2 BEHAVIORAL HEALTH SERVICES

2.1 Mental Health Plan (MHP)

HHSA Behavioral Health Services serves as the local Mental Health Plan (hereinafter referred to as MHP). The section of Exhibit A serves as the MOA between the MHP and MCP in order to implement certain provisions of Title 9 of the California Code of Regulations, Chapter 11 (Medi-Cal Specialty Mental Health Services).

The purpose of this section is to describe the responsibilities of the MHP and the Plan in the delivery of specialty mental health services to Medi-Cal beneficiaries served by both parties. It is the intention of both parties to coordinate care between providers of physical and mental health care. All references to "Members" are limited to the MCP's San Diego County Medi-Cal Members.

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2.1.1 **LIAISON**	a. The MHP will maintain responsibility for: • Medication treatment and other mental health services for mental health conditions that would not be responsive to physical healthcare-based treatment and meet criteria for specialty Mental Health services. • Consultation services to Plan providers, particularly PCPs about specialty mental health issues and treatments, including medication consultation. • The treatment of physical reactions induced from medications prescribed by the MHP providers. b. The MHP liaison will coordinate activities with the Plan and will notify the MHP providers of the roles and responsibilities of the MHP Liaison. c. The MHP will meet with the Plan at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and update the MOA as necessary. The MHP Liaison will be responsible for communicating suggestions for MOA changes to the MHP leadership and Plan Liaison.	a. The Plan liaison will coordinate activities with the MHP and will notify its contracting Primary Care Providers (PCPs) of the roles and responsibilities of the Plan Liaison. b. The Plan Liaison will meet with the MHP at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and update the MOA as necessary. The Plan will be responsible for communicating suggestions for MOA changes to the Plan leadership and the MHP Liaison. The Plan will also communicate MOA changes to Healthy San Diego (HSD), the State Department of Health Services, and Plan providers. c. At the discretion of the Plan, the Liaison may represent the Plan in the dispute resolution process. d. The Plan will provide the MHP with the phone numbers of its member services, provider services, and support programs that provide liaison services. e. With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, Plan member, clinical, or other pertinent information will be

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	d. The MHP will also communicate MOA changes to the State Department of Mental Health and MHP providers. e. At the discretion of the MHP, the Liaison may represent the MHP in the dispute resolution process. f. The MHP will assist and provide the Plan with the phone numbers of its beneficiary and provider services and support programs that provide liaison services.	shared between the Plan and the MHP and its providers for coordination of care.
2.1.2 **ANCILLARY MENTAL HEALTH SERVICES**	a. The MHP will provide hospital based ancillary mental health services, other than routine services, to Plan members when medical necessity criteria are met. Ancillary services are included in the per diem rate and may include but are not limited to electro-convulsive therapy (ECT).	a. The Plan will arrange ancillary services for the MHP members when medically necessary. The Plan will direct contracting providers to cover ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.
2.1.3 **CLINICAL CONSULTATION AND TRAINING**	a. The MHP will provide and make available to Plan Providers clinical consultation and training, including consultation and training on psychotropic medications to meet the needs of a beneficiary whose mental illness is not being treated by the MHP. b. The MHP will include consultation on medications to Primary Care physician for Plan members on medications whose mental illness is being treated by the PCP. c. Clinical consultation between the MHP and the PCP will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by the MHP to the PCP on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the PCP.	a. The Plan will direct contracting providers to provide clinical consultation and training to the MHP or other providers on physical health care conditions and on medications prescribed through Plan providers. b. The Plan will direct contracting providers to arrange clinical consultation to the MHP or other providers of mental health services on a member's physical health condition. Such consultation will include consultation by the PCP to the MHP on medications prescribed by the PCP for a Plan member whose mental illness is being treated by the MHP.
2.1.4	a. The MHP will arrange for appropriate management of a member's care, including the exchange of medical	a. The Plan will arrange for appropriate management of a member's care, including the exchange of medical

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CONFIDENTIALITY OF MEDICAL RECORDS	records information with a member's other healthcare providers or providers of specialty mental health services. b. The MHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. c. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member or as otherwise permitted by state and federal privacy law and regulations. d. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise permitted by law.	records information, with a member's other healthcare providers or providers of specialty mental health services. b. The Plans contracted providers will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. c. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization by the member or as otherwise permitted by state and federal privacy law and regulations. d. Unless otherwise permitted by state and federal privacy law,the Plans contracted providers will not release any information pertaining to a member's physical or mental health treatment without a signed release from the member or legal guardian describing the information requested, its intended use or uses, the length of time during which the information will be kept before being destroyed or disposed of, and a statement that the information will not be used for other purposes and will be destroyed within the designated timeframe, and otherwise satisfying the requirements of applicable federal law. The timeframe may be extended, provided that the Plan is notified of the extension, the reasons for the extension, and additional intended uses and the expected date that the information will be destroyed. e. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is

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		otherwise permitted by law.
2.1.5 **DIAGNOSTIC ASSESSMENT**	a. The MHP will evaluate and triage plan members and when authorized will provide specialty mental health services to the Plan members who meet Medi-Cal Specialty Mental Health Criteria. b. The MHP will assess a member's symptoms, level of impairment, and focus of intervention to determine if a member meets medical necessity criteria for specialty mental health services. c. When medical necessity criteria is met, the MHP will arrange for an appointment with the appropriate provider. d. When medical necessity criteria is not met, the MHP staff may refer the member back to the referring PCP, notify the Plan and/or refer the member to community resources as appropriate. e. Individual mental health providers may arrange for records transfer by direct communication with the referring physician.	a. The Plan or its subcontractors will arrange and pay, at the Medi-Cal rate, for appropriate medically necessary assessments of Plan members to identify co-morbid physical and mental health conditions, to: • Rule out general medical conditions causing psychiatric symptoms • Rule out mental disorders and/or substance-related disorders caused by a general medical condition. • Identify and treat those general medical conditions that are causing or exacerbating psychiatric symptoms. b. The PCP will be advised to identify and/or treat non-disabling psychiatric conditions that may be responsive to primary care, i.e., mild to moderate anxiety and/or depression or more serious mental health conditions if stabilized on medication or other physical healthcare-based treatment, if within the scope of practice of the member's PCP. c. The member's PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the member to specialty physical health care for such treatment.

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2.1.6 **EMERGENCY SERVICES & CARE – EMERGENCY ROOM FACILITY CHARGES AND PROFESSIONAL SERVICES**	a. The MHP will be responsible for the facility charges resulting from the emergency services and care of a Plan member whose condition meets the 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. b. The MHP will cover and pay for the professional services of a mental health specialist, subject to submission of a valid claim with appropriate documentation, provided in an emergency room to a Plan member whose condition meets the MHP medical necessity criteria or when the mental health specialist services are required to assess whether the MHP medical necessity is met. c. 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 the MHP medical necessity criteria will be assigned as follows: • Payment for 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 fee-for-service system, and not the responsibility of the MHP.	a. The Plan will cover at the Medi-Cal rate the facility charges resulting from the emergency services and care of a Plan member, whose condition meets the 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. b. The Plan will cover at the Medi-Cal rate all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose conditions meets the MHP medical necessity criteria. c. 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 will be assigned as follows: • The Plan will cover at the Medi-Cal rate the facility charges and the medical professional services, excluding specialty mental health 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.

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2.1.7 **HOME HEALTH AGENCY SERVICES**	a. The MHP will notify the Plan of members who need home health services or who are receiving home health services through the Home and Community Based Services Waiver Program (HCBS) or the In-Home Supportive Services Program (IHSS). b. The MHP will pay for medically necessary specialty mental health services solely related to the included mental health diagnoses, or if the MHP determines a Plan member requires necessary Specialty Mental Health Services c. The MHP is not responsible to provide or arrange for Home Health Agency Services as described in Title 22, Section 51337.	a. The Plan will cover at the Medi-Cal rate home health agency services, as described in Title 22, Section 51337, prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHCS. b. A homebound Plan member is a patient who is essentially confined to his 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 relative short duration, e.g., for a short walk prescribed as therapeutic exercise. c. The Plan is not obligated to cover 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 Plan member. For example, the Plan would not be obligated to cover home health agency services for the purpose of medication monitoring when those services are not typically medically necessary or for a patient who is not homebound. d. Home health agency services prescribed by Plan providers to treat mental health conditions of Plan members are the responsibility of the Plan.
2.1.8 **HOSPITAL OUTPATIENT DEPARTMENT SERVICES**	a. The MHP will be responsible for the payment of specialty mental health services provided by hospital outpatient which are credentialed as MHP group providers for Plan members who meet medical necessity criteria for specialty mental health services. Hospital outpatient services	a. The Plan will cover at the Medi-Cal rate professional services and associated room charges for hospital outpatient services consistent with medical necessity and the Plan's contract with its subcontractors and the Department of Health Care Services (DHCS). Separately billable

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	will be reasonably available and accessible to Plan members.	outpatient services related to *electroconvulsive therapy, such as anesthesiologist services* are the contractual responsibility of the Plan.
2.1.9 **LABORATORY, RADIOLOGICAL, AND RADIOISOTOPE SERVICES**	a. Laboratory, radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the MHP, ***except*** when provided as hospital based ancillary services and are included in the per diem. b. Medi-Cal beneficiaries may obtain Medi-Cal covered 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. c. The MHP will coordinate with laboratory, radiological, and radioisotope and Plan as appropriate to assist beneficiaries in receiving laboratory, radiological, and radioisotope services, prescribed through the MHP including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedure. d. Information will be disseminated to the MHP providers primarily through provider handbook by the MHP.	a. The Plan will be responsible for covering at the Medi-Cal rate medically necessary laboratory, radiological, and radioisotope services described in CCR Title 22, Section 51311. b. The Plan will cover at the Medi-Cal rate laboratory services to Plan members who require the specialty mental health services of the MHP or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis and treatment of Plan member's mental health condition. c. The Plan will also cover at the Medi-Cal rate services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan's contracted provider will coordinate these services with the member's specialty mental health provider.
2.1.10 **MEDICAL TRANSPORTATION SERVICES (EMERGENCY AND NON-EMERGENCY)**	a. The MHP is responsible for medical transportation services when the transportation is required to transfer an enrollee from one psychiatric inpatient hospital to another psychiatric inpatient hospital, or to another type of 24-hour care facility, when such transfers are not medically indicated. (i.e., undertaken with the purpose of reducing the MHP's cost of providing services.)	a. The Plan will cover at the Medi-Cal rate all *medically necessary emergency* and non-emergency medical transportation services for Plan members including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services. b. The Plan will cover at the Medi-Cal rate medically necessary non-emergency medical transportation

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		services, when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP, when authorization is obtained.
2.1.11 **MEDICAL NECESSITY CRITERIA FOR SPECIALTY MENTAL HEALTH**	a. The MHP will provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries 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. b. Medical necessity criteria is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. The MHP will accept referrals received through beneficiary self-referral or through referral by another person or organization.	a. Beneficiaries whose diagnoses are not included in the applicable listing of MHP covered diagnoses may obtain mental health services through the Medi-Cal fee-for-service system under applicable provisions of Title 22, CCR, Division 3, Subdivision 1 (MMCD Policy Letter 00-01 Rev., page 16). b. Plan members whose mental health diagnoses are covered by the MHP, but whose conditions do not meet the program impairment and intervention criteria, are not eligible for mental health care under the Medi-Cal fee-for-service program. These beneficiaries are eligible for care from a primary care or other physical health provider. The Medi-Cal fee-for-service system will deny claims from mental health professionals for such beneficiaries.
2.1.12 **NURSING FACILITY SERVICES**	a. The MHP will provide medically necessary specialty mental services, typically visits by psychiatrists and psychologists who are credentialed by the MHP in a skilled nursing facility.	a. Skilled nursing facility services with special treatment programs for the mentally disordered are covered by the Medi-Cal fee-for-service program. These services are billed to the Medi-Cal fee-for-service system using accommodation codes 11, 12, 31, and 32, for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs). The Plan is responsible for these services in accordance with the terms of the Plans contract for coverage of long-term care.

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2.1.13 **PSYCHIATRIC ACUTE INPATIENT HOSPITAL SERVICES**	a. The MHP will be responsible for medically necessary psychiatric inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c). b. Psychiatric Inpatient Hospital Services for a fee-for-service Medi-Cal hospital will include in the per diem rate: • Routine hospital services • All hospital based ancillary services. c. Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal hospital will include: • Routine hospital services • All hospital based ancillary services, and • Psychiatric inpatient hospital professional services. d. The MHP will utilize the Plan contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for Plan members unless otherwise covered by the hospital's per diem rate.	a. The Plan will cover and pay at the Medi-Cal rates for all medically necessary professional services to meet the physical health care needs of the Plan members who are admitted to the psychiatric ward of a general acute hospital or a free standing licensed inpatient psychiatric hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations. b. The Plan is 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.

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2.1.14 **PHYSICIAN SERVICES**	a. The MHP will not be responsible to provide or arrange and pay for physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, Psychiatrist Services, even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205.	a. The Plan will cover at the Medi-Cal rate physician services related to the delivery of outpatient mental health services, which are within the PCPs 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. b. The Plan is not required to cover physician services provided by Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapist, or other specialty mental health providers. c. When medically necessary, the Plan will cover at the Medi-Cal rate physician services provided by Specialists.
2.1.15 **PROVIDER NETWORK AND MEMBER EDUCATION**	a. The MHP will credential and contract with sufficient numbers of licensed mental health professionals to maintain a MHP provider network sufficient to meet the needs of the Plan members. b. The MHP will continually monitor the MHP provider network to ensure beneficiary access to quality mental health care. The MHP will assist the Plan in arranging for an appropriate MHP provider when the Plan is unable to locate an appropriate mental health service provider for a	a. 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 health services as required by contract. b. 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

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	Plan member. c. The MHP will make available a list of providers or provider organizations. Any updates to the list will be provided to the Plan upon request.	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 resource in the community, if known to the Plan, that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or another appropriate local provider or provider organization. c. The Plan will request assistance from the MHP whenever the PCP is unable to arrange for an appropriate MHP provider for a Plan member. The Plan will initiate a referral to the appropriate MHP provider or provider organization as recommended by the MHP. For those services that do not meet the MHP medical necessity criteria, a copy of the referral will be kept in the member's referral chart.
2.1.16 **REFERRALS**	a. The MHP will accept referrals from the Plan staff, Plan providers and Plan Medi-Cal members for determination of MHP medical necessity. b. When medically necessity criteria are met, the MHP will arrange for specialty mental health services by a MHP provider. In the case of self-referrals or referrals from providers other than the member's PCP, in which the planned specialty mental health services involves a MHP psychiatrist, the MHP will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information. c. When medically necessity criteria are not met, or if it is felt that the member's mental health condition would be responsive to physical healthcare-based treatment, the MHP will refer the member back to the Plan and the referring physician with the	a. The Plan will instruct the PCP to maintain responsibility for physical healthcare based primary mental health treatment, which includes: • Basic education, assessment, counseling, and referral and linkage to other services for all beneficiaries. b. The Plan will instruct the MHP to refer for an assessment and appropriate services when: • An assessment is needed by the MHP to confirm or arrive at a diagnosis. • Mental health services other than medications are needed for a beneficiary with a diagnosis included in the responsibilities of the MHP. c. After the PCP's diagnostic assessment, the Plan or PCP will

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	assessment results, diagnosis, need for service and/or recommendations for an appropriate provider to treat the member's symptoms. d. The MHP will encourage its providers to coordinate care with member's primary care provider. e. The MHP will encourage providers to secure the Behavioral Health Services Coordination Form and Guidelines (Attachment 2.1). f. Referrals may include a provider with whom the member already has a patient-provider relationship, or a provider in the area that has indicated a willingness to accept referrals. This will include but is not limited to a Federally Qualified Health Center (FQHC), a Rural Health Clinic, an Indian Health Clinic, or Indian Clinic. The MHP is not required to ensure a member's access to physical health care-based treatment or to treatment from licensed mental health professionals for diagnoses not covered by the MHP. g. When the MHP has provided specialty mental health services and has determined that the member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare-based treatment, the MHP will refer the member back to the Plan and referring physician with the assessment and treatment results, diagnosis, need for ongoing service and recommendations for an appropriate provider to treat the member's symptoms. h. The MHP can utilize the Plan's referral authorization form and with the member's consent will inform the PCP of services provided and/or medications prescribed. The MHP will attempt to coordinate information with the member's other health care	refer those members whose psychiatric condition would not be responsive to physical health care, to the MHP to determine if MHP medical necessity criteria are met. d. In the event a member does not meet the State Department of Mental Health Medi-Cal specialty mental health criteria, the MHP will inform the Plan and PCP. The Plan will arrange for primary mental health services within the member's PCP's scope of practice. e. The Plan will encourage its providers to use the Behavioral Health Services Coordination Form and Guidelines (Attachment 2.1). f. When the MHP informs the Plan and PCP that a member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare-based treatment, the Plan will refer for primary mental health services within the member's PCP's scope of practice.

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	providers and ensure that contact with the Plan is made.	
2.1.17 **RESOLUTION OF DISPUTES**	a. The MHP will provide a resolution of dispute process in accordance with Title 9, Section 1850.505, Chapter 11. b. When the MHP has a dispute with the Plan that cannot be resolved to the satisfaction of the MHP, concerning the obligations of the MHP, or the Plan, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOA as described in Section 1810.370, the MHP may submit a request for resolution to the State Department of Mental Health (DMH). c. Regardless of MOU status, MCPs and MHPs agree to comply with All Plan Letter 21-013 and any superseding notices that relate to the dispute resolution process. d. A dispute between the MHP and the Plan will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. e. Nothing in this section will preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process or any similar process offered by the Plan or to request a fair hearing. f. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP	a. The Plan will provide a resolution of dispute process in accordance with CCR Title 9, Section 1850.505, Chapter 11 and the Medi-Cal contract between the Plan and the State Department of Health Care Services (DHCS). b. When the Plan has a dispute with the MHP that cannot be resolved to the satisfaction of the Plan, the Plan may submit a request for resolution to the DHCS. c. Regardless of MOU status, MCPs and MHPs agree to comply with All Plan Letter 21-013 and any superseding notices that relate to the dispute resolution process.. d. A dispute between the Plan and the MHP will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. e. Nothing in this section will preclude a beneficiary from utilizing the Plan's beneficiary problem resolution process or any similar process offered by the MHP or to request a fair hearing. f. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP has determined that treatment would not be within the PCP's scope of

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	has determined that treatment would not be within the PCP's scope of practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.	practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.
2.1.18 **SERVICE AUTHORIZATIONS**	a. The MHP will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the MHP for services that meet MHP medical necessity criteria. This will be done through the MHP access programs. Services will be rendered according to the MHP responsibility. b. MHP staff will be available to assist in coordinating care, including service authorizations. c. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.	a. The Plan and its subcontractors will authorize medical assessment and/or treatment services in accordance with the Medi-Cal contract with the State DHCS. b. Plan staff will be available to assist in coordinating care and obtaining appropriate service authorizations. c. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.
2.1.19 **SERVICES EXCLUDED FROM COVERAGE**	a. The MHP will not be responsible to provide or arrange and pay for the following services: • **Medi-Cal services, that are not specialty mental health services**, • **Prescribed Drugs**, and • **Laboratory, Radiological, and Radioisotope services**, except when provided as hospital-based ancillary services and included in the per diem. • **Medical Transportation Services**, except when the purpose of the medical transportation service is to transport a 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	The Plan is not responsible to arrange and cover the services listed below to its members in accordance with the MOA and as contractually required. • **Medi-Cal Services**, that are specialty mental health services. • Pharmaceutical Services • A copy of the drugs excluded from Plan coverage should be included as part of this MOA package. The drug list can be found as Appendix-I HSD Pharmacy Card.

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	beneficiary is being transported will result in lower costs to the MHP. • **Physician Services**, that are not psychiatric services even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205. • **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 the department or the State Department of Developmental Services. • **Specialty Mental Health Services**, provided to a beneficiary eligible for Medicare, prior to the exhaustion of the beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRG) when the DRG reimbursement covers administrative day services according to Medicare (Part A). • **Specialty Mental Health Services**, provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent that specialty mental health services are covered by the Medi-Cal Managed Care Plan. • **Psychiatric Inpatient Hospital Services**, received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a). • **Medi-Cal Services**, that may include specialty mental health services as a component of a	

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	larger service package as follows: 1. **Psychiatrist and Psychologist Services**, provided by adult day health centers. **2. Home and Community Based Waiver Services** 3. **Specialty Mental Health Services**, authorized by the CCS program to treat CCS eligible beneficiaries. **4. LEA Services** 5. **Specialty Mental Health Services**, provided by FQHCs, Indian Health Centers, and Rural Health Clinics. **6. Home Health Agency Services** b. Beneficiaries whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Div.3, Subdivision 1.	
2.1.20 **SERVICES FOR THE DEVELOPMENTALLY DISABLED**	a. The MHP will refer members with developmental disabilities to a Regional Center (RC) for covered services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. When appropriate, the MHP will inform the Plan, its delegated entity, and the PCP of such referrals.	a. The Plan will instruct its PCPs to refer members with developmental disabilities to a Regional Center (RC) for psychiatric and non-medical services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. b. The Plan must enter into a Memorandum of Understanding (MOU) with a RC to cover all members receiving Behavioral Health Treatment (BHT) services, regardless of diagnosis. The Plan is responsible for providing medically necessary BHT services as a managed care benefit as required by the Early and Periodic Screening, Diagnostic and Treatment mandate, including the coordination of a member's health

CATEGORY	LOCAL MENTAL HEALTH PLAN	MEDI-CAL MANAGED CARE PLAN
		care with the member's RC and BHT providers, as applicable.
2.1.21 **SPECIALTY MENTAL HEALTH SERVICES PROVIDERS AND COVERED SPECIALTY MENTAL HEALTH SERVICES (EPSDT)**	a. The MHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 with full scope Medi-Cal is eligible for EPSDT supplemental services. If these criteria are met, the MHP will be responsible for arranging EPSDT supplemental mental health services provided by specialty mental health professionals. The MHP will pay for EPSDT supplemental services that are part of the member's specialty mental health treatment. b. When the MHP determines that EPSDT supplemental ser vices criteria are not met, and the child is CCS eligible, the MHP will refer the child to the PCP. c. When the MHP determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, the MHP will refer the child to the PCP for treatment of conditions within the member's PCP's scope of practice. d. The MHP will provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205 and 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. e. The MHP will not be required to provide or arrange for any specific specialty mental health service but will ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as required or applicable. f. The MHP will provide specialty mental	a. The Plan will assist the MHP and members by providing links to known community providers of supplemental services.

CATEGORY	LOCAL MENTAL HEALTH PLAN	MEDI-CAL MANAGED CARE PLAN
	health services only to the extent the beneficiary is eligible for those services, based on the beneficiary's Medi-Cal eligibility under Title 22.	

CCS = California Children's Services

DHCS = Department of Health Care Services

DMH = Department of Mental Health

FFS = State Fee-For-Service

FQHC = Federally Qualified Health Center

LEA = Local Education Agencies

MHP = Name of Local Mental Health Plan

PCP = Primary Care Provider

Plan = Name of Health Plan

2.2 Patient Protection and Affordable Care Act Addendum

This Addendum (“Addendum”) is an addendum to the signed Memorandum of Agreement (MOA) between San Diego County Division of Behavioral Health, Mental Health Plan (hereinafter referred to as MHP) and the Medi-Cal Managed Care Health Plan, (hereinafter referred to as the "Plan”). The purpose of the Addendum is to describe the responsibilities of the MHP and Plan for coordination of Medi-Cal mental health services for Plan Members served by both parties in San Diego County under the Department of Health Care Services (DHCS) Medi-Cal Managed Care Program.

The Addendum delineates the specific roles and responsibilities by the MHP and Plan for outpatient mental health benefits available through the Plan for Plan Members with mild to moderate impairment of mental, emotional or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual; who meet the medical necessity criteria for Medi-Cal specialty mental health services and identified by DHCS as a Medi-Cal Managed Care Health Plan benefit. MMCD All Plan Letter (APL) 13-018 has been used as the reference for the required elements in the Addendum. All references in the addendum to “Members” are limited to the Plan’s Members.

Healthy San Diego (HSD) and its workgroups are the County collaborative for addressing the operations of Medi-Cal managed care for San Diego County. The HSD Behavioral Health Work Group consists of all San Diego County Medi-Cal Managed Care plans, County Behavioral Health Services (MHP), health plan and MHP providers, community clinics, psychiatric hospitals, and advocates. The HSD Behavioral Health Work Group's Operations Team is a subgroup with a focus on operational issues including oversight, MOA development and management, selection of screening tools, referral guides and development of policy & procedures.

BACKGROUND

Pursuant to Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014, mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 10112.27 and approved by the United States Secretary of Health and Human Services under Title 42, Section 18022 of the United States Code, shall be covered Medi-Cal benefits. The Plan shall provide mental health benefits covered in the state plan, excluding those benefits provided by the County MHPs under the Specialty Mental Health Services Waiver.

On January 1, 2014, the DHCS expanded the array of Medi-Cal mental health services available to Medi-Cal beneficiaries. The following outpatient mental health benefits will be available through the Plan for Members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual:

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

Medi-Cal specialty mental health services currently provided by the MHP will continue to be provided by the MHP for Medi-Cal beneficiaries that meet the medical necessity criteria pursuant to Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210.

TERMS

This Addendum commenced on January 1, 2014, and shall continue under the terms of the existing MOA.

COVERED SERVICES AND POPULATIONS

Refer to the prevailing Medi-Cal Coverage and Population Matrix developed by DHCS (Attachment 2.2).

OVERSIGHT RESPONSIBILITIES OF THE PLAN AND THE MHP

1. The Plan organizational approach to mental health management for Members with a mild to moderate mental health condition is to use health plan contracted mental health providers. The Plan has 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 through the Healthy San Diego Behavioral Health Work Group's Operations Team, as will any actions required to identify and resolve any issues or problems that arise.
2. The Healthy San Diego Behavioral Health Work Group's Operations Team will serve as the committee that will be responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the addendum to the existing MOA.
3. The Plan and MHP will formulate a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. The Plan and MHP will determine the final composition of the multidisciplinary teams to conduct this oversight function.
4. The Plan and the MHP will designate as appropriate and when possible, the same staff to conduct tasks associated within the oversight and multidisciplinary clinical teams.

SPECIFIC ROLES AND RESPONSIBLITIES

A. Screening, Assessment, and Referral

1. Determination of Medical Necessity
   a. The MHP 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.
2. Assessment Process
   a. The Plan and MHP shall develop and agree to written policies and procedures regarding agreed-upon screening, assessment, and referral processes, including screening and assessment tools for use in determining if the Plan or MHP will provide mental health services within a reasonable period that allows for timely access to services for Members.
   b. The MHP and Plan will distribute to the community and to their providers, the Medi-Cal Mental Health Screening Tool developed by the Healthy San Diego Behavioral Health Work Group, Operations Work Team.
   c. The Plan will conduct a mental health assessment for Members with a potential mental health condition using a tool mutually agreed upon with the MHP to determine the appropriate care needed.
3. Referrals
   a. The MHP and Plan shall develop and agree to written policies and procedures regarding referral processes, including the following:
      i. The MHP will accept referrals from Plan staff, providers, and Members' self-referral for determination of medical necessity for specialty mental health services.
      ii. The Plan's Primary Care Provider refers the Member to the Plan to obtain a referral to a network provider for an initial evaluation (except in emergency situations or in cases when the beneficiary clearly has a significant impairment that the member can be referred directly to the MHP). If it is determined by the Plan mental health provider that the Member may meet specialty mental health services medical necessity criteria, the Plan's mental health network provider refers the Member to the MHP for further screening, assessment, and treatment as appropriate.
      iii. The Plan accepts referrals from MHP staff, providers, and Members' self-referral for assessment, makes a determination of medical necessity for outpatient services, and provides referrals within the Plan mental health provider network. The MHP refers to the Plan when the service needed is one provided by the Plan and not the MHP, and when it has been determined by the MHP that the Member does not meet the specialty mental health medical necessity criteria and has a mild to moderate mental health condition.

B. Care Coordination

1. The Plan and County will develop and agree to policies and procedures for coordinating inpatient and outpatient medical and mental health care for Members enrolled in the Plan and receiving Medi-Cal specialty mental health services through the MHP.
2. An identified point of contact from each party to serve as a liaison and initiate, provide, and maintain the coordination of care as mutually agreed upon in Plan and MHP protocols.
3. Coordination of care for inpatient mental health treatment provided by the MHP, including a notification process between the MHP and the Plan which shall be initiated 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) which will include triggers for updating care plans and coordinating with outpatient mental health providers.
4. Transition of care for Members transitioning to or from Plan or MHP services.
5. Regular meetings to review referral, care coordination, and information exchange protocols and processes.

C. Information Exchange

1. The MHP and Plan will develop and agree to Information sharing policies and procedures and agreed upon roles and responsibilities for timely sharing of personal 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, alcohol and drug treatment information (See Attachment 2.3 for jointly developed policies and procedures).

D. Reporting and Quality Improvement Requirements

1. The MHP and Plan will have policies and procedures to address quality improvement requirements and reports.
    a. Hold regular meetings, as agreed upon by the MCP and the Plan, to review the referral and care coordination process and monitor Member engagement and utilization.
    b. Hold a no less than a semi-annual calendar year review of referral and care coordination processes to improve quality of care; and at least 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 the Plan and MHP.
    c. Reports that track cross-system referrals, beneficiary engagement, and service utilization will be determined in collaboration with DHCS, including, but not limited to, the number of disputes between the Plan and MHP, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access, and the dispositions/outcomes of those grievances. The reports shall address utilization of

mental health services by Members receiving such services from the Plan and the MHP, as well as quality strategies to address duplication of services.

d. The performance measures and quality improvement initiatives will be determined in collaboration with DHCS.

E. Dispute Resolution Process

1. The Plan and County agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Plans and the State Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). A dispute will not delay member access to medically necessary services and the referenced process is outlined in Section 2.1.8 (Resolution of Disputes).

F. Telephone Access

1. The MHP must ensure that Members will be able to assess services for urgent or emergency services 24 hours per day, 7 days a week.
   a. The approach will be the “no wrong door” to service access. There will be multiple entry paths for beneficiaries to access mental health services. Referrals may come from primary care physicians, providers, Plan staff, County Departments, and self-referral by calling the Plan’s 800 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

1. The Plan and MHP shall determine the requirements for coordination of Member and provider information about access to Plan and MHP covered services. The Plan and MHP have developed a “Quick Guide” that will assist for referrals and access to outpatient services, along with a Medi-Cal Psychiatric Hospital Guide.

H. Point of Contact for the MOA Addendum

1. The Point of Contact for the MOA Addendum will be a designated liaison from both the MHP and the Plan.

2.3 Cal MediConnect Addendum:

This section applies only to Cal-MediConnect Plans

This Addendum to MOA ("Addendum") is an addendum to the signed Memorandum of Agreement (MOA) between San Diego County Division of Behavioral Health, Mental Health Plan (hereinafter referred to as MHP) and the Medi-Cal Managed Care Plans. The purpose of this addendum is to describe the responsibilities of the MHP and the Duals Demonstration Health Plans (hereinafter referred to as Plans) in the delivery of specialty mental health services to demonstration enrollees served by both parties in the San Diego County Duals Demonstration (DD), now referred to as Cal MediConnect.

The addendum delineates the specific roles and responsibilities by the MHP and the Plans for the demonstration enrollees who meet the medical necessity criteria for Medi-Cal Specialty Mental Health or Drug Medi-Cal Services. It is the intention of both parties to coordinate care between providers of physical and behavioral health care. All references in the addendum to "Members" are limited to the Plan's San Diego County DD Members.

In the duals demonstration, participating health plans are responsible for providing member access to all medically necessary behavioral health services (mental health and substance use disorder treatment) currently covered by Medicare and Medi-Cal. While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration and included in their capitation payment, Medi-Cal specialty mental health services not covered by Medicare and Drug Medi-Cal benefits are not included in the capitation payment made to the participating health plans (i.e., these are considered "carved out). The demonstration plans will coordinate with County agencies to ensure members have seamless access to these services.

This addendum includes the following concepts specific to the demonstration:

- Delineation of roles and responsibilities;
- Policies and procedures for sharing information;
- Policies and procedures for care; and
- Agreement on the specifically described Shared Accountability performance measures and financial incentives tied to achieving the quality withhold (these measures will be finalized and included in the three-way contracts between DCHS, CMS, and the health plans).

BACKGROUND

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for Dual Eligibles while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. To execute this initiative, eight counties, including San Diego County, were selected by the State to implement a three-year demonstration project for Dual Eligibles who are beneficiaries of Medicare and Medi-Cal services. There are four local managed care health plans designated by the State Department of Health Care Services (DHCS) and the Center for Medicare and Medicaid Services (CMS) to provide the physical, behavioral health and Long Term Services and Supports services.

PARTIES

This Addendum to existing MOA is entered into by Care1st Health Plan, Community Health Group, Health Net Community Solutions and Molina Healthcare hereinafter referred to as "Plans", and the San Diego County Division of Behavioral Health responsible for the provision of Medi-Cal Specialty Mental Health and Drug Medi-Cal services hereinafter referred to as "County." County Behavioral Health Providers are those working in a County operated or contracted (Organizational Provider) system of care. Health Plan contracted providers are those who are not working at a County Behavioral Health Program.

TERMS

This memorandum commenced on January 1, 2014, and shall continue through the duration of the San Diego County Duals Demonstration (DD), now referred to as Cal MediConnect.

TASKS, RESPONSIBIITIES, AND/OR OBLIGATIONS

A. Roles and Responsibilities

1. Covered Services are listed in the most recent version of the "Behavioral Health Benefits in the Duals Demonstration" matrix developed by the DHCS (Attachment 2.4).
2. Determination of Medical Necessity
    a. The Plans and 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. To determine medical necessity for Drug Medi-Cal Substance Abuse Services, the PARTIES will follow Title 22, California Code of Regulations Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.
3. Assessment Process
    a. The Plans and County shall develop and agree to written policies and procedures regarding agreed-upon screening and assessment processes that comply with all federal and state requirements including the Care Coordination Standards and Behavioral Health Coordination Standards (See Attachment 2.5 for jointly developed policies and procedures).
4. Referrals
    a. The Plans and County shall develop and agree to written policies and procedures regarding referral processes, including the following:
        i. The County will accept referrals from Plan staff, providers, and members' self-referral for determination of medical necessity.
        ii. The Plans will accept referrals from the County when the service needed is one provided by the Plans and not the County and the beneficiary does not meet the Medi-Cal Specialty Mental Health and/or Drug Medi-Cal medical necessity criteria.

b. County Behavioral Health referral timeline are as follows:
   i. *Emergency Psychiatric Condition* Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the client, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter, or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility services. Goal for Services: Face-to-face clinical contact within one (1) hour of initial client contact/ referral.
   ii. *Urgent Psychiatric Condition* Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. Goal for Services: Face-to-face clinical contact within seventy-two (72) hours of initial client contact/referral.
   iii. *Routine Condition* A "Routine Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services. Goal for Services – Adult Mental Health Services: System wide average of eight (8) calendar days from initial contact to mental health assessment.

c. Health Plan Behavioral Health referral timeline are based on the Department of Managed Health Care guidelines:
   i. Urgent Appointments that do not require prior authorization within 48 hours.
   ii. Urgent Appointments that require prior authorization within 96 hours.
   iii. Routine Appointment with a behavioral health professional within 10 days.

d. The DD project will have a "no wrong door" approach to service access. There will be multiple entry paths for beneficiaries to access mental health services. Referrals may come from primary care physicians, providers, health plans, County Departments, and self-referral by calling the health plan's 800 number that will be available 24 hours per day, 7 days a week for service authorization and referral.

5. Authorization of Services
   a. All services, except emergency psychiatric treatment must have prior authorization.
   b. The County will provide the Plan a list of County Behavioral Health Providers and send updated lists as necessary.
   c. The Plan will refer members to a County Behavioral Health Provider for an assessment to determine if member meets criteria for Medi-Cal Specialty Mental Health Services.
   d. The County Behavioral Health Provider will perform an initial evaluation and send the Plan a Treatment Recommendation.
   e. If Medi-Cal Specialty Mental Health criteria are met, the Plan will authorize Medicare covered treatment to be provided by the County Behavioral Health Provider. Behavioral health services covered by Medicare are the responsibility of the Plan.

f. The Plan will reimburse County Behavioral Health Providers for authorized services covered by Medicare and provided by a licensed behavioral health professional. The Plan will also reimburse Medicare covered services provided at the San Diego County Emergency Psychiatric Unit. Emergency services do not require prior authorization.
g. If Medi-Cal Specialty Mental Health criteria is not met, the Plan will arrange for medically necessary behavioral health treatment with a Plan contracted behavioral health provider.

6. Provider Credentialing
   a. The Plans will jointly contract with one Credentialing Verification Organization (CVO) for the purpose of credentialing County Providers.
   b. The County and Plan will ensure that all County Behavioral Providers serving DD Plan members are credentialed by the joint CVO contracted for the Plans.
7. Payment Mechanism
   a. The reimbursement mechanism between County and Plan shall be determined locally and agreed upon by both parties, as specified in this MOA addendum and subject to federal timeliness and other requirements.
   b. The Plans shall reimburse the County for medically necessary Medicare-covered behavioral health services rendered by the County. Except for emergency services treatment authorized as stipulated in sub-section 8. The County will recover the federal Medi-Cal reimbursement for Medi-Cal specialty mental health services after receiving the Plan's payment consistent with the provisions of the demonstration and the current Medi-Cal specialty mental health 1915(b) waiver and California' Medicaid State Plan.
   c. The Plans shall provide information necessary for coordination of benefits in order for the County to obtain appropriate reimbursement under the Medi-Cal program.
8. Rates
   a. Subject to the provisions of sub-section 7, the Plans shall reimburse the County for behavioral health services covered by Medicare at the most current Medicare published rate.
9. Dispute Resolution Process
   a. The Plans and County agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Plans and the State Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). The process referenced above is outlined in Section 2.1.8 (Resolution of Disputes).

10. Telephone Access
    a. The Plan shall provide members with the number of the San Diego County Access & Crisis Line.
    b. The San Diego County Access & Crisis Line will be available to assist Dual Eligible members in crisis. If a Dual Eligible member calls the San Diego County Access & Crisis Line, and it is determined no immediate behavioral health intervention is required, the member will be referred to their Plan to obtain a referral to a Plan contracted behavioral health provider or County Organizational provider.
    c. The COUNTY must ensure that a live person be available to speak with beneficiaries to assess their need for urgent or emergency services 24 hours per day, 7 days a week.

B. Information Exchange

1. County and Plans will develop and agree to Information sharing policies and procedures that include milestones over the three years and agreed upon roles and responsibilities for sharing personal 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, alcohol and drug treatment information.
2. The Plans will create a list of DD enrollees who are receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services to track their care coordination and service delivery to the extent possible under state and federal privacy laws.
3. Signed consents to release information will be required for exchange of all information between providers not covered under coordination of care.

C. Care Coordination

1. The Plans and County will develop and agree to policies and procedures for coordinating medical and behavioral health care for beneficiaries enrolled in the Plans and receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the County that may include the following:
    a. One or more identified points of contact who will initiate and maintain ongoing care coordination, including agreement on who has primary responsibility for care planning.
    b. County will participate in Interdisciplinary Care Teams (ICTs) for members receiving County-administered services and identified as needing an ICT, in accordance with a beneficiary's decisions about appropriate involvement of providers and caregivers on the ICT.
    c. The County will request participation from the Plans in developing behavioral health care plans, as needed.
    d. The Plans will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or wellbeing, change in level of care or request for change of providers, and for coordinating with the County behavioral health providers, when necessary.

e. The Plans will coordinate with the County to perform an annual review, analysis, and evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

D. Shared Accountability

1. Shared Accountability between the Plans and County aims to promote care coordination. Shared accountability builds on the performance-based withhold of 1%, 2%, and 3% in the capitation rates respectively for years one, two and three of the demonstration. By meeting specified quality measures, the Plans can earn back the withheld capitation revenue by meeting specified quality objectives. Under this Shared Accountability strategy, one withhold measure each year will be tied to behavioral health coordination with the County.
2. The Plans and County agree to the Shared Accountability Performance Metrics, as specified in the three-way contracts between CMS, DHCS and the Plan. Refer to current DHCS metrics available at: https://www.dhcs.ca.gov/services/Pages/ManagedCareMonitoring.aspx
3. The Plans and County agree that if the specified shared accountability measure is met in each year, the Plans will provide an incentive payment to the County under mutually agreeable terms. This payment will be structured in a way so it does not offset the County's Certified Public Expenditure (CPE).

E. Provider and Member Education

1. The Plans and County will develop, in coordination with one another, education materials and programs for their members and providers about the availability of behavioral health services, including roles and responsibilities in the demonstration and care coordination policies and procedures. At a minimum, education will include initial and regularly scheduled provider trainings (at least annually), and a provider manual that includes information regarding access to services, the beneficiary problem resolution processes, authorization process, provider cultural and linguistic requirements, regulatory and contractual requirements, formulary use, and other activities and services needed to assist beneficiaries in optimizing their health status, including assistance with self- management skills or techniques, health education and other modalities to improve health status.

F. Point of Contact for the MOA Addendum

1.The Point of Contact for the MOA Addendum is outlined in Section 2.1.1 (Liaison) which also includes the specific roles and responsibilities of the liaison for both the MHP and the Plans.

2.4 Drug Medi-Cal Organized Delivery System (DMC-ODS) Addendum

This Addendum to MOA ("Addendum") is an addendum to the signed Memorandum of Agreement (MOA) between San Diego County Division of Behavioral Health Services (hereinafter referred to as SDCBHS) and the Medi-Cal Managed Care Health Plan, (hereinafter referred to as the "Plan"). The purpose of the Addendum #2 is to describe the responsibilities of the SDCBHS and Plan for coordination of Medi-Cal substance use disorder services for Plan Members served by both parties in San Diego County under the Department of Health Care Services (DHCS) Medi-Cal Managed Care Program.

The Addendum #2 delineates the specific roles and responsibilities by SDCBHS and Plan for screening, referral, coordination and delivery of substance use disorder services for Medi-Cal beneficiaries , who meet the medical necessity criteria for Medi-¬Cal services and identified by DHCS as a Medi-Cal Managed Care Health Plan benefit. MHSUDS Information Notice No: 16-005 has been used as the reference for the required elements in the Addendum. All references in this addendum to "Members" are limited to the Plan's Members.

Healthy San Diego (HSD) and its workgroups are the County collaborative for addressing the operations between the County and the managed care plans related to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver within San Diego County. The HSD Behavioral Health Work Group consists of all San Diego County Medi-Cal Managed Care plans, SDCBHS, health plan and Alcohol and Drug Services providers, community clinics, psychiatric hospitals, and advocates. The HSD Behavioral Health Work Group's Operations Team is a sub group with a focus on operational issues including oversight, MOA development and management, selection of screening tools, referral guides and development of policy & procedures.

BACKGROUND

On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's Health and Human Services Agency request for approval regarding the California section 1115 five-year Medicaid Demonstration, titled "California's Bridge to Reform" (Waiver 11-W- 3/9) under the authority of section 1115(a) of the Social Security Act. On December 30, 2015, CMS approved California's 1115 Waiver Renewal, titled Medi-Cal 2020, to continue to pursue a positive transformation of the Medi-Cal system.

On August 13, 2015, CMS approved the California Department of Health Care Services proposed amendment of the Special terms and Conditions of Waiver 11-W-00193/9. This amendment to California's Bridge to Reform Waiver authorizes California to implement a new paradigm for Medicaid eligible individuals with substance use disorder (SUD) called the Drug Medi-Cal Organized Delivery System (DMC-ODS). Critical elements include:

- Providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services
- Increased local control and accountability
- Greater administrative oversight
- Creation of utilization controls to improve care and efficient use of resources
- Evidence based practices in substance abuse treatment
- Integrate care with mental health and physical health

TERMS

This Addendum commenced on July 1, 2018, and shall continue under the terms of the existing MOA.

OVERSIGHT RESPONSIBILITIES OF THE PLAN AND THE SDCBHS

1. The Plan has 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 through the Healthy San Diego Behavioral Health Work Group's Operations Team, as will any actions required to identify and resolve any issues or problems that arise.
2. The Healthy San Diego Behavioral Health Work Group's Operations Team will serve as the committee that will be responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the addendum to the existing MOA.
3. The Plan and SDCBHS will formulate a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. The Plan and SDCBHS will determine the final composition of the multidisciplinary teams to conduct this oversight function.
4. The Plan and the SDCBHS will designate as appropriate and when possible the same staff to conduct tasks associated within the oversight and multidisciplinary clinical teams.

SPECIFIC ROLES AND RESPONSIBLITIES

A. Screening, Assessment, and Referral

1. Determination of Medical Necessity

    a. SDCBHS will be responsible for determining and following medical necessity criteria outlined for the Drug Medi-Cal Organized Delivery System described in the 1115 Waiver Standard Terms and Conditions. DMC-ODS 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.
    b. The Plan will be responsible for determining medical necessity as it relates to covered health plan covered services, as outlined in 22 CCR51303(a).

2. Assessment Process
    a. The Plan and SDCBHS shall develop and agree to written policies and procedures regarding agreed-upon screening, assessment, and referral processes.
    b. SDCBHS and the Plan will make the most current version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC Adult & Adolescent) crosswalk available. The crosswalk 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.
    c. The Plan providers will ensure a substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services for Members, is available.
3. Referrals
    a. SDCBHS and Plan shall develop and agree to written policies and procedures regarding referral processes and tracking of referrals, including the following:
        i. SDCBHS will accept referrals from Plan staff, providers, and Members' self-referral for determination of medical necessity for substance use disorder services.
        ii. The Plan accepts referrals from SDCBHS staff, providers, and Members' self-referral for physical health services.

B. Care Coordination

1. The Plan and County will develop and agree to policies and procedures for coordinating health care for Members enrolled in the Plan and receiving substance use disorder services through SDCBHS.
2. An identified point of contact from each party to serve as a liaison and initiate, provide, and maintain the coordination of care as mutually agreed upon in Plan and SDCBHS protocols.
3. Coordination of care for substance use disorder treatment provided by SDCBHS 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. The County and the Plan will promote availability of clinical consultation for shared clients receiving physical health, mental health and/or SUD services, including consultation on medications when appropriate.
5. The delineation of case management responsibilities will be outlined.
6. Regular meetings to review referral, care coordination, and information exchange protocols and processes will occur with County and Plan representatives.

C. Information Exchange

1. SDCBHS and Plan will develop and agree to Information sharing policies and procedures and agreed upon roles and responsibilities for timely sharing of personal 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, Title 22 and 42 CFR part 2, governing the confidentiality of mental health, alcohol and drug treatment information. (See Attachment 2.6 for jointly developed policies and procedures).

D. Reporting and Quality Improvement Requirements

1. SDCBHS and Plan will have policies and procedures to address quality improvement requirements and reports.
   a. Hold regular meetings, as agreed upon by the SDCBHS and the Plan, to review the referral and care coordination process and monitor Member engagement and utilization.

E. Dispute Resolution Process

1. At this time, the Plan and SDCBHS agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Plans and the State Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). A dispute will not delay member access to medically necessary services and the referenced process is outlined in Section 2.1.8 (Resolution of Disputes).

F. Telephone Access

1. SDCBHS must ensure that Members will be able to access services for urgent or emergency services 24 hours per day, 7 days a week.
   a. The “no wrong door” approach will be utilized by SDCBHS to ensure service access. There will be multiple entry paths for beneficiaries to access substance use disorder services. Referrals may come from primary care physicians, providers, Plan staff, County Departments, and self-referral by calling SDCBHS’ 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

1. The Plan and SDCBHS shall determine the requirements for coordination of Member and provider information about access to Plan and SDCBHS covered services to increase navigation support for beneficiaries and their caregivers.

H. Point of Contact for the MOA Addendum

1. The Point of Contact for the MOA Addendum will be a designated liaison from both SDCBHS and the Plan.