

All responsibilities performed by the ANTHEM under this Agreement shall be in strict conformance with all applicable Federal, State of California and/or local laws and regulations relating to confidentiality

11. NON-DISCRIMINATION

During the performance of this Agreement, ANTHEM shall not unlawfully discriminate

against any employee or applicant for employment, or recipient of services, because of race, religion, color, national origin, ancestry, physical disability, medical condition, sexual orientation, marital status, age or gender, pursuant to all applicable State of California and Federal statutes and regulations.

12. NOTICES

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

COUNTY	ANTHEM
Director, Fresno County Department of Behavioral Health 4441 E. Kings Canyon Rd. Fresno, CA 93702	Manager, CRC 3330 W. Mineral King Ave., Suite A Visalia, CA 93219

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

13. GOVERNING LAW

The parties agree that for the purposes of venue, performance under this Agreement is to be in Fresno County, California.

The rights and obligations of the parties and all interpretation and performance of this Agreement shall be governed in all respects by the laws of the State of California.

14. COVERED SERVICES AND POPULATIONS

The Mental Health Services Description Chart for Medi-Cal Managed Care Members included with APL 17-018 as developed by DHCS and identified as Exhibit D, is attached hereto and incorporated herein.

15. OVERSIGHT RESPONSIBILITIES OF ANTHEM AND THE COUNTY

A. ANTHEM will oversee a subcontracted behavioral health provider network, which will provide the above additional behavioral health services to the extent they are not provided by the COUNTY under the Specialty Mental Health Services Waiver to its Medi-Cal Members and under the

Drug Medi-Cal Organized Delivery System Waiver (herein after referred to as "DMC-ODS Waiver") to its Drug Medi-Cal Members.

B. ANTHEM has the responsibility to work with the COUNTY to ensure that oversight is coordinated and comprehensive and that the Member's healthcare is at the center of all oversight. Specific processes and procedures will be developed cooperatively with COUNTY, as well as any actions required to identify and resolve any issues or problems that arise.

C. ANTHEM and COUNTY will configure a behavioral health Medi-Cal oversight team comprised of representatives from ANTHEM and COUNTY that are responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of this MOU.

D. ANTHEM and COUNTY will formulate a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. ANTHEM and COUNTY will determine the final composition of the multidisciplinary teams to conduct this oversight function.

E. ANTHEM and the COUNTY will designate as appropriate and when possible the same staff to conduct tasks associated within the oversight and multidisciplinary clinical teams.

16. <u>SPECIFIC ROLES AND RESPONSIBLITIES</u>

A. Screening, Assessment and Referral

1. Determination of Medical Necessity

a. COUNTY will follow the medical necessity criteria for Medi-Cal specialty mental health 1915(b) waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

b. COUNTY will follow the medical necessity criteria outlined for the DMC-ODS described in the 1115 Waiver Standard Terms and Conditions. DMC-ODS Substance Use Disorder (SUD) Services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program.

c. ANTHEM will be responsible for determining medical necessity as it relates to covered health care benefits, as outlined in 22 CCR 51303(a).

2. Assessment Process

a. ANTHEM and COUNTY shall develop and agree to written policies and procedures regarding screening, assessment and referral processes, including screening and assessment tools for use in determining if ANTHEM or COUNTY will provide behavioral health services within a reasonable period that allows for timely access to services for Members.

b. ANTHEM will conduct a behavioral health assessment for Members with a potential behavioral health condition using an assessment tool mutually agreed upon with the COUNTY to determine the appropriate care needed.

c. For SUD Services ANTHEM and COUNTY will distribute to their providers the current version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC Adult and Adolescent) crosswalk that identifies the criteria utilized to assist with determining the appropriate treatment level of care to ensure providers are aware of SUD levels of care for referral purposes.

d. ANTHEM providers shall ensure a comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for Members, is available.

3. Referrals

a. ANTHEM and COUNTY shall develop and agree to written policies and procedures regarding referral processes and tracking referrals, including the following:

i. The COUNTY agrees to accept referrals from ANTHEM staff, providers, and Members' self-referral for determination of medical necessity for specialty mental health services and/or alcohol and other drug services.

ii. ANTHEM Primary Care Provider agrees to refer the Member to the ANTHEM's behavioral health network provider for initial assessment and treatment (except in emergency situations or in cases when the Member clearly has a significant impairment that the Member can be referred directly to the COUNTY). If it is determined by ANTHEM behavioral health provider that the Member may meet specialty mental health services and/or alcohol and other drug services medical necessity criteria, the ANTHEM behavioral health network provider agrees to refer the Member to the COUNTY for further assessment and treatment.

iii. ANTHEM agrees to accept referrals from COUNTY staff, providers, and Members' self-referral for assessment; make a determination of medical necessity for outpatient services; and provide referrals within ANTHEM behavioral health provider network. The COUNTY agrees to refer to ANTHEM when the service needed is one provided by ANTHEM and not the COUNTY, and when it has been determined by the COUNTY that the Member does not meet the specialty mental health medical necessity criteria and/or when SUD medical necessity suggests that the member needs Early Intervention or higher levels of care not supported by Fresno County contracted providers.

B. Care Coordination

ANTHEM and COUNTY agree to develop policies and procedures for coordinating inpatient and outpatient medical and behavioral health care for Members enrolled with ANTHEM and receiving Medi-Cal specialty mental health and/or alcohol and other drug services through the COUNTY. These policies and procedures shall include:

1. An identified point of contact from each party to serve as a liaison and initiate, provide, and maintain ongoing care coordination as mutually agreed upon in ANTHEM and COUNTY protocols.

2. Coordination of care for inpatient behavioral health treatment provided by the COUNTY, including a notification process between the COUNTY and ANTHEM within 24 hours of admission and discharge to arrange for appropriate follow-up services. A process for reviewing and updating the care plan of Members, as clinically indicated (i.e., following crisis intervention or hospitalization). The process must include triggers for updating care plans and coordinating with outpatient behavioral health providers.

3. Coordination of care for alcohol and other drug treatment provided by COUNTY shall occur in accordance with all applicable federal, state and local regulations. A process for shared development of care plans by the beneficiary, caregivers and all providers and collaborative treatment planning activities will be developed to ensure clinical integration between DMC-ODS and managed care providers.

4. ANTHEM shall arrange for the provision of non-emergency medical transportation as outlined in APL 17-010, Exhibit E, attached hereto and by this reference incorporated herein.

5. ANTHEM and COUNTY will promote availability of clinical consultation for shared clients receiving physical health, mental health or substance use disorder services, including consultation on medications when appropriate.

6. Transition of care for Members transitioning to or from ANTHEM or COUNTY services.

7. Regular meetings to review referral, care coordination, and information exchange protocols and processes will occur with COUNTY and ANTHEM representatives.

8. The delineation of case management responsibilities will be outlined.

C. Information Exchange

The COUNTY and ANTHEM will develop and agree to information sharing policies and procedures and agreed upon roles and responsibilities for sharing protected health information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3) and other pertinent state and federal laws and regulations, including the Health Insurance Portability and Accountability Act and 42 CFR part 2, governing the confidentiality of mental health and alcohol and drug treatment information.

D. Reporting and Quality Improvement Requirements

The COUNTY and ANTHEM will have policies and procedures to address quality improvement requirements and reports.

1. Hold regular meetings, as agreed upon by the COUNTY and ANTHEM, to review the referral and care coordination process and monitor Member engagement and utilization.

2. Hold a no less than a semi-annual calendar year review of referral and care coordination processes to improve quality of care; and provide no less than semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. The reports summarizing findings of the review must address the systemic strengths and barriers to effective collaboration between ANTHEM and COUNTY.

3. Reports that track cross-system referrals, beneficiary engagement, and service utilization will be determined in collaboration with DHCS, including, but not limited to: 1) the number of disputes between ANTHEM and COUNTY, 2) the dispositions/outcomes of those disputes, 3) the number of grievances related to referrals and network access, and 4) the dispositions/outcomes of those grievances. The reports shall address utilization of behavioral health services by Members receiving such services from ANTHEM and the COUNTY, as well as quality strategies to address duplication of services.

4. The performance measures and quality improvement initiatives will be determined by DHCS.

E. Dispute Resolution Process

ANTHEM and COUNTY agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between Medi-Cal Managed Care Plans and DHCS and Centers for Medicare & Medicaid Services ("CMS"). A dispute will not delay member access to medically necessary services and the referenced process above is outlined in Exhibit A of the signed MOU.

F. Telephone Access

ANTHEM shall ensure that Members will be able to assess urgent or emergency behavioral health services 24 hours per day, 7 days a week. The approach will be the "no wrong door" to service access. There will be multiple entry paths for Members to access behavioral health services. Referrals may come from primary care physicians, providers, ANTHEM staff, County Departments, and self-referral by calling the COUNTY's toll-free number that will be available 24 hours per day, 7 days a week for service access, service authorization, and referral.

G. Provider and Member Education

ANTHEM and COUNTY shall determine the requirements for coordination of Member and provider information about access to ANTHEM and COUNTY covered services to increase navigation support for beneficiaries and caregivers. ANTHEM and COUNTY may develop a "Quick Guide" that will assist for referrals and access to services.

H. Point of Contact for the MOU Amendment

The Point of Contact for the MOU will be a designated liaison from both the COUNTY and ANTHEM.

17. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

COUNTY and ANTHEM each consider and represent themselves as covered entities as defined by the U.S. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and agree to use and disclose PHI as required by law. COUNTY and ANTHEM acknowledge that the exchange of PHI between them is only for treatment, payment, and health care operations. COUNTY and ANTHEM intend to protect the privacy and provide for the security of PHI pursuant to the Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HIPAA Regulations) and other applicable laws.

18. SEVERABILITY

The provisions of this Agreement are severable. The invalidity or unenforceability of any one provision in the Agreement shall not affect the other provisions.

19. ENTIRE AGREEMENT

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

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first hereinabove written.

BLUE CROSS OF CALIFORNIA PARTNERSHIP PLAN, INC.:

(Authorized Signature)

Steven McCurdy - President
Print Name & Title

3330 W. Mineral King Ave
Suite A
Mailing Address
Visalia, CA 93291

COUNTY OF FRESNO

Sal Quintero,
Chairperson of the Board of Supervisors
of the County of Fresno

ATTEST:
Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By: Susan Bishop
Deputy

FOR ACCOUNTING USE ONLY:

Fund/Subclass: 0001/10000
Account No.: 7295 ($0)
Org No.: 56302666 ($0)

MEMORANDUM OF UNDERSTANDING (MOU)
DEPARTMENT OF BEHAVIORAL HEALTH (COUNTY)
AND
ANTHEM

CATEGORY	COUNTY	ANTHEM BLUE CROSS
A. Liaison	1. COUNTY's Administrative Staff is the liaison to coordinate activities with ANTHEM and to notify COUNTY providers and relevant staff of their roles and responsibilities 2. COUNTY Liaison will provide ANTHEM with an updated list of approved COUNTY providers, specialists and behavioral health care centers in the county. 3. Information for Mental Health (MH) services is also available on the COUNTY's managed care website and is updated at a minimum on a quarterly basis. 4. Information for Substance Use Disorder (SUD) treatment and recovery services is also available on the COUNTY's Substance Use Disorders Services Webpage and is updated at a minimum on a 30 day basis.	1. ANTHEM has a liaison that coordinates activities with the COUNTY and COUNTY Liaison. 2. The Liaison will notify ANTHEM staff and ANTHEM providers of their responsibilities to coordinate services with the COUNTY. 3. The ANTHEM Provider Directory is available on line and updated at a minimum on a quarterly basis. 4. The ANTHEM Provider Operations Manual is available on line.
B. Behavioral Health Service	1. COUNTY will credential and contract with sufficient numbers of licensed behavioral health professionals to maintain a COUNTY provider network sufficient to meet the needs of Members. 2. COUNTY will assist with identification of COUNTY providers who have the capacity and willingness to accept Medi-Cal Fee for Service reimbursement to serve Members in need of MH services MH service who do not meet the COUNTY medical necessity criteria and require services outside the scope of practice of the Primary Care Physicians (PCP) per Exhibit B, attached hereto. 3. For SUD services, COUNTY will provide a centralized intake function that will screen clients using the ASAM criteria and determine a presumptive level of care. Once the client attends an intake at a COUNTY contracted provider, they will be assessed for medical necessity including diagnosis. COUNTY centralized intake will approve services through a Treatment Authorization Request process.	1. ANTHEM will utilize the COUNTY to identify COUNTY providers who are willing to accept Medi-Cal fee for service reimbursement to provide services for MH services to Members who do not meet COUNTY medical necessity criteria for COUNTY services and require services outside the scope of practice of the PCP per Exhibit B, attached hereto. 2. ANTHEM will coordinate care with the appropriate COUNTY provider or provider organization as recommended by the COUNTY for those services that do not meet the COUNTY medical necessity criteria. 3. For SUD services, ANTHEM will screen and offer brief intervention. For clients who appear to need further assessment and more intensive services, a referral to COUNTY centralized intake or a provider on the list will be required. 4. ANTHEM will collaborate with COUNTY to maintain a list of COUNTY providers or provider organizations to be made available to Members upon request. 5. Any updates to the list will be provided to ANTHEM liaison quarterly and upon request.

	4. COUNTY will continually monitor the COUNTY provider network to ensure Member access to quality behavioral health care. COUNTY will assist ANTHEM in arranging for a specific COUNTY provider or community service. 5. COUNTY will assist ANTHEM to develop and update a list of providers or provider organizations to be made available to Members. For MH services this list is available on the COUNTY's managed care website. Any updates to the list will be forwarded to the ANTHEM liaison quarterly and upon request. For SUD services, this list is available on the COUNTY's SUD Services Webpage. Any updates to the list will be forwarded to the ANTHEM liaison quarterly and upon request.	
C. Medical Records Exchange of Information	1. COUNTY will follow all applicable laws pertaining to the use and disclosure of protected health information including but not limited to: • HIPAA / 45 C.F.R. Parts 160 and 164 • LPS / W & I Code Sections 5328-5328.15 • 45 C.F.R. Part 2 • HITECH Act (42. U.S.C. Section 17921 *et. seq.* • CMIA (Ca Civil Code 56 through 56.37)	1. ANTHEM and contracted providers are allowed to release medical information under HIPAA regulations specific to the HIPPA Privacy Rule (45 C.F.R. Part 164.)
D. Scope of Service	1. COUNTY has a toll-free telephone number available 24 hours a day, seven days a week for access to emergency, specialty MH and SUD services for Members who meet the medical necessity criteria as identified in Exhibit B, attached hereto. 2. COUNTY maintains responsibility for: a. Medication treatment for behavioral health conditions that would not be responsive to physical healthcare-based treatment and the condition meets COUNTY medical necessity criteria. b. All other outpatient specialty MH and SUD services covered by the COUNTY when the Member's behavioral health condition meets COUNTY medical	1. ANTHEM PCPs will be responsible for providing 24 hours a day, seven days a week, access to health care services for Members as specified in the ANTHEM contract with Department of Health Care Services (DHCS). 2. PCP will refer to the COUNTY for assessment and appropriate services. PCP's will refer Members for: a. An assessment to confirm or arrive at a diagnosis b. Behavioral health services other than medication management are needed for a Member with a diagnosis included in the responsibilities of the COUNTY. c. For identification of conditions not responsive to physical healthcare-based treatment. 3. PCP's will provide primary care behavioral health treatment which includes:

	necessity criteria, such as individual and group therapies, case management, crisis intervention, treatment plan, assessment, and linkage with community resources. c. Consultation and training services to PCPs, particularly related to specialty MH and SUD issues and treatments, including medication consultation. 3. To receive behavioral health services, the Member must meet the criteria for each of the following categories for MH services: a. Category A—Included Diagnosis b. Category B—Impairment Criteria c. Category C—Intervention Related Criteria Per Enclosure 1a of Exhibit A. 4. To receive behavioral health services, the Member must meet the criteria for each of the following categories for SUD services: a. Early Intervention Services b. Outpatient/Intensive Outpatient c. Residential Services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0) d. Withdrawal Management e. Opioid Treatment f. Recovery Services For further details on SUD ASAM levels of care please see Exhibit C. For SUD ICD-10 Diagnostic Codes see Enclosure 1b. 5. COUNTY providers will refer Members back to their identified PCP for medical and non-specialty behavioral health conditions that would be responsive to appropriate physical health care.	a. Basic education, assessment (MH services only), counseling (MH services only) and referral and linkage to other services for all Members b. Medication and treatment for i. Behavioral health conditions that would be responsive to physical healthcare-based treatment ii. Behavioral health disorders due to a general medical condition c. Medication-induced reactions from medications prescribed by physical health care providers. 4. PCPs will provide or arrange for: a. Covered medical services b. Primary behavioral health intervention for Member with "Excluded Diagnosis" as identified in Specialty MH Services identified in ATTACHMENT A, Page 17 of this Exhibit A. c. Screening and brief intervention for behavioral health services within the PCP's scope of practice 5. ANTHEM and COUNTY recognize that the PCP's ability to treat behavioral health disorders will be limited to each provider's training and scope of practice. 6. When the Member does not meet MH medical necessity, ANTHEM and PCP will be responsible for coordinating a referral in accordance with Category B2 "Mental Health Services" or an ANTHEM contracted provider. 7. When the member meets SUD medical necessity for COUNTY contracted services, ANTHEM and PCP will refer client to a county provider or coordinate care with inpatient facilities and out-of-county facilities accepting Fresno County clients as appropriate.
E. Ancillary Behavioral Health Services	1. When medical necessity criteria are met and services are approved by the COUNTY, the COUNTY and its contracted providers will provide hospital based specialty MH ancillary services, which include, but are not limited to Electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI) that are received by a Member admitted to a psychiatric inpatient hospital other than routine services, per Exhibit B, attached	1. ANTHEM must cover and pay for medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Section 51311. ANTHEM will cover and pay for related services for Electroconvulsive Therapy (ECT), anesthesiologist services provided on an outpatient basis, per Exhibit B, attached hereto. 2. ANTHEM will cover and pay for all medically necessary professional services to meet the physical health care needs of the Members

	hereto. 2. When SUD medical necessity criteria is met and services are approved by the COUNTY for ASAM levels 3.7 and 4.0 and medical detox, COUNTY will refer Member to ANTHEM. 3. COUNTY will make training available for community based physicians interested in providing MAT services, including an eight hour Buprenorphine Waiver Training required to become a community based MAT service provider.	who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital or Psychiatric Health Facility (PHF). These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultation, per Exhibit B, attached hereto. 3. ANTHEM is not required to cover room and board charges or behavioral health services associated with a Member's admission to a hospital or inpatient psychiatric facility for psychiatric inpatient services, per Exhibit B, attached hereto. 4. ANTHEM will provide SUD treatment for Members who meet medical necessity for Medically Monitored Intensive Inpatient Services (ASAM Level 3.7) which includes 24 hour nursing care with physician availability for significant problems with acute intoxication and/or withdrawal potential, biomedical conditions and emotional, behavioral or cognitive conditions and complications and 16 hour/day counselor availability. 5. ANTHEM will provide SUD treatment for Members who meet medical necessity for Medically Managed Intensive Inpatient Services (ASAM Level 4.0) which includes 24 hour nursing care and daily physician care for severe, unstable problems with acute intoxication and/or withdrawal potential, biomedical conditions and emotional, behavioral or cognitive conditions and complications with counseling available to engage Member in treatment. 6. ANTHEM will provide SUD treatment for Members who meet medical necessity for Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7 – WM) which includes severe withdrawal needing 24-hour nursing care and physician visits. 7. ANTHEM will provide SUD treatment for Members who meet medical necessity for Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4 – WM) which includes severe, unstable withdrawal needing 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability. Once the client has stabilized ANTHEM will refer to a lower level of care to increase the likelihood of successful recovery. 8. ANTHEM Providers will have the ability to prescribe, dose and/or refer Members with an Opioid Use Disorder to Medication

		Assisted Treatment (MAT) when appropriate. ANTHEM will encourage its physicians to complete an eight hour Buprenorphine Waiver Training course required to prescribe and dispense Buprenorphine. This training is available through SAMHSA. 9. ANTHEM shall coordinate with COUNTY NTP providers when medically indicated for MAT services.
E1. Emergency Room Urgent Behavioral Health Care	1. The COUNTY toll free 24 hour line is available to Members. 2. The COUNTY shall cover and pay for the professional services of a behavioral health specialist provided in an emergency room to a Member whose condition meets COUNTY medical necessity criteria or when behavioral health specialist services are required to assess whether COUNTY medical necessity is met, per Exhibit B, attached hereto. 3. The COUNTY is responsible for the facility charges resulting from the emergency services and care of a Member whose condition meets COUNTY medical necessity criteria when such services and care do result in the admission of the Member for psychiatric and/or SUD inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay, per Exhibit B, attached hereto. 4. The COUNTY is responsible for facility charges directly related to the professional services of a behavioral health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric and/or SUD inpatient hospital services at that facility or any other facility, per Exhibit B, attached hereto.	1. ANTHEM will maintain a 24 hour member service and Nurse Advice Line. 2. ANTHEM shall cover and pay for all professional services, except the professional services of a behavioral health specialist when required for the emergency services and care of a member whose condition meets COUNTY medical necessity criteria. 3. ANTHEM shall cover and pay for the facility charges resulting from the emergency services and care of a Member whose condition meets COUNTY medical necessity criteria when such services and care do not result in the admission of the member for psychiatric and/or SUD inpatient hospital services or when such services result in an admission of the member for psychiatric and/or SUD inpatient hospital services at a different facility. 4. ANTHEM shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Member with an excluded diagnosis or a Member whose condition does not meet COUNTY medical necessity criteria and such services and care do not result in the admission of the Member for psychiatric and/or SUD inpatient hospital services. 5. Payment for the professional services of a behavioral health specialist required for the emergency services and care of a Member with an excluded diagnosis is the responsibility of ANTHEM.
E2. Home Health Agency Services	1. COUNTY shall cover and pay for medication support services, case management, crisis intervention services, or any other specialty MH services as provided under Section 1810.247, which are prescribed by a psychiatrist and are provided to a Member who is homebound. COUNTY will collaborate with ANTHEM on any specialty MH services being provided to a Member.	1. ANTHEM will cover and pay for prior authorized home health agency services as described in Title 22, CCR, Section 51337 prescribed by an ANTHEM provider when medically necessary to meet the needs of homebound Members. ANTHEM is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program. 2. ANTHEM will refer Members who may be at risk of institutional placement to the Home and Community Based services (HCBS)

		Waiver Program (ANTHEM/DHCS Contract 6.7.3.8) if appropriate.
E3. Nursing and Residential Facility Services	1. COUNTY will arrange and coordinate payment for nursing facility services, i.e., Augmented Board and Care (ABC), Skilled Nursing Facility (SNF), Institution for Mental Disease (IMD), etc., for Members who meet medical necessity criteria and who require a special treatment program [Title 22, California Code of Regulations (CCR), Section 51335(k)]. 2. COUNTY's provide medically necessary specialty MH services, typically visits by psychiatrists and psychologists.	1. ANTHEM will arrange and pay for nursing facility services for Members who meet the medical necessity criteria for the month of admission plus one month, per Title 22, CCR, Section 51335. 2. ANTHEM will arrange for disenrollment from managed care if Member needs nursing services for a longer period of time. 3. ANTHEM will pay for all medically necessary DHCS contractually required Medi-Cal covered services until the disenrollment is effective.
E4. Emergency and Non-Emergency Medical Transportation	1. Medical transportation services as described in Title 22, Section 51323 are not the responsibility of the COUNTY except when the purpose of the medical transportation service is to transport a Medi-Cal beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the COUNTY.	1. ANTHEM will arrange and pay for transportation of Members needing medical transportation from: a. The emergency room for medical evaluation. b. A psychiatric inpatient hospital to a medical inpatient hospital required to address the Member's change in medical condition. c. A medical inpatient hospital to a psychiatric inpatient hospital required to address the Member's change in psychiatric condition. 2. ANTHEM will cover and pay for all medically necessary emergency transportation (per CCR Title 22, 51323). Ambulance services are covered when the Member's medical condition contraindicates the use of other forms of medical transportation. 3. Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the Member as per CCR Title 22, 51323. 4. Ambulance, litter van and wheelchair van medical transportation services are covered when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. Ambulance services are covered when the member's medical condition contraindicates the use of other forms of medical transportation 5. ANTHEM will cover all nonemergency medical transportation, necessary to obtain program covered services a. When the service needed is of such an urgent nature that written

		authorization could not have been reasonably submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization. b. Transportation shall be authorized only to the nearest facility capable of meeting the member's medical needs. 6. ANTHEM will cover and pay for medically necessary non-emergency medical transportation services when prescribed for a Member by a Medi-Cal behavioral health provider outside the COUNTY when authorization is obtained. ANTHEM will maintain a policy of non-discrimination regarding Members with behavioral health disorders who require access to any other transportation services provided by ANTHEM. 7. ANTHEM will assure that SUD clients receive Non-Emergency medical transportation services when prescribed for a Member as described in APL 17-010, attached as Exhibit E. These transportation services will be provided when the SUD services are medically necessary and the Non-Emergency medical transportation has prior authorization.
E5. Developmentally Disabled Services	1. COUNTY will refer Members with developmental disabilities to the Central Valley Regional Center for non-medical services such as respite, out-of-home placement, supportive living, etc., if such services are needed. 2. COUNTY has a current list of names, addresses and telephone numbers of local providers, provider organizations, and agencies that is available to a Member when that Member has been determined to be ineligible for COUNTY covered services because the Member's diagnosis is not included in Exhibit B Pages 32 to 36.	1. ANTHEM PCP will refer Members with developmental disabilities to the Central Valley Regional Center for non-medical services such as respite, out-of-home placement supportive living, etc., if such services are needed. 2. ANTHEM will maintain a current MOU with Central Valley Regional Center
E6. History and Physical for Psychiatric Hospital Admission	1. COUNTY will utilize ANTHEM network providers to perform medical histories and physical examinations required for behavioral health examinations required for behavioral health and psychiatric hospital	1. ANTHEM will cover and pay for all medically necessary professional services to meet the physical health care needs of Members who are admitted to the psychiatric ward of a general acute care hospital or freestanding licensed psychiatric inpatient hospital. These

	admissions for ANTHEM members.	services include the initial health history and physical assessment required within 24 hours of admission and any necessary physical medicine consultations, per Exhibit B attached hereto.
E7. Hospital Outpatient Department Services (Electroconvulsive Therapy)	1. COUNTY will cover and pay for all psychiatric professional services associated with electroconvulsive therapy. Per Title 9, CCR Section 1810.350	1. ANTHEM is responsible for separately billable outpatient services related to electroconvulsive therapy, such as anesthesiologist services, per Exhibit B, attached hereto. 2. ANTHEM will cover and pay for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and ANTHEM's contract with its contractors and DHCS, per Exhibit B, attached hereto.
F. Diagnostic Assessment and Triage	1. COUNTY or COUNTY provider will screen and apply ASAM criteria for level of care placement. When Member is determined to meet medical necessity for a level of care not provided by COUNTY Member will be referred to ANTHEM. 2. COUNTY will arrange and pay for specialty COUNTY provider services for Members whose psychiatric condition may not be responsive to physical health care. a. Initial access and availability will be via the COUNTY Access Unit (a twenty-four hour toll free telephone triage system) b. Crisis/emergency triage via COUNTY provider is available 24 hours a day. 3. COUNTY provider will assess and diagnose Member's symptoms, level of impairment and focus of intervention. Included ICD-9 Diagnoses codes are identified in Enclosure 1a, attached hereto and incorporated herein. 4. COUNTY provider assessments will: a. Determine if Member meets medical necessity criteria (See Attachment B, attached hereto and incorporated herein by reference.) b. Provide a resolution of diagnostic dilemmas not resolved by consultations (e.g., multiple interacting syndromes, patient's symptoms interfere with the diagnostic conclusion and	1. ANTHEM will provide Members with SUD screenings, brief intervention (SBIRT), referral and assessment. If it is found that a Member preliminarily meets medical necessity for COUNTY provided services ANTHEM will refer the Member to an appropriate COUNTY access point (24/7 Access Line, Urgent Care Wellness Center or COUNTY provider)for further assessment and treatment. 2. ANTHEM will arrange and pay for assessments of ANTHEM members by PCPs to: a. Rule out general medical conditions causing psychiatric and SUD symptoms. b. Rule out behavioral health disorders caused by a general medical condition. 3. The PCP will identify those general medical conditions that are causing or exacerbating psychiatric and/or SUD symptoms. 4. The PCP will be advised to identify and treat non-disabling psychiatric conditions which may be responsive to primary care, i.e., mild to moderate anxiety and/or depression. 5. When medically necessary ANTHEM will cover and pay for physician services provided by specialists such as neurologists, per Exhibit B, attached hereto.

	has a bearing on the primary care physician's treatment plan or if the diagnostic conclusion is needed to determine appropriateness for specialized MH care. c. Identify stability level, if the result is needed to determine appropriateness for specialty MH services.	
G. Referrals	1. COUNTY will accept referrals from ANTHEM staff and providers. ANTHEM providers and Members will be referred to determine medical necessity for specialty MH services. For SUD members, screening will be completed to determine if further assessment is necessary. If so clients will be referred to the 24/7 Access Line. 2. COUNTY will coordinate with ANTHEM Customer Care Center to facilitate appointment and referral verification assistance as needed. 3. When all medical necessity criteria are met, COUNTY will arrange for specialty MH and/or SUD services by COUNTY provider. 4. When Member is appropriately treated and/or stabilized, Member may be referred back, if appropriate to PCP for maintenance care. The COUNTY and ANTHEM will coordinate services as necessary in such cases 5. COUNTY and COUNTY provider will track referrals to PCP to verify that Member has access to appointment and assistance to keep appointment as needed. a. COUNTY provider will have the option of contacting the ANTHEM Health Services for information and assistance concerning a referred Member. 6. The COUNTY will refer the Member to a source of treatment or a source of referral for treatment outside the COUNTY when the COUNTY determines that the Member's diagnosis is not included in Title 9, CCR, Section 1830.205. 7. Per Welfare & Institution Code, Section 5777.5 (b)(1) for behavioral health services the COUNTY will designate a process or entity to receive notice of actions, denials, or	1. Following the PCP assessment, ANTHEM staff and/or PCP will refer those Members whose psychiatric condition or SUD would not be responsive to physical health care to the COUNTY to determine if specialty MH and/or SUD services medical necessity criteria are met. 2. ANTHEM and PCP will coordinate and assist the COUNTY and Member to keep their appointments and referrals back to their PCP as appropriate for all other services not covered by the COUNTY. a. ANTHEM may request assistance from the COUNTY Liaison to facilitate removal of barriers to a successful referral such as transportation difficulties, resistance to treatment or delays to access. 3. Members not meeting COUNTY medical necessity guidelines will be referred by ANTHEM to appropriate community resources for assistance in identifying programs available for low income Medi-Cal beneficiaries.

	deferrals from ANTHEM , and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination. 8. Per Welfare & Institution Code, Section 5777.5(b) (2) for behavioral health services the COUNTY will respond by the close of business day following the day the deferral notice is received.	
H. Service Authorizations	1. For MH services, COUNTY will authorize assessment and/or treatment services by COUNTY providers who are credentialed and contracted with COUNTY for services that meet specialty MH services medical necessity criteria. 2. For SUD services, COUNTY will perform screening and referral to treatment. Once the provider assessment is complete COUNTY will authorize a Treatment Authorization Request (TAR) for level of care to receive treatment by COUNTY providers who are Drug Medi-Cal certified and contracted with the COUNTY for SUD services that meet medical necessity criteria.	1. ANTHEM will authorize medical assessment and/or treatment services by ANTHEM network providers who are credentialed and contracted with ANTHEM for covered medically necessary services. 2. ANTHEM will inform PCPs that they may refer Members to the COUNTY for initial diagnosis and assessment of the Member.
I. Consultation	1. COUNTY encourages consultations between COUNTY providers, specialty providers and ANTHEM PCP providers as it relates to specialty MH and/or SUD issues including but not limited to medication issues, linkage with community resources, etc., in accordance with HIPAA federal and state regulations regarding confidentiality per HIPPA Privacy Rule 45 C.F.R. Part 164. 2. For those Members who are excluded from COUNTY services, COUNTY will provide clinical consultation and training to the ANTHEM PCPs, other behavioral health providers and/or ANTHEM staff on the following topics: a. Recommended physical healthcare-based treatment for diagnosed conditions b. Complex diagnostic assessment of behavioral health disorders (e.g., multiple co-occurring diagnosis, atypical symptom patterns) c. Treatment of stabilized but	1. PCP providers will be available to consult with COUNTY and COUNTY providers regarding Members who are treated by both, in accordance with HIPAA federal and state regulations regarding confidentiality, per HIPPA Privacy Rule 45 C.F.R. Part 164. 2. For those Members who meet COUNTY medical necessity criteria and whose psychiatric symptoms and/or SUD will be treated by a COUNTY provider, ANTHEM and/or PCP will provide consultation to COUNTY providers and/or COUNTY staff on the following topics: a. Acquiring access to covered ANTHEM medical services. b. Treatment of physical symptoms precipitated by medications used to treat behavioral health disorders. c. Treatment of complicated sub-syndrome medical symptoms. d. Complex medication interactions with medications prescribed by PCP not commonly used in psychiatric or SUD specialty practice.

	serious and debilitating mental disorders d. Complex psychotropic medications practices (medication interactions, polypharmacy, use of novel psychotropic medication) e. Treatment of complicated sub-syndrome psychiatric symptoms f. Treatment of psychiatric symptoms precipitated by medications used to treat medical conditions g. Treatment of outpatient behavioral health services that are within the ANTHEM PCP's scope of practice. 3. For those Members who are excluded from COUNTY services, COUNTY will provide clinical consultation and training to the ANTHEM PCPs, and/or ANTHEM staff on the following topics: a. ASAM Multidimensional Assessment b. From Assessment to Service Planning and Level of Care c. Title 22/Documentation d. Evidence Based Practices e. DSM-5 f. Co-occurring Disorders g. Medication Assisted Treatment	
J. Early Periodic Screening, Diagnosis and treatment (EPSDT) Supplemental Services.	1. COUNTY will utilize Medi-Cal medical necessity criteria established for EPSDT supplemental services to determine if a child, 21 years of age and under, meets those criteria. 2. When EPSDT supplemental criteria are met, COUNTY is responsible for arranging and paying for EPSDT supplemental services provided by COUNTY specialty MH and SUD providers. 3. When EPSDT supplemental criteria are not met, COUNTY will refer Member children as follows: a. For MH services, Referral to California Children's Services (CCS)- for those children who have a CCS medically eligible condition and require behavioral health provider services related to the eligible condition b. For SUD services, ASAM criteria will be applied, level	1. When ANTHEM determines that EPSDT supplemental services criteria are not met and the Member child's condition is not CCS eligible, ANTHEM will refer the Member child to the PCP for treatment of conditions within the PCP's scope of practice. 2. Referrals to the COUNTY for an appropriate linked program will be made for treatment of conditions outside the PCP's scope of practice. ANTHEM will assist the COUNTY and Members by providing links to known community providers of supplemental services. 3. ANTHEM will cover all medically necessary professional services to meet the physical health care needs of Members admitted to a general acute care hospital ward or to a freestanding licensed psychiatric inpatient hospital.

	of care will be determined and a referral to treatment will be made. c. When a referral is made, the COUNTY will notify ANTHEM of the referral.	
K. Pharmaceutical Services and Prescribed Drugs	1. COUNTY providers will prescribe and monitor the effects and side effects of psychotropic medications for Members under their treatment. 2. COUNTY will coordinate with ANTHEM representatives to ensure that psychotropic drugs prescribed by COUNTY providers are included in the ANTHEM formulary and/or available for dispensing by ANTHEM network pharmacies unless otherwise stipulated by state regulation. 3. COUNTY will inform COUNTY providers regarding process and procedure for obtaining prescribed medications for Members. 4. COUNTY providers will utilize ANTHEM contracted laboratories for laboratory tests required for medication administration and management of psychotropic medications. 5. COUNTY will assist ANTHEM in the utilization review of psychotropic drugs prescribed by out-of-network psychiatrists. 6. COUNTY will share with ANTHEM a list of non-contracted psychiatrist COUNTY providers contracted to provide behavioral health services in areas where access to psychiatrists is limited, on a quarterly basis.	1. ANTHEM will: a. Allow COUNTY credentialed providers access to pharmacy and laboratory services as specialty providers. b. Will make available a list of participating pharmacies and laboratories on the internet. c. Will make available the formulary and information regarding drug formulary procedures on the internet. d. Consider recommendations from COUNTY for utilization management standards for behavioral health pharmacy and laboratory services. e. Provide the process for obtaining timely authorization and delivery of prescribed drugs and laboratory services to the COUNTY. 2. ANTHEM will coordinate with COUNTY to ensure that covered psychotropic drugs prescribed by COUNTY providers are available through the authorization process or formulary for dispensing by ANTHEM network pharmacies unless otherwise stipulated by state regulation. (See Enclosure2, “Drugs Excluded from Plan Coverage” of Exhibit B) 3. ANTHEM will apply utilization review procedures when prescriptions are written by out-of-network psychiatrists for the treatment of psychiatric conditions. a. Covered psychotropic drugs written by out-of-network psychiatrists will be filled by ANTHEM network pharmacies. b. ANTHEM will provide Members with the same drug accessibility written by out-of-network psychiatrists as in-network providers. c. ANTHEM will not cover and pay for behavioral health drugs written by out-of-network physicians who are not psychiatrists unless these prescriptions are written by non-psychiatrists contracted by the COUNTY to provide behavioral health services in areas where access to psychiatrists is limited per Exhibit B, attached hereto. 4. ANTHEM PCPs will monitor the effects and

		side effects of psychotropic medications prescribed for those members whose psychiatric conditions are under their treatment. 5. Reimbursement to pharmacies for new psychotropic drugs classified as antipsychotics and approved by the FDA will be made through the Medi-Cal FFS system whether these drugs are provided by a pharmacy contracting with ANTHEM or by a FFS pharmacy, per Enclosure 2 of this Exhibit A, attached hereto and incorporated herein.
L. Laboratory, Radiological and Radioisotope Services	1. COUNTY or a Medi-Cal FFS behavioral health services provider needing laboratory, radiological, or radioisotope services for a Member when necessary for the diagnosis, treatment or monitoring of a behavioral health condition will utilize the list of ANTHEM contract providers.	1. ANTHEM will cover and pay for medically necessary laboratory, radiological and radioisotope services when ordered by a COUNTY or a Medi-Cal FFS behavioral health services provider for the diagnosis, treatment or monitoring of a behavioral health condition (and side effects resulting from medications prescribed to treat the behavioral health diagnosis) as described in Title 22, CCR Section 51311 and Exhibit B, attached hereto. 2. ANTHEM will coordinate and assist the COUNTY or Medi-Cal FFS behavioral health provider in the delivery of laboratory radiological or radioisotope services. 3. A list of ANTHEM contracted providers is available on-line. 4. Provide the process for obtaining timely authorization and delivery of prescribed drugs and laboratory services.
M. Grievances and Complaints	1. COUNTY will share with ANTHEM its established processes for the submittal, processing and resolution of all member and provider grievances and complaints regarding any aspect of the behavioral health care services in accordance with CFR 42 Part 438. These processes include timelines/deadlines and member information that must be provided. 2. COUNTY and ANTHEM will work collaboratively to resolve any formal grievance or complaint brought to the attention of either plan.	1. ANTHEM has in place a written process for the submittal, processing and resolution of all member and provider grievances and complaints which is inclusive of any aspect of the health care services or provision of services. 2. ANTHEM liaison will coordinate and share the established complaint and grievance process for its Members with the COUNTY
N. Appeal Resolution Process	1. COUNTY will ensure that the Members and providers are given an opportunity for reconsideration and appeal for denied, modified or delayed services. 2. COUNTY will ensure that the Members receive specialty MH and/or SUD services and prescription drugs	1. ANTHEM will ensure that Members and providers are given an opportunity for reconsideration and an appeal for denied, modified or delayed services 2. ANTHEM will ensure that medically necessary services continue to be provided to Members while the dispute is being resolved. ANTHEM's appeal process will be

	while the dispute is being resolved.	shared with the COUNTY.
O. Conflict Resolution/MOU Monitoring	1. COUNTY Liaison will meet with the ANTHEM Liaison to monitor this MOU quarterly and/or upon request. a. Within two weeks of a formal request, COUNTY Liaison will meet with ANTHEM Liaison when COUNTY or ANTHEM management identifies problems requiring resolution through the MOU. b. COUNTY Liaison will be responsible for coordinating, assisting and communicating suggestions for MOU changes to the COUNTY leadership and ANTHEM. c. COUNTY Liaison will communicate and coordinate MOU changes to the State Department of Health Care Services (DHCS), COUNTY service providers and to ANTHEM and its providers. 2. COUNTY Liaison will participate in an annual review, update and/or renegotiations with ANTHEM, as mutually agreed. 3. COUNTY management will provide 60 days advance written notice to ANTHEM should the COUNTY decide to modify this MOU. [Unless mandated by the Department of Health Care Services directives, state mandated requirements and/or Federal guidelines.]	1. Local ANTHEM liaison will meet with the COUNTY Liaison to monitor this MOU quarterly and/or upon request. a. Within two weeks of a formal request, ANTHEM Liaison will meet with the COUNTY Liaison when the COUNTY or ANTHEM management identifies problems requiring resolution through the MOU. b. ANTHEM Liaison will be responsible for coordinating, assisting and communicating suggestions for MOU changes for to ANTHEM and the COUNTY leadership. c. ANTHEM will coordinate and communicate MOU changes to the California Department of Health Care Services (DHCS), COUNTY providers and ANTHEM network services providers. d. ANTHEM Liaison will make a good faith effort to agree to resolutions that are in the best interest of Members and are agreeable to all parties involved. 2. ANTHEM Liaison will conduct an annual review, update and/or renegotiations of this MOU, as mutually agreed. 3. ANTHEM management will provide 60 day advance written notice to COUNTY should ANTHEM decide to modify this MOU.
P. Protected Health Information	1. COUNTY will comply with all applicable laws pertaining to use and disclosure of PHI including but not limited to: • HIPAA / 45 C.F.R. Parts 160 and 164 • LPS / W & I Code Sections 5328-5328.15 • 45 C.F.R. Part 2 • HITECH Act (42. U.S.C. Section 17921 *et. seq.* • CMIA (Ca Civil Code 56 through 56.37) 2. COUNTY will train its workforce in policies and procedures regarding Protected Health Information (PHI) as necessary and appropriate to perform processes and functions within the scope of duties under this MOU. 3. Only encrypted PHI as specified in the HIPAA Security Rule will be transmitted via email. Unsecured PHI will not be	1. ANTHEM will comply with Confidentiality of Medical Information Act [California Civil Code 56 through 56.37] the Patient Access to Health Records Act (California Health and Safety Code 123100, et seq) and the Health Insurance Portability and Accountability Act (Code of Federal Regulations Title 45 Parts 160 and 164). 2. ANTHEM will train its workforce in policies and procedures regarding Protected Health Information (PHI) as necessary and appropriate to perform processes and functions within the scope of duties under this MOU. 3. ANTHEM will encrypt any data transmitted via Electronic Mail (Email) containing confidential data of Members such as PHI and Personal Confidential Information (PCI) or other confidential data to ANTHEM or anyone else including state agencies. 4. ANTHEM will notify COUNTY within 24 hours

	transmitted via email. 4. COUNTY will notify ANTHEM within 24 hours during a work week of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable Federal and State laws and regulations.	during a work week of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable Federal and State laws or regulations.

Enclosure 1a

Table 1 - Included ICD-10 Diagnoses - All Places of Services except Hospital Inpatient

F20.0-F29	F60.0-F60.1	F98.0-F98.4
F30.10-F30.9	F60.3-F68.13	G21.0-G25.9
F31.10-F39	F80.82-F80.9	R15.0-R69
F40.00-F45.1	F84.2-F84.9	Z03.89
F45.22-F50.9	F90.0-F94.1	

DSM-5 Diagnoses and New ICD-10-CM Codes

As Ordered in the DSM-5 Classification

AMERICAN PSYCHIATRIC ASSOCIATION

Disorder	DSM-5 Recommended ICD-10-CM Code for use through September 30, 2017	DSM-5 Recommended ICD-10-CM Code for use beginning October 1, 2017
Avoidant/Restrictive Food Intake Disorder	F50.89	F50.82
Alcohol Use Disorder, Mild	F10.10	F10.10
Alcohol Use Disorder, Mild, in early or sustained remission	F10.10	F10.11
Alcohol Use Disorder, Moderate	F10.20	F10.20
Alcohol Use Disorder, Moderate, in early or sustained remission	F10.20	F10.21
Alcohol Use Disorder, Severe	F10.20	F10.20
Alcohol Use Disorder, Severe, in early or sustained remission	F10.20	F10.21
Cannabis Use Disorder, Mild	F12.10	F12.10
Cannabis Use Disorder, Mild, in early or sustained remission	F12.10	F12.11
Cannabis Use Disorder, Moderate	F12.20	F12.20
Cannabis Use Disorder, Moderate, in early or sustained remission	F12.20	F12.21
Cannabis Use Disorder, Severe	F12.20	F12.20
Cannabis Use Disorder, Severe, in early or sustained remission	F12.20	F12.21
Phencyclidine Use Disorder, Mild	F16.10	F16.10
Phencyclidine Use Disorder, Mild, in early or sustained remission	F16.10	F16.11
Phencyclidine Use Disorder, Moderate	F16.20	F16.20
Phencyclidine Use Disorder, Moderate, in early or sustained remission	F16.20	F16.21
Phencyclidine Use Disorder, Severe	F16.20	F16.20
Phencyclidine Use Disorder, Severe, in early or sustained remission	F16.20	F16.21
Other Hallucinogen Use Disorder, Mild	F16.10	F16.10
Other Hallucinogen Use Disorder, Mild, in early or sustained remission	F16.10	F16.11
Other Hallucinogen Use Disorder, Moderate	F16.20	F16.20
Other Hallucinogen Use Disorder, Moderate, in early or sustained remission	F16.20	F16.21
Other Hallucinogen Use Disorder, Severe	F16.20	F16.20
Other Hallucinogen Use Disorder, Severe, in early or sustained remission	F16.20	F16.21
Inhalant Use Disorder, Mild	F18.10	F18.10
Inhalant Use Disorder, Mild, in early or sustained remission	F18.10	F18.11
Inhalant Use Disorder, Moderate	F18.20	F18.20

Inhalant Use Disorder, Moderate, in early or sustained remission	F18.20	F18.21
Inhalant Use Disorder, Severe	F18.20	F18.20
Inhalant Use Disorder, Severe, in early or sustained remission	F18.20	F18.21
Opioid Use Disorder, Mild	F11.10	F11.10
Opioid Use Disorder, Mild, in early or sustained remission	F11.10	F11.11
Opioid Use Disorder, Moderate	F11.20	F11.20
Opioid Use Disorder, Moderate, in early or sustained remission	F11.20	F11.21
Opioid Use Disorder, Severe	F11.20	F11.20
Opioid Use Disorder, Severe, in early or sustained remission	F11.20	F11.21
Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild	F13.10	F13.10
Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild, in early or sustained remission	F13.10	F13.11
Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate	F13.20	F13.20
Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate, in early or sustained remission	F13.20	F13.21
Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe	F13.20	F13.20
Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe, in early or sustained remission	F13.20	F13.21
Amphetamine-type Substance Use Disorder, Mild	F15.10	F15.10
Amphetamine-type Substance Use Disorder, Mild, in early or sustained remission	F15.10	F15.11
Amphetamine-type Substance Use Disorder, Moderate	F15.20	F15.20
Amphetamine-type Substance Use Disorder, Moderate, in early or sustained remission	F15.20	F15.21
Amphetamine-type Substance Use Disorder, Severe	F15.20	F15.20
Amphetamine-type Substance Use Disorder, Severe, in early or sustained remission	F15.20	F15.21
Cocaine Use Disorder, Mild	F14.10	F14.10
Cocaine Use Disorder, Mild, in early or sustained remission	F14.10	F14.11
Cocaine Use Disorder, Moderate	F14.20	F14.20
Cocaine Use Disorder, Moderate, in early or sustained remission	F14.20	F14.21
Cocaine Use Disorder, Severe	F14.20	F14.20
Cocaine Use Disorder, Severe, in early or sustained remission	F14.20	F14.21
Tobacco Use Disorder, Moderate	F17.200	F17.200
Tobacco Use Disorder, Moderate, in early or sustained remission	F17.200	F17.201
Tobacco Use Disorder, Severe	F17.200	F17.200

Tobacco Use Disorder, Severe, in early or sustained remission	F17.200	F17.201
Other (or Unknown) Substance Use Disorder, Mild	F19.10	F19.10
Other (or Unknown) Substance Use Disorder, Mild, in early or sustained remission	F19.10	F19.11
Other (or Unknown) Substance Use Disorder, Moderate	F19.20	F19.20
Other (or Unknown) Substance Use Disorder, Moderate, in early or sustained remission	F19.20	F19.21
Other (or Unknown) Substance Use Disorder, Severe	F19.20	F19.20
Other (or Unknown) Substance Use Disorder, Severe, in early or sustained remission	F19.20	F19.21

ATTACHMENT A

Medical Necessity For Specialty MH Services That Are The Responsibility Of MH Plan

Must have *all,* A, B *and* C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnosis:

- Pervasive Development Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia & Other Psychotic Disorder
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identify Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders (related to other included diagnoses).

Excluded Diagnosis:

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communications Disorders
- Autistic Disorder, Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that may be a focus of clinical attention, except Medication induced Movement Disorders which are included.

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have *one* of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria; must have *one*, 1, 2 *or* 3:

1 A significant impairment in an important area of life functioning, *or*

2 A probability of significant deterioration in an important area of life functioning, *or*

3 Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have *all*, 1, 2 *and* 3 below:

1 The focus of proposed intervention is to address the condition identified in impairment criteria "B" above *and*

2 It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*

3 The condition would not be responsive to physical health care based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

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

DEPARTMENT OF HEALTH SERVICES
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March 16, 2000 REV.

MMCD Policy Letter No. 00-01 REV.

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

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

PURPOSE

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

GOALS

The goals of this letter are:

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

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

- To clarify the responsibilities of Plans in delivering medically necessary contractually required Medi-Cal covered physical health care services to Plan members who may require specialty mental health services through the Medi-Cal Specialty Mental Health Services Consolidation program.

BACKGROUND

In Fiscal Year 1991-92, legislation was enacted that allowed the Department of Health Services (DHS), as the single state agency with the authority to administer the Medicaid program in California, to establish new managed care programs for the delivery of Medi-Cal services to beneficiaries.

Subsequent legislation required DHS, in consultation with DMH, to ensure that all systems for Medi-Cal managed care include a process for screening, referral, and coordination with medically necessary mental health services. The statute designated DMH as the state agency responsible for the development and implementation of a plan to provide local mental health managed care for Medi-Cal beneficiaries; and further required DMH to implement managed mental health care through fee-for-service (FFS) or capitated rate contracts negotiated with MHPs. A MHP could include a county, counties acting jointly, any qualified individual or organization, or a non-governmental agency contracting with DMH and sharing in the financial risk of providing mental health services; however, counties were given the right of first refusal for MHP contracts.

DMH, with input from a broad range of stakeholders, developed a plan for the provision of Medi-Cal managed mental health care at the local level that consolidated two separate systems of mental health care service delivery; the Medi-Cal FFS system, which allowed clients a free choice of providers, and the Short-Doyle/Medi-Cal system administered through the county mental health departments. By consolidating the two systems of care and their separate funding streams, it was felt that the Medi-Cal program would both improve care coordination and reduce administrative costs.

DMH implemented the first phase of managed mental health care, the consolidation of Medi-Cal inpatient mental health services at the county level, in January 1995.

Because it restricted Medi-Cal beneficiaries' choice of providers to the MHP in their county of residence and its network of contract providers, the new mental health program required a waiver from the federal Health Care Financing Administration

(HCFA) of provisions of the Social Security Act that otherwise guarantee beneficiaries a choice of providers.

In September 1997, HCFA approved California's request to expand Medi-Cal managed mental health care to include outpatient specialty mental health services and renewed the waiver for an additional two years. DMH implemented the second phase of Medi-Cal managed mental health care, the consolidation of psychiatric inpatient hospital services and outpatient specialty mental health and certain other services, in November 1997. A request to renew the waiver for an additional two years was submitted to HCFA by DMH in June 1999.

This comprehensive program of Medi-Cal funded mental health managed care services, which is administered by DMH through an interagency agreement with DHS, is now known as the Medi-Cal Specialty Mental Health Services Consolidation program.

Currently, the county mental health department is the MHP in all 58 counties of California, although a few Plans have elected to cover some, but not all Medi-Cal covered specialty mental health services. Two MHPs, Sutter-Yuba and Placer-Sierra, cover a bi-county area. The MHP selects and credentials its provider network, negotiates rates, authorizes specialty mental health services, and provides payment for services rendered by specialty mental health providers in accordance with statewide criteria.

Under the Medi-Cal Specialty Mental Health Services Consolidation program, MHPs are financed through a combination of state, federal and local funds. ~~**However, only funding for specified outpatient specialty mental health services and inpatient psychiatric services is provided to MHPs.**~~ MHPs receive no specific Medi-Cal funding for physical health services or any mental health services not specifically covered by the Consolidation program.

Unless otherwise excluded by contract, Plans are capitated for physical health care services, including but not limited to, those services described on pages 7 through 15 and mental health services that are within the primary care physician's scope of practice. Consistent with Plan contracts, some Plans may also receive capitation for specific mental health services such as psychologist and psychiatrist professional services, psychiatric inpatient hospital services, and long-term care services including nursing facility services for Plan members whose need for such services is based on mental illness.

As the state agency responsible for the development and implementation of local Medi-Cal managed mental health care, the California Department of Mental Health (DMH) has adopted emergency regulations entitled, "Medi-Cal Specialty Mental Health Services." These regulations are at Title 9, Division 1, Chapter 11, California Code of Regulations (CCR). Chapter 11 incorporates existing rules governing the provision of Medi-Cal inpatient psychiatric services by MHPs and adds new standards for additional services. Chapter 11 also makes specific program requirements for provision of Medi-Cal outpatient specialty mental health services by MHPs.

Field Tests

Specialty mental health services are provided to Medi-Cal beneficiaries in two counties, San Mateo and Solano, through local MHPs operated by the county mental health departments under separate field test authority from HCFA.

San Mateo County is field testing the acceptance of additional financial risk of federal reimbursement based on all-inclusive case rates for Medi-Cal inpatient hospital and outpatient services. Additionally, the MHP in San Mateo County is responsible for pharmacy and related laboratory services prescribed by psychiatrists.

Solano County is field testing various managed care concepts as a subcontractor on a capitated basis to the County Organized Health System, while also providing Short-Doyle/Medi-Cal services to beneficiaries under the regular, non-waivered Medi-Cal program.

POLICY

Consistent with contract requirements, each Plan is required to enter into a memorandum of understanding (MOU) with the MHP in each county covered by the contract. Each Plan is contractually responsible for the arrangement and payment of all medically necessary Medi-Cal covered physical health care services not otherwise excluded to Medi-Cal members who require specialty mental health services.

Memorandum of Understanding Between the Plan and the MHP

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal covered services to beneficiaries who are served by both parties is a shared Plan/MHP responsibility. Pursuant to contract requirements regarding local MHP coordination, Plans are required execute an MOU with the local MHP in each

county covered by the contract. Title 9, CCR, Section 1810.370, requires the MHP to execute an MOU with the Plan in each county served by the MHP.

The MOU is required to specify, consistent with contract requirements, the respective responsibilities of the Plan and the MHP in delivering medically necessary Medi-Cal covered physical health care services and specialty mental health services to beneficiaries. It is essential that circumstances that present a potential for unique operational difficulties be clearly addressed as components of the MOU.

It is suggested that Plans include a matrix of Plan/MHP responsibilities similar to the sample shown on Enclosure 3.

At a minimum, the MOU must address the following:

1. Referral protocols between plans, which must include:

   - How the Plan will provide a referral to the MHP when the Plan determines specialty mental health services covered by the MHP may be required;

   - How the MHP will provide a referral to a provider or provider organization outside the MHP, including the Plan, when the MHP determines that the beneficiary's mental illness does not meet the medical necessity criteria for coverage by the MHP or would be responsive to physical health care based treatment.

   - The availability of clinical consultation between a Plan and the MHP, which must include the availability of clinical consultation on a beneficiary's physical health condition. Such consultation must also include consultation by the Plan to the MHP on medications prescribed by the Plan for a Plan member whose mental illness is being treated by the MHP; and consultation by the MHP to the Plan on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the Plan.

2. Procedures for the delivery of contractually required Medi-Cal covered inpatient and outpatient specialty mental health services through the MHP including but not limited to:

- The responsibility of the MHP relating to the prescription by MHP providers of mental heath drugs and related laboratory services that are the contractual obligation of the Plan to cover and reimburse.

- The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Plan.

- Emergency room facility and related charges.

- Medical transportation services when the purpose of such transportation is to reduce the cost of psychiatric inpatient hospital services to the MHP.

- Specialty mental health services prescribed by a psychiatrist and delivered at the home of a beneficiary.

- Direct transfers between psychiatric inpatient hospital services and inpatient hospital services to address changes in a beneficiary's medical condition.

3. Procedures for the delivery by the Plan of Medi-Cal covered physical health care services that the Plan is contractually obligated to cover and are necessary for the treatment of mental health diagnoses covered by the MHP.

   These procedures must address, but are not limited to, provision of the following:

   - Outpatient mental health services within the primary care physician's scope of practice.

   - Covered ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

   - Prescription drugs and laboratory services.

   - The Plan's obligation to provide the procedures for obtaining timely authorization and delivery of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP.

   - Emergency room facility and related services.

- Emergency and non-emergency medical transportation.
- Home health agency services.
- Long-term care services (to the extent that these services are included by Plan contract).
- Direct transfers between inpatient hospital services and psychiatric inpatient hospital services to address changes in a Plan member's mental health condition.

4. The appropriate management of Plan member care, including procedures for the exchange of medical records information, which maintain confidentiality in accordance with applicable state and federal laws and regulations.

5. A mutually satisfactory process for resolving disputes between the Plan and the MHP that includes a means for Plan members to receive medically necessary physical and mental health care services, including specialty mental health services and prescription drugs, while a dispute is being resolved.

   To the extent a Plan has not executed an MOU by the date of this letter or submitted an MOU to DHS for review and approval, the Plan must immediately submit documentation substantiating its good faith efforts to enter into an MOU with the MHP or provide justification for the delay in the submission of an MOU to DHS. The Plan shall submit monthly reports to DHS documenting the Plan's continuing good faith efforts to execute an MOU with the MHP, which provides justification for the delay in meeting this requirement. At its discretion, DHS may take steps to mediate closure to an impasse in the efforts of plan parties engaged in the MOU process.

   When enrollment in a Plan in any county is 2,000 beneficiaries or less, DHS may, at the request of the Plan or the MHP, grant a waiver from these requirements, provided that both the Plan and the MHP shall provide assurance that beneficiary care will be coordinated in compliance with Title 9, CCR, Section 1810.415.

Plan Responsibility For Medi-Cal Covered Physical Health Care Services

Medi-Cal covered services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840.

Physical health care and physical health care based treatment ~~as defined by Title 9, CCR, Section 1810.231.1~~ means health care provided by health professionals, including non-physician medical practitioners, whose practice is predominately general medicine, family practice, internal medicine, pediatrics, obstetrics, gynecology, or whose practice is predominately a health care specialty area other than psychiatry or psychology. Physical health care does not include a physician service as described in Title 22, Section 51305, delivered by a psychiatrist, a psychologist service as described in Title 22, Section 51309, or an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental service as described in Title 22, Section 51340 or 51340.1, delivered by a licensed clinical social worker, a marriage, family and child counselor, or a masters level registered nurse for the diagnosis and treatment of mental health conditions of children under age 21.

Each Plan is contractually obligated to cover medical care needed by Medi-Cal members for mental health conditions that are within the primary care physician's scope of practice.

Each Plan is contractually obligated to assist Plan members needing specialty mental health services whose mental health diagnoses are covered by the MHP or whose diagnoses are uncertain, by referring such members to the local MHP. If a member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the member to an appropriate Medi-Cal FFS mental health provider, if known to the Plan, or to a resource in the community that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or other appropriate local provider or provider organization.

A Plan may negotiate with the MHP to provide specialty mental health services to Plan members, or through an arrangement made with the concurrence of the local MHP, DMH, and DHS, elect to include responsibility for some specialty mental health services in its contract with DHS.

Enclosure 1, Medi-Cal Managed Care Plan Specialty Mental Health Coverage Alternatives, outlines the unique arrangements some Plans have with a MHP regarding mental health services. Currently, coverage for specialty mental health services is excluded under most Plan contracts.

Plans are required to provide medical case management and cover and pay for all medically necessary Medi-Cal covered physical health care services not otherwise excluded by contract for a Plan member receiving specialty mental health services

including, but not limited to, the services listed below, and must coordinate these services with the MHP. Protocols for the delivery of these services must be addressed as a component of the MOU consistent with contract requirements. This section shall not be construed to preclude the Plan from requiring that covered services be provided through the Plan's provider network or applying utilization controls to these services, including prior authorization, consistent with the Plan's contractual obligation to provide covered services.

Physician Services

The Plan shall cover and pay for physician services as described in Title 22, Section 51305, except the physician services of mental health specialists, even if the services are provided to treat an included mental health diagnosis. The Plan is not required to cover and pay for physician services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family, and child counselors, or other specialty mental health providers. **When medically necessary, the Plan shall cover and pay for physician services provided by specialists such as neurologists.**

The Plan shall cover and pay for physician services related to the delivery of outpatient mental health services, which are within the primary care physician's scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses whose conditions do not meet the MHP medical necessity criteria.

Emergency Services and Care

The assignment of financial responsibility to the Plan or the MHP for charges resulting from ~~emergency~~ services to determine whether a psychiatric emergency exists under the conditions provided in Title 9, CCR, Section 1820.225~~, and the care and treatment necessary to relieve or eliminate the emergent condition~~ is generally determined by:

- The diagnosis assigned to the emergent condition;
- The type of professional performing the services; and
- Whether such services result in the admission of the Plan member for psychiatric inpatient hospital services **at the same or a different facility**.

It is suggested that the assignment of financial responsibility for emergency room facility charges and professional services be addressed as a component of the MOU.

Emergency Room Facility Charges and Professional Services

Financial responsibility for charges resulting from the emergency services and care of a Plan member whose condition meets the medical necessity criteria for coverage by the MHP is contractually assigned as follows:

- The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services **or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility**.

- The MHP ~~**shall cover and pay**~~ **is responsible** for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services **at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.**

- ~~**The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria at a hospital that does not provide psychiatric inpatient hospital services, when such services and care do result in the transfer and admission of the member to a hospital or psychiatric health facility that does provides psychiatric inpatient hospital services. The Plan is not responsible for the separately billable facility charges related to the professional services of a mental health specialist at the hospital of assessment. The MHP may pay this charge, depending on its arrangement with the hospital.**~~

- **The MHP is responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric inpatient hospital services at that facility or any other facility.**

- ~~**The Plan shall cover and pay for the medical professional services required for the emergency services and care of a member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services.**~~

- The MHP shall cover and pay for the professional services of a mental health specialist ~~**required for the emergency services and care of**~~ **provided in an emergency room to** a Plan member whose condition meets MHP medical necessity criteria **or when mental health specialist services are required to assess whether MHP medical necessity is met** ~~**when such services and care do result in the admission of the member for psychiatric inpatient hospital services.**~~

- **The Plan shall cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets MHP medical necessity criteria.**

Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a plan member whose condition does not meet MHP medical necessity criteria shall be assigned as follows:

- The Plan shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.

- Payment for the professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.

Note: Effective January 1, 2000, SB 349 (Chapter 544, Statutes of 1999), redefines the definition of emergency services and care as it applies only to health care service plans where coverage for mental health is included as a benefit. SB 349 redefines the Health and Safety Code definition of emergency services and care to include an additional screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility. The provisions of SB 349 are a clarification of the

definition of emergency services and care and a clarification of an existing responsibility and not the addition of a new responsibility. SB 349 does not change the assigned responsibilities of the Plan and the MHP to pay for emergency services as described above.

Pharmaceutical Services and Prescribed Drugs

Each Plan is contractually obligated to cover and pay for pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services or otherwise excluded under the Plan contract.

Each Plan must cover and pay for psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions.

A Plan may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists; however, application of utilization review procedures should not inhibit Plan member access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan shall ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. ~~This~~ **These** requirement**s** should be addressed as a component of the MOU.

The Plan is not required to cover and pay for prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists, unless these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited.

Enclosure 2 lists the prescription drugs that are currently excluded from **most** Plan contracts. Reimbursement to pharmacies for psychotropic drugs listed in Enclosure 2, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal FFS system whether these drugs are provided by a pharmacy contracting with the Plan or by a FFS pharmacy provider.

Laboratory, Radiological, and Radioisotope Services

Each Plan must cover and pay for medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Section 51311.

The Plan must cover and pay for these services for a Plan member who requires the services of the MHP or a Medi-Cal FFS specialty mental health services provider when necessary for the diagnosis and treatment of the Plan member's mental health condition. The Plan must also cover and pay for services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan must coordinate these services with the member's specialty mental health provider.

Home Health Agency Services

Each Plan must cover and pay for home health agency services as described in Title 22, CCR, Section 51337 **prescribed by a Plan provider** when medically necessary to meet the ~~**physical health care**~~ needs of homebound Plan members. A homebound Plan member as defined by Title 22, CCR, Section 51146 is one who is essentially confined to home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration.

The Plan is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a beneficiary. **However, home health agency services prescribed by Plan providers to treat the mental health conditions of Plan members are the responsibility of the Plan.**

Medical Transportation Services

Each Plan must cover and pay for all medically necessary emergency and non-emergency medical transportation services as described in Title 22, CCR, Section 51323 for Plan members, including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services.

Each Plan must also cover and pay for medically necessary non-emergency medical transportation services when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP.

Each MHP must arrange and pay for medical transportation when the **MHP's** purpose ~~of~~ **for** the medical transportation service is to transport a Plan member receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

Hospital Outpatient Department Services

Each Plan must cover and pay for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contracts with its subcontractors and DHS. **Separately billable outpatient services related to E**electroconvulsive therapy**,** ~~**and related services**~~ **such as anesthesiologist services,** ~~**provided on an outpatient basis**~~ are also the contractual responsibility of the Plan.

Psychiatric Inpatient Hospital Services

Each Plan must cover and pay for all medically necessary professional services to meet the physical health care needs of Plan members who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations ~~**and separately billable hospital-based ancillary services for which the Plan is otherwise contractually responsible. Such services may include, but are not limited to, prescription drugs (except antipsychotics), laboratory services, x-ray, electroconvulsive therapy and related services, and magnetic resonance imaging that are received by a Plan member admitted to a hospital or psychiatric health facility for psychiatric inpatient hospital services.**~~

Plans are not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

Nursing Facility Services

If long-term care is included by contract, a Plan must cover and pay for the room, board, and all medically necessary medical and other covered services provided to a Plan member in a nursing facility in accordance with the terms of the Plan's contract for coverage of long-term care.

Because long-term care is capitated to Plans as a service irrespective of diagnosis, this responsibility also includes coverage for Plan members whose need for nursing facility services is based on mental illness. Consistent with applicable contract requirements, Plans will initiate a disenrollment request for members whose projected length of stay in a nursing facility, including skilled nursing facilities with special treatment programs for the mentally disordered, or other long-term care residential treatment facility will exceed the term of the Plan's obligation for coverage of long-term care.

Each Plan is responsible for ensuring a member's orderly transfer to the Medi-Cal FFS system upon disenrollment, and must arrange and pay for all medically necessary contractually required Medi-Cal covered services until the disenrollment is effective.

Currently, MHPs are not contractually responsible for any nursing facility services, although consideration has been given to having MHPs cover skilled nursing facility services with special treatment programs for the mentally disordered. If MHPs assume this responsibility in the future, the Plan will continue to be contractually responsible to cover and pay for all medically necessary medical and other covered services not included under the per diem rate, consistent with a Plan's coverage obligations for long-term care.

Under current federal law, states are permitted to provide Medicaid coverage to individuals 21 years of age or under in psychiatric hospitals or to individuals 65 years of age or older in Institutions for Mental Diseases (IMD) that are psychiatric hospitals or nursing facilities. **Individuals who are receiving these services on their 21st birthday may continue to be covered until the earlier of their 22nd birthday or discharge.** The Medi-Cal program has elected to cover these services (psychiatric hospital services are covered by MHPs).

The Medi-Cal program also covers skilled nursing facility services with special treatment programs for the mentally disordered (these services are billed to the Medi-Cal FFS system using accommodation codes 11, 12, 31, and 32) for beneficiaries of any age in facilities that have not been designated as IMDs. Plans, therefore, are

responsible for these services in accordance with the terms of the Plan's contract for coverage of long-term care.

Under current federal law, states are not permitted to claim federal financial participation for any services provided to beneficiaries over the age of 21 and under the age of 65 residing in IMDs. The Medi-Cal program, however, does cover all services, except the nursing facility services themselves, as state-only Medi-Cal services (e.g., prescription drugs and doctor's visits). Plans are responsible for these services in accordance with the terms of the Plan's contract. MHPs provide medically necessary specialty mental health services (typically visits by psychiatrists and psychologists). Nursing facility services provided to individuals over the age of 21 and under the age of 65 in nursing facilities that are designated IMDs are funded by county realignment and other funds and are not Medi-Cal covered services.

When coverage for long-term care is excluded by Plan contract, or upon the expiration of the Plan's obligation under its contract to provide such services, payment is handled through the Medi-Cal FFS system.

MEDI-CAL COVERED SPECIALTY MENTAL HEALTH SERVICES

Medi-Cal covered specialty mental health services are those services defined in Title 9, CCR, Section 1810.247 ~~**delivered by a person or entity who is licensed, certified, or otherwise recognized or authorized to provide specialty mental health services under state law governing the healing arts.**~~

The scope of Medi-Cal covered specialty mental health services **covered by MHPs** is set forth in Title 9, CCR, Sections 1810.345 and 1810.350.

Access standards for Medi-Cal covered specialty mental health services **covered by MHPs** are set forth in Title 9, CCR, Section 1810.405.

Medical Necessity Criteria

Under the Medi-Cal Specialty Mental Health Services Consolidation program, each MHP is obligated to provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries of the county served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.

The medical necessity criteria are met when:

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

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

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

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

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

Specialty Mental Health Services Providers

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

Mental health professionals may continue to participate in the Medi-Cal FFS program, but the Medi-Cal program will only cover specialty mental health services related to mental health diagnoses that are not the responsibility of either the MHP or the Plan. Hospitals not affiliated with the MHP may provide psychiatric inpatient hospital services to Medi-Cal beneficiaries in emergency situations at FFS rates established by regulation.

Covered Specialty Mental Health Services

Covered specialty mental health services include:

- Rehabilitative Services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
- Psychiatric Inpatient Hospital Services;
- Targeted Case Management;
- Psychiatrist Services;
- Psychologist Services;
- EPSDT Supplemental Specialty Mental Health Services for children under the age of 21~~(including services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional disturbance is related to family substance abuse)~~; and
- Psychiatric Nursing Facility Services. **(Currently, MHPs are not contractually required to provide any nursing facility services.)**

  ~~(Currently, MHPs are not contractually required to provide any nursing facility services.)~~

Many MHPs also provide services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional or behavioral disturbance is related to family substance abuse.

Services Excluded From Coverage by the MHP

The MHP is not responsible to provide or arrange and pay for the services excluded from coverage by the MHP under Title 9, CCR, Section 1810.355. Plans may be responsible to arrange and pay for these services when contractually required.

Services excluded from coverage by the MHP are:

- Medi-Cal services, which are those services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, that are not specialty mental health services for which the MHP is responsible pursuant to Title 9, CCR, Section 1810.345.

- Prescribed drugs as described in Title 22, CCR, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, CCR, Section 51311, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP under applicable provisions of Title 22, Division 3, Subdivision 1.

- Medical transportation services as described in Title 22, CCR, Section 51323, except when the purpose of the medical transportation service is to transport a beneficiary receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

- Physician services as described in Title 22, CCR, Section 51305, that are not psychiatric services as defined in Title 9, CCR, Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205.

- Personal care services as defined in Title 22, CCR, Section 51183, and as may be defined by DHS as EPSDT supplemental services pursuant to Title 22, CCR, Section 51340(e)(3).

- Out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

- Specialty mental health services provided by a hospital operated by DMH or the Department of Developmental Services.
- Specialty mental health services provided to a Medicare beneficiary eligible for Medicare mental health benefits.
- Specialty mental health services provided to a beneficiary enrolled in a Plan to the extent that specialty mental health services are covered by the Plan.
- Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as specified in Title 9, CCR, Section 1820.100(a).
- Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:
    - Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, CCR, Section 54325.
    - Home and community-based waiver services as defined in Title 22, CCR, Section 51176.
    - Specialty mental health services, other than psychiatric inpatient hospital services, authorized by the California Children Services (CCS) program to treat CCS eligible beneficiaries.
    - Local Education Agency services as defined in Title 22, CCR, Section 51190.4.
    - Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.
    - Home health agency services as described in Title 22, CCR, Section 51337.

COORDINATION OF MEDI-CAL COVERED PHYSICAL HEALTH CARE SERVICES AND SPECIALTY MENTAL HEALTH SERVICES

Plan Responsibilities

The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental services as required by contract. Title 9, CCR, Section 1810.415 sets forth the requirements of the MHP in the coordination of physical and mental health care.

The Plan is responsible for the appropriate management of a Plan member's care which includes, but is not be limited to, the coordination of all medically necessary contractually required Medi-Cal covered services both within and outside the Plan's provider network, and:

- Assistance to Plan members needing specialty mental health services by referring such members to the MHP, or to an appropriate Medi-Cal FFS mental health provider or provider organization if the beneficiary is not eligible for MHP covered services or because the MHP has determined that the Plan member's mental health condition would be responsive to physical health care based treatment;

- The provision of clinical consultation and training to the MHP or other providers of mental health services on a Plan member's medical condition and on medications prescribed through Plan providers;

- Medical case management;

- The exchange of medical records information with the MHP and other providers of mental health care; and

- The coordination of discharge planning from inpatient facilities.

The Plan is required to maintain procedures for monitoring the coordination of care provided to a Plan member. When a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1) ~~**, or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based**~~

~~treatment~~ and the Plan initiates a referral to a local provider or provider organization outside the Plan, the Plan should document such referrals in the member's medical record. The Plan is not responsible for ensuring member access to such providers, but must maintain a current list of the names, addresses, and telephone numbers of local providers and provider organizations that is available to Plan enrollees. The MHP's role in providing or assisting the Plan in the development of this list should be addressed as a component of the MOU.

A list of such sources of referral to a local provider or provider organization may include:

- **County mental health departments**
- **County departments administering alcohol and drug programs**
- **The county health and human services agency**
- **CalWorks funded programs for mental illness or substance abuse**
- **Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers**
- **The regional center for persons who are developmentally disabled**
- **The Area Agency on Aging for referrals to services for Individuals aged 60 and over**
- **The local medical society**
- **The psychological association**
- **The mental health association**
- **Family services agencies**
- **Faith-based social services agencies**
- **Community employment and training agencies**

MHP Responsibilities

The MHP is required to make clinical consultation and training, including consultation and training on psychotropic medications, available to meet the needs of a beneficiary whose mental illness is not being treated by the MHP.

The MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist beneficiaries in receiving prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. If a Plan requires the MHP to utilize the Plan's drug formulary when psychotropic drugs are prescribed through the MHP, such requirement should be addressed as a component of the MOU.

When **the MHP determines that** a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1), or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based treatment, **the MHP is responsible to refer the member to the Plan for services covered by the Plan or to other sources of care or referral for care for services not covered by the Plan. ~~the beneficiary shall be referred to:~~ Other sources of care or referral may include:**

1. A provider outside the MHP which may include:

   - A provider with whom the beneficiary already has a patient-provider relationship;

   ~~⊟The Plan in which the beneficiary is enrolled;~~

   - A provider in the area who has indicated a willingness to accept MHP referrals, including Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Clinics; or

2. An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include where appropriate:

   - The Health Care Options program described in Welfare and Institutions Code Section 14016.5;

- The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;
- Provider organizations;
- Other community resources available in the county served by the MHP. ~~which may include, but are not limited to:~~

  ~~County mental health departments~~

  ~~County departments administering alcohol and drug programs~~

  ~~The county health and human services agency~~

  ~~CalWorks funded programs for mental illness or substance abuse~~

  ~~Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers~~

  ~~The regional center for persons who are developmentally disabled~~

  ~~The Area Agency on Aging for referrals to services for Individuals aged 60 and over~~

  ~~The local medical society~~

  ~~The psychological association~~

  ~~The mental health association~~

  ~~Family services agencies~~

  ~~Faith-based social services agencies~~

  ~~Community employment and training agencies~~

The MHP is not required to ensure a beneficiary's access to **physical health care based treatment or to** treatment from licensed mental health professionals for diagnoses not covered in Title 9, CCR, Section 1830.205(b)(1). ~~**When the situation generating a referral by the MHP to a provider or provider organization outside the MHP meets the criteria established in Title 9, Section 1850.210(i), a Notice of Action will be provided.**~~

Confidentiality of Medical Records Information

The Plan and the MHP are responsible for the development of protocols to maintain the confidentiality of beneficiary medical records, including all information, data, and data elements collected and maintained for the operation of the contract and shared with the other party, in accordance with all applicable federal and state laws and regulations and contract requirements.

Note: Recently enacted legislation, SB 19 (Chapter 526, Statutes of 1999), and AB 416 (Chapter 527, Statutes of 1999), expand provisions related to the confidentiality of medical records information in both the Civil Code and the Health and Safety Code.

Resolution of Disputes

The resolution of disputes is a shared Plan/MHP responsibility. The Plan is responsible for establishing procedures for the resolution of disputes with the MHP as required by contract. As set forth in Title 9, CCR, Section 1810.370, the MHP is responsible for establishing procedures for the resolution of disputes with the Plan.

When a Plan has a dispute with a MHP that cannot be resolved to the satisfaction of the Plan concerning its contractual obligations, state Medi-Cal laws and regulations, or an MOU with the MHP, the Plan may submit a request for resolution to DHS in accordance with the rules governing the resolution of disputes in Title 9, CCR, Section 1850.505. A dispute between a Plan and a MHP shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to Plan members.

Additional information regarding the Medi-Cal specialty mental health managed care program may be accessed via the Internet through DMH's Web site at http://www.dmh.cahwnet.gov.

The text of the emergency regulations governing the provision of Medi-Cal specialty mental health services, and other documents pertinent to DMH's rulemaking proceedings for these regulations may be accessed through the DMH, Office of Regulations Web site at http://www.dmh.cahwnet.gov/regulations/SPEC/rulemaking.htm. The regulations will remain in effect until July 1, 2000, or until they are made permanent, whichever occurs first. The public comment period for these regulations closed on December 20, 1999. After considering all the timely and relevant comments received, DMH may adopt these regulations, or may make modifications to the text with proper notice to the public.

Substantive changes between the text of the emergency regulations on which this policy letter is based and the permanent regulations adopted, if any, will be addressed in future communication to the Plans.

Should you have questions, or require additional information regarding the content of this policy letter, please contact your contract manager.

Susanne Hughes

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

MEDI-CAL MANAGED CARE PLAN
SPECIALTY MENTAL HEALTH COVERAGE ALTERNATIVES

Plan Type	Plan Name	County of Operation	Coverage Alternatives
Primary Care Case Management	Positive HealthCare Foundation	Los Angeles	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs
County Organized Health System	Partnership Health Plan of California*	Solano	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Santa Barbara Health Initiative	Santa Barbara	Covers prescription drugs including psychotropic drugs
	Health Plan of San Mateo**	San Mateo	Excludes drugs and related labs prescribed by the MHP
Geographic Managed Care	Kaiser Foundation Health Plan, Inc.	Sacramento	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Western Health Advantage	Sacramento	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs

* Solano County Mental Health has been a subcontractor on a capitated basis to the County Organized Health System in Solano under separate field test authority from HCFA since 1994. Mental health services are excluded by Partnership Health Plan in Napa County.

** The MHP in San Mateo County is financially responsible for prescription drugs and related laboratory services prescribed by the MHP under separate field test authority from HCFA.

Enclosure 2

Psychiatric Drugs

Drugs Excluded From Plan Coverage:

Psychotropic Drugs	Psychotropic Drugs	Drugs for the Treatment of HIV/AIDS	Drugs for the Treatment of HIV/AIDS
Amantadine HCl	Olanzapine Fluoxetine HCl	Abacavir/Lamivudine	Stavudine
Aripiprazole	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)	Abacavir Sulfate	Tenofovir Disoproxil-Emtricitabine
Asenapine (Saphris)			
Benztropine Mesylate	Paliperidone (Invega)	Amprenavir	Tenofovir Disoproxil Fumarate
Biperiden HCl	Paliperidone Palmitate (Invega Sustenna)	Atazanavir Sulfate	Tipranavir
Biperiden Lactate			
Chlorpromazine HCl	Perphenazine	Darunavir Ethanolate	Zidovudine/Lamivudine
Chlorprothixene	Phenelzine Sulfate	Delavirdine Mesylate	Zidovudine/Lamivudine/ Abacavir sulfate
Clozapine	Pimozide	Efavirenz	
Fluphenazine Decanoate	Proclyclidine HCl	Efavirenz/Emtricitabine/Tenofovir	
Fluphenazine Enanthate	Promazine HCl	Disoproxil Fumarate	
Fluphenazine HCl	Quetiapine	Emtricitabine	
Haloperidol	Risperidone	Enfuvirtide	
Haloperidol Decanoate	Risperidone Microspheres	Etravirine	
Haloperidol Lactate	Selegiline (transdermal only)	Fosamprenavir Calcium	
Iloperidone (Fanapt)	Thioridazine HCl	Indinavir Sulfate	
Isocarboxazid	Thiothixene	Lamivudine	
Lithium Carbonate	Thiothixene HCl	Lopinavir/Ritonavir	
Lithium Citrate	Tranylcypromine Sulfate	Maraviroc	
Loxapine HCl	Trifluoperazine HCl	Nelfinavir Mesylate	
		Nevirapine	
Loxapine Succinate	Triflupromazine HCl	Raltegravir Potassium	
Lurasidone Hydrochloride	Trihexyphenidyl	**Rilpivirine Hydrochloride**	
Mesoridazine Mesylate	Ziprasidone	Ritonavir	
Molindone HCl	Ziprasidone Mesylate	Saquinavir	
Olanzapine		Saquinavir Mesylate	

SAMPLE

(For demonstration purposes only. Not Intended to be inclusive of all services to be addressed in an MOU between a Plan and a MHP.)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Psychiatric Inpatient Hospital Medical Necessity Criteria Met	Psychiatric Inpatient Hospital Medical Necessity Criteria Not Met
Psychiatric Inpatient Hospital Services - General Acute Hospitals	Facility Charges	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment
Institutions for Mental Diseases - Acute Psychiatric Hospitals	Facility Charges Patient aged 0 to 21	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 22 to 64	No MHP, MCP, or EDS payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 65 or over	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment

SAMPLE (continued)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Included Diagnosis and Meets MHP Impairment and Intervention Criteria	Excluded Diagnosis	Included Diagnosis But Does Not Meet MHP Impairment and Intervention Criteria
Emergency Departments	Facility Charges	MCP for initial triage and medical services MHP for any facility charges related to a covered psychiatric service Note: When a beneficiary is admitted to a psychiatric bed at the same facility, there is no separate payment for the ER by the MHP or the MCP	MCP	MCP
	Psychiatric Professional Services	MHP	EDS	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	MCP	MCP

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

Section 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders
(L) Somatoform Disorders
(M) Dissociative Disorders
(N) Eating Disorders
(O) Intermittent Explosive Disorder
(P) Pyromania
(Q) Adjustment Disorders
(R) Personality Disorders
(2) A beneficiary must have both (A) and (B):
(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:
1. Has symptoms or behaviors due to a mental disorder that (one of the following):
a. Represent a current danger to self or others, or significant property destruction.
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.
d. Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:
a. Further psychiatric evaluation.
b. Medication treatment.
c. Other treatment that can reasonably be provided only if the patient is hospitalized.
(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:
(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).
(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
(3) Presence of new indications which meet medical necessity criteria specified in (a).
(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.
(c) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

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

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

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

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Forth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

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

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.
(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
(C) The condition would not be responsive to physical health care based treatment.
(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

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

(a) For beneficiaries under 21 years of age who do meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:
(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.
(b) The MHP shall not approve a request for an EPSDT Supplemental Speciality Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.
(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

NOTE

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

Drug Medi-Cal Organized Delivery System

SUMMARY

California's Medi-Cal 2020 Section 1115(a) Demonstration (No. 11-W-00193/9) authorizes the State to test a new paradigm for the organized delivery of health care services for Medicaid (or "Medi-Cal" in California) eligible individuals with a SUD.

The amendment includes a five-year demonstration program, the DMC-ODS Pilot that will include a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services.

The DMC-ODS Pilot services shall be available as a Medi-Cal benefit for Medi-Cal eligible individuals who meet the SUD medical necessity criteria and reside in a participating county.

The DMC-ODS Pilot is expected to provide the Medi-Cal Beneficiary with access to the care and system interaction needed in order to achieve sustainable SUD recovery.

Counties participating in the DMC-ODS Pilot shall enter into a Memorandum of Understanding (MOU) with selected Medi-Cal managed care plans that enroll Beneficiaries served by the DMC-ODS Pilot.

Anthem has been selected by the Fresno County Department of Behavioral Health as one of the managed care plans to ensure collaborative treatment planning, care coordination and effective communication among providers for DMC-ODS services to eligible Beneficiaries in Fresno County.

The DMC-ODS Pilot is authorized and financed under the authority of California's Medi-Cal 2020 Demonstration Waiver. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP). The purpose of these demonstrations, which gives states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. The section 1115 demonstrations, such as the DMC-ODS Pilot, are approved for a five-year period.

The DMC-ODS is a pilot to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with SUD. The DMC-ODS will demonstrate how organized SUD care increases the success of DMC Beneficiaries while decreasing other health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the ASAM Criteria for SUD services, increased local control and accountability, greater use of resources, evidence-based practices in SUD treatment, and increased coordination with other systems of care.

DEFINITIONS

Access Line - A 24-hour, 365 days per year toll-free line operated on behalf of Fresno County Department of Behavioral Health, that conducts substance use disorder screening interviews with callers using the standardized adolescent or adult brief triage assessment (based on the ASAM Criteria), determines the provisional level of care, and schedules an assessment and admission appointment with a SUD network provider.

ASAM Criteria - Also known as the ASAM patient placement criteria, provides a multi-dimensional assessment framework for SUD placement determination and the development of comprehensive and individualized treatment plans tailored to medical necessity. These criteria are used as a comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with SUD and co-occurring conditions.

Behavioral Health - Refers to both substance use disorder and mental health services/conditions.

Beneficiary - An individual who is eligible for Medi-Cal benefits, receives covered services through Anthem and who is eligible for DMC-ODS Pilot services due to a qualifying SUD condition.

California Department of Health Care Services (DHCS) - The state department that has responsibility for administering statewide, health care services funded by Medi-Cal.

Care Coordination - The management of physical, mental health, and/or SUD services for Beneficiaries to help ensure that delivered services are well integrated and provided seamlessly to ensure maximum benefit, effectiveness, and safety.

Determination of DMC-ODS Medical Necessity Criteria - As described in the DMC-ODS Special Terms and Conditions (STC), Beneficiaries receiving services through DMC-ODS must be enrolled in Medi-Cal and meet the following medical necessity criteria:

1. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) V for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at-risk for developing a SUD (for youth under 21).
2. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
3. If applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under the age of 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, Beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are covered under section 1905(a) Medicaid authority.

Determination of DMC-ODS Medical Need - All individuals seeking SUD treatment services can access services by (1) contacting the Access Line which is a dedicated toll-free telephone line, (2) contacting any network treatment provider, or (3) direct referral from a County partner/referring agency. When contacting the Access Line, staff will conduct an initial brief triage assessment based on the ASAM Criteria, and refer the Beneficiary to the identified provisional level of care with a contracted SUD Provider. The SUD Provider will determine initial medical necessity and conduct a more intensive ASAM assessment to establish and/or confirm the appropriate SUD level of care.

Diagnostic and Statistical Manual of Mental Disorders (DSM) - The standard classification of mental disorders used by mental health professionals in the United States which contains a listing of diagnostic criteria for every psychiatric disorder recognized by the United States healthcare system. Also a necessary tool for collecting and communicating accurate public health statistics about the diagnosis of psychiatric disorders, including SUD.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - A Medicaid benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Evidence Based Programs (EBP) - Programs that meet the criteria of the National Registry for Evidence Based Programs and Practices (NREPP) for effectiveness and scientific rigor.

Level of Care - Refers to the SUD treatment services outlined in the ASAM Criteria and offered under Fresno County's DMC-ODS benefit package. This includes outpatient (ASAM 1.0, 2.1), residential (ASAM 3.1, 3.3, 3.5) withdrawal management (ASAM 1-WM, 2-WM, 3.2-WM) and opioid treatment program (ASAM 1-OTP) modalities.

Licensed Practitioner of the Healing Arts (LPHA) - Professional staff who are licensed, registered, certified, or recognized under California State scope of practice statutes that provide services within their scope of practice and receive supervision required under their scope of practice laws. LPHA includes the following professional categories:

- Physician
- Licensed/waivered Clinical Psychologist
- Licensed/waivered/registered Clinical Social Worker
- Licensed/waivered/registered Marriage and Family Therapist
- Licensed/waivered/registered Professional Clinical Counselor
- Registered Nurse
- Nurse Practitioner
- Physician Assistant
- Registered Pharmacist
- Licensed eligible practitioner under the supervision of licensed clinicians

Primary Care - 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 a 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) - A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary, and who is responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) - An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Substance Use Disorder (SUD) - SUD occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school, or home. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), defines SUD as mild, moderate, or severe to indicate the level of severity, by the number of diagnostic criteria met by an individual.

Substance Use Disorder (SUD) Services - SUD services include outpatient, intensive outpatient, residential, withdrawal management, opioid (narcotic) treatment program, and recovery support services that are made available to persons with substance use disorders. Types of services include assessment, screening, evaluation, crisis intervention, individual counseling, group counseling, family counseling, case-management, medication assisted treatment, and recovery support.

Substance Use Disorder (SUD) Provider - An entity/organization contracted with Fresno County DBH and certified or licensed to provide SUD treatment services as required. 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, California Medi-Cal 2020 Section 1115(a) Demonstration Special Terms and Conditions, Section X: Drug Medi-Cal Organized Delivery System and DBH contract requirements.

SUBSTANCE USE DISORDER ASAM DESCRIPTIONS

Early Intervention Services - (ASAM Level 0.5) Screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder. SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers. The components of Early Intervention are screening, counseling and referral.

Outpatient Services (ASAM Level 1) Counseling services are provided to beneficiaries when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized beneficiary plan. Services can be provided in-person, by telephone or by telehealth. Counseling session types include individual, group, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.

- Adult Services – up to 9 hours per week
- Adolescent Services – less than 6 hours per week

Intensive Outpatient Treatment (ASAM Level 2.1) Structured programming services are provided to beneficiaries when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized beneficiary plan. Lengths of treatment can be extended when determined to be medically necessary. Services can be provided in-person, by telephone or by telehealth. Counseling sessions are the same as Outpatient.

- Adult Services – minimum 9 hours per week to a maximum of 19 hours per week
- Adolescent Services – minimum of 6 hours per week with a maximum of 19 hours per week

Residential Treatment (ASAM Level 3) is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized treatment plan. Residential services are provided in licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

The length of residential services range from 1 to 90 days unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period.

- Adult Services – 90 day maximum.
- Adolescent Services – 30 day maximum.
- Perinatal Services - Perinatal beneficiaries may receive a longer length of stay based on medical necessity. Perinatal beneficiaries may receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends.)
- Criminal Justice Services - up to 6 months residential; 3 months FFP with a one-time 30-day extension.

Residential levels of treatment include:

- **ASAM Level 3.1** - Clinically Managed Low-Intensity Residential Services. 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.

- **ASAM Level 3.3** - Clinically Managed Population-Specific High-Intensity Residential Services 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense

milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.

- **ASAM Level 3.5** - Clinically Managed High-Intensity Residential Services. 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.

- **ASAM Level 3.7** - Medically Monitored Intensive Inpatient Services. 24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability.

- **ASAM Level 4.0** - Medically Managed Intensive Inpatient Services. 24-hour nursing care and daily physician care for severe, unstable problems. Counseling available to engage patient in treatment

Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of five levels of Withdrawal Management in the ASAM Criteria when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized beneficiary plan. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.

Withdrawal Management levels of treatment include:

- **1-WM** – Ambulatory withdrawal management without extended on-site monitoring. Mild withdrawal with daily or less than daily outpatient supervision.

- **2-WM** – Ambulatory withdrawal management with extended on-site monitoring. Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.

- **3.2-WM** – Clinically managed residential withdrawal management. Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

- **3.7-WM** - Medically monitored inpatient withdrawal management. Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.

- **4-WM** - Medically managed intensive inpatient withdrawal management. Severe unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and

authorized according to the State of California requirements. NTPs/OTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram. A patient must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

Additional Medication Assisted Treatment (ASAM OTP Level 1) includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

Recovery Services - Treatment must emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community. Recovery Services components are outpatient counseling services, recovery monitoring, substance abuse assistance, education and job skills, family support, support groups and ancillary services. Recovery services may be utilized when the beneficiary is triggered, when the beneficiary has relapsed or simply as a preventative measure to prevent relapse.

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

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

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

PURPOSE:

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

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

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

BACKGROUND:

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

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

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

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

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

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

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[4] SHMS Waiver Information can be found at: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx

[5] Medical necessity criteria for inpatient specialty mental health services (Title 9, CCR, §1820.205) are not described in detail in this APL, as this APL is primarily focused on outpatient mental health services.

[6] Title 9, CCR, §1830.205

[7] Title 9, CCR, §1830.210

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

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

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

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

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

POLICY:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Original signed by Nathan Nau

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

Attachments

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

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

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

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

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

[13] Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

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

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

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

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

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

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

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

[1] CMS-2333-F

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

REQUIREMENTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEMT Physician Certification Statement Forms

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions for Non-Medical Transportation Services:

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

Non-Medical Transportation Private Vehicle Authorization Requirements

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

[21] VEH Section 465

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

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

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

Non-Medical Transportation Authorization

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

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

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

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

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

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division