C. Practice Guidelines

Practice guidelines refer to methods and standards for providing clinical services to members. The BHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs Welfare and Institutions Code 14184.402. They are based on clinical consensus and research findings as to best practices and evidence-based practices available. Because they reflect current best practices, the guidelines may change as new information and/or technology becomes available.

As these changes occur, the BHP is responsible for disseminating the guidelines to Providers, as well as ensuring that changes being made are done so with consideration to the needs of the consumers. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. The BHP collaborates with Providers as needed, with continuous feedback channels established through various venues including Provider Association Executive meetings and Quality Improvement subcommittee meetings, Quality Improvement Partners (QIP) meetings and various Level of Care Program Manager meetings. .

Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the member's service needs. Members shall be routinely asked, at the time of accessing services, about their needs for language assistance. Providers must document the offer and whether linkage was made to interpreter service for members requesting or needing translation services in threshold or other languages.

BHS policy prohibits the expectation that family members, including minor children will provide interpreter services., If members choose to use family or friends, this choice also should be documented. To comply with State and federal regulations, providers must be able to provide information on Behavioral Health Plan (BHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

If program staff are not available to meet the language needs of a member, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. The County contracts with several vendors to provide written translation and interpreter services, including ASL.

County operated programs can contact Interpreters Unlimited at (800) 726-9891 to arrange for language assistance, including ASL,for reoccurring and/or one-time meetings occurring both virtually and in person. Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website, San Diego's Insite- Purchasing & Contracting > Language website.

Member Deaths

All member deaths must be reported promptly and in accordance with County requirements. Notify both the HIMS department and the County MEDS Coordinator when a member passes.

1. Submit a BHS 025 Form with date of member death in the comments

2. Send an email to 37Crdnt.HHSA@sdcounty.ca.gov including:

    i. Member Name
    ii. Social Security Number
    iii. Date of Birth
    iv. Date of Death

Retain a copy of the sent email(s) as documentation of compliance. Death reporting is monitored by QA as part of the Medi-Cal recertification process. The program should ensure all documentation is entered within the EHR prior to emailing these departments

Please reference the Optum Website > *Incident Reporting tab* to determine if the member death also requires a Critical Incident Report (CIR).

Admission Policies, Procedures and Protocols

Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that members are admitted to treatment regardless of anticipated treatment outcome that are in line with harm reduction principles. Policies shall also comply with the entry criteria and priority as defined by the contracts.

In the occasion that providers should exclude members from their program (example: member become violent), providers are to engage in warm hand-offs to appropriate services. Medi-Cal members are entitled to receive Medi-Cal services. Providers should consult with their legal entity and/or CORs when excluding Medi-Cal members from receiving services.

Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for: W&I Code 14148.402 Access Criteria. The Target Population for Adult/ Older Adult BHS programs include:

- Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.

- People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational, and educational goals.

This criterion applies to all members, including Medi-Cal and indigent members.

Coordination of Care & Transitioning Planning

Coordination of care among service providers is essential to ensuring continuity of care for members and supporting an efficient behavioral health system. Providers are expected to complete a **warm handoff** when transitioning members between services to promote continuity of care and facilitate successful linkage to the receiving provider. Providers shall develop discharge plans that support members transitioning between the same or different levels of care, including transitions to services outside the Behavioral Health Services (BHS) system of care.

This may include the referring provider contacting and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage.

As appropriate, the warm handoff may include the referring provider establishing collaborative communication with a designated staff member responsible for intake at the receiving provider, arranging transportation to the receiving provider, and supporting appointment attendance. Providers should confirm and document that the member has successfully linked to the receiving provider, including completion of a face-to-face appointment when applicable.

Long Term Members

The BHP defines a long-term member as an individual who receives behavioral health services for more than sixty (60) days following admission to a behavioral health program. Long-term members are expected to have a completed behavioral health assessment, problem list, and care plan, as applicable.

Medication-Assisted Treatment (MAT) and Overdose Prevention

Members diagnosed with a primary or co-occurring opioid use disorder and/or alcohol use disorder should be offered a referral for an assessment for Medication-

Assisted Treatment (MAT), as clinically indicated. Although recommending specific medications is outside the scope of practice for non-prescribing staff, staff may recommend a referral for a MAT assessment during intake and at other points throughout the treatment process, as appropriate.

Staff are encouraged to use motivational interviewing to support members in exploring medication treatment options when clinically appropriate. Members with an opioid use disorder and/or stimulant use disorder should also be referred or linked to naloxone access and overdose prevention services, as appropriate, to reduce the risk of overdose.

Program policies and procedures shall address clinical training and supervision to ensure staff can provide appropriate MAT referrals when clinically indicated, including during treatment and following an overdose. Training and supervision should also address access to naloxone, particularly for members with an opioid use disorder who decline a MAT referral, to support overdose prevention and member safety.

Transition of Care Tool

Completion of the Transition of Care Tool for Medi-Cal Mental Health Services is required when facilitating applicable transitions of care between the Behavioral Health Plan (BHP) and Managed Care Plan (MCP) delivery systems, including transitions from Specialty Mental Health Services (SMHS) to Non-Specialty Mental Health Services (NSMHS), and when coordinating additional services across delivery systems, consistent with applicable requirements.

The TOC Tool supports continuity of care by leveraging existing clinical information to document a member's mental health needs and facilitate referrals for transitions of care or additional services through the MCP or BHP, as appropriate. Members may transition all or a subset of their mental health services to another delivery system based on their individual needs. The tool applies to both adults and youth. The TOC Tool supports members in achieving and maintaining the highest possible level of stability and independence. The BHP System of Care requires providers to assign each member a care coordinator who serves as the single point of accountability for rehabilitation and recovery planning through service coordination and linkage to appropriate resources. The BHP monitors coordination of care to support continuity and effective service delivery.

Purpose and Required Information

The TOC Tool communicates relevant member information from the referring entity to the receiving delivery system to support a coordinated transition or referral. It includes fields for the following information:

- Referring plan contact information and care team.
- Member demographics and contact information.

- Behavioral health diagnoses, cultural and linguistic needs, presenting behaviors and symptoms, environmental factors, behavioral health history, medical history, and current medications.

- Services requested and receiving plan contact information.

Additional supporting documentation, such as medical history reviews, care plans, and medication lists, may be attached to the tool as appropriate.

The TOC Tool is intended to facilitate coordinated care when:

- **Existing services need to transition** to another delivery system, such as from BHP SMHS to MCP NSMHS or to substance use disorder services, as applicable.

- **Additional services are needed** from another delivery system while the member continues receiving existing services. This includes coordination consistent with *No Wrong Door* policies regarding concurrent treatment under Welfare and Institutions Code section 14184.402(f), BHIN 22-011, and APL 22-005, as well as applicable continuity-of-care requirements under MHSUDS Information Notice 18-059 and APL 18-008, or subsequent updates.

Limitations

Completion of the TOC Tool does not constitute a clinical assessment and does not replace:

- BHP policies and procedures addressing urgent or emergency care needs, including crisis response and urgent or emergent referrals.
- BHP protocols for ensuring clinically appropriate, timely, and equitable access to care.
- Required clinical assessments, level-of-care determinations, or service recommendations.
- BHP requirements to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Administration of the TOC Tool

BHPs are required to use the TOC Tool to facilitate applicable transitions of care to MCPs for members of all ages, including adults age 21 and older and youth under age 21, when their service needs change. The decision to transition services to another delivery system or add services from the MCP must be made by a clinician through a **patient-centered, shared decision-making process**, consistent with BHP protocols.

Once the clinician determines that a transition or referral for additional services is appropriate, the TOC Tool may be completed by a clinician or non-clinician. Clinicians include provider types identified as providers of Rehabilitative Mental Health Services in Supplemental 3 to Attachment 3.1.A, pages 2m–2p, of the California Medicaid State Plan.

Non-clinicians may include administrative staff, peer support staff, or other professionals who do not meet the definition of a clinician.

Members must be engaged in the process, and appropriate consents must be obtained in accordance with accepted standards of clinical practice. The tool may be completed in person, by telephone, or by video conference. The TOC Tool must be completed in the electronic health record (EHR). A downtime PDF version is available on the Optum website. If the downtime version is used, the completed document must be scanned into the EHR. Additional supporting documentation, such as medical history reviews, care plans, and medication lists, may be attached as appropriate.

Follow-Up

After the Transition of Care Tool is completed, the member shall be referred to their MCP. Consistent with BHIN 22-011, APL 22-005, and subsequent updates, BHPs must coordinate with MCPs to facilitate transitions of care and referrals for additional services. Coordination must include ensuring that:

- The referral process has been completed.
- The member has been connected with a provider in the receiving delivery system.
- The receiving provider has accepted responsibility for the member's care.
- Medically necessary services have been made available to the member.
- All appropriate consents have been obtained in accordance with accepted standards of clinical practice.

For MCP contact information related to the TOC Tool, refer to the Screening and Transition of Care Contact Card, available on the Optum website under the *Healthy San Diego* page. The TOC *Tool* and its *Explanation Sheet* are also available on the Optum website under the *UCRM* tab.

Members Who Must Transfer to a New Provider

Many members are unable to complete an entire treatment episode with the same therapist or mental health worker. This happens because of staff resignations, program closings, member change of residence or placement, transition of youths to programs that serve Adults as clinically indicated and/or age appropriate, and completion of internships and field placements. Good clinical practice indicates that the following should be implemented whenever possible to ease transition.

The member and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least fourteen (14) days prior to the final visit with the first provider. The member and caregiver should be informed of the member's right to request a new provider. The member and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.

Report transfers on the *Suggestion and Provider Transfer Log*, which is found on the required Quarterly Status Report. The member should be assisted in making a first appointment with the new program. The old and new program/provider must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials. A thorough discharge summary (or a transfer note if the member will continue in the same program) should be written and incorporated into the chart. Final outcome tools should be administered if the member will go to another provider program. A written plan for emergency services should be developed with the member and caregiver, to include the ACL, the new program, and informal supports.

Transitional Age Youth (TAY) Transition Process

Youth receiving behavioral health services in the Children, Youth and Families Behavioral Health System of Care may require system coordination to successfully transition to the Adult/Older Adult Behavioral Health System of Care when they reach the ages of eighteen to twenty- one (18-21).

Planning and consultation with the youth prior to a referral is needed so that the planned services match the needs and desires of the transition aged youth. Clinical staff shall meet with the youth and their supports, including other system of care partners such as CFWB & Probation as applicable, to strategize about planned services as some youth may be best served by continued services in BHP programs that serve Children, Youth and Families, and for others a referral to BHP programs that serve Adults may be indicated. Involvement of the family in transition planning is integral when family is available. It is critical that the youth and family understand the differences within the BHP System of Care in terms of consent to treat and expectations of support systems.

The following considerations should be taken if the youth is also involved with the following sectors:

- Child and Family Wellbeing Services: In an effort to coordinate care with CFWB, a call to 858-694-5191can be made to access the name and phone number of a San Diego County foster youth's social worker. To access the name of a youth's Independent Living Skills (ILS) worker, the ILS INFO Line can be called at 866-ILS INFO (866-457-4636). The ILS INFO Line can also be used as the starting point for an eligible former foster youth to re-enter foster care after age 18. Additional information about ILS and transitional housing opportunities can be found at https://www.fosteringchangeforchildren.org/.

- Probation: If a youth has probation involvement, communication with the Probation Officer would be an important aspect of services.

- Education: If a youth has been in Special Education and did not receive a diploma, they are eligible for educational services through their school district until age 22. Their last school of attendance would be able to assist with school records and

educational placement. If there is any difficulty at the school site getting information, it is advised to contact either the Special Education Department Chair at that school site or the Vice Principal of Special Education. If a youth was not receiving Special Education services, they can be referred to "Adult Education" which is provided through the San Diego Community College District.

If a referral to a BHS program that serves Adults, it is recommended that a call to the selected program be made to discuss the referral process and to allow for some transition time when the youth can be introduced to the new program on a timeline that is comfortable to all parties. It is also recommended that visits with the youth, their supports, the existing provider, and the prospective provider occur, as this can be a helpful step in supporting a transition.

Procedures to follow if a routine referral is unsuccessful:

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the current program, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:

    - Referral Form/Cover Letter
    - Children's Behavioral Health Assessment and most recent update
    - The Mental Health Diagnosis
    - Youth Transition Evaluation
    - Mental Status conducted by psychiatrist within the last forty- five (45) days
    - Physical Health Information
    - Medication Sheet
    - Care Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
    - Psychological Testing done within past year (if available)
    - Individual Education Plan and Individual Transition Plan
    - Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
    - Any self-evaluations recently given to youth.

2. This packet shall be submitted with releases to the Behavioral Health Program Coordinator (BHPC) of Behavioral Health Services in the region where the youth resides. The BHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108. The BHPC will review the packet to determine if access criteria are met for SMHS and the Service Eligibility Policy.

3. If the member does not meet criteria to access SMHS, then the member shall be referred back to the referral source for services in the community. If the youth is eighteen (18) or over, an assessment will be requested from a BHS provider agreeable to the member and family. If the assessment indicated a Medi-Cal member does not meet criteria to access SMHS, a Notice of Adverse Benefit Determination (NOABD) will be issued, advising him/her of his/her rights to appeal the decision.

4. If a transition plan is agreed upon, the member's BHS program Case Manager or Care Coordinator will attempt to link the member with the appropriate service. If the linkage is not successful, the BHPC shall coordinate an initial meeting with a multidisciplinary support team within two (2) weeks of the initial referral that will include relevant persons that may include, but are not limited to, the following:

    - Youth
    - Support System as defined by the youth/family (i.e. parent, social worker, family members
    - Existing BHS Program Case Manager and /or Therapist
    - Current Psychiatrist
    - Children, Youth and Families BHS Contracting Officer's Representative (CORS), or designee
    - New Program BHS COR if applicable, or designee
    - Probation Officer (if applicable)
    - CFWB Social Worker (if applicable)
    - Education/Vocational Specialist

5. Team will review youth defined needs and options and create a transition plan, The Care Coordinator will include a copy of the transition planin the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified, and same procedure followed.

Post Discharge Coordination of Care

New members discharged from a twenty- four (24)-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within seventy-two (72) hours, unless deemed Urgent, as indicated below. Current members discharged from an acute care twenty-four (24) hour facility (hospital or crisis house) must receive a high-risk assessment within a clinically appropriate timeframe and thereafter anytime a member presents with risk factors. The County of San Diego is defining a "clinically appropriate

timeframe" as between seventy- two (72) hours and five (5) days post discharge. If the risk assessment cannot be completed for any reason within timeframes the documentation must at minimum document attempted efforts to complete the risk assessment and/or reasons why it was not completed on time.

If the referral is deemed urgent, member shall be seen within forty-eight (48) hours of contact with program. A need for urgent services is defined in 8 HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21) health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.

The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. Compliance to this standard is monitored through the Quality Assurance Program Review process.

Requests for Continuity of Care

Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State (and BHP) to have in effect a transition of care policy to ensure continued access to services during a member's transition from Medi-Cal fee-for-service (FFS) to a managed care program or transition from one managed care entity to another, when the member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

All eligible Medi-Cal members who meet access criteria for SMHS have the right to request continuity of care. Members with pre-existing provider relationships who make a continuity of care request to the county BHP must be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the BHP or a contracted organizational provider, provider group, or individual practitioner).

This policy applies to all Medi-Cal members who are transitioning as follows:

- The provider has voluntarily terminated employment or the contract with the BHP.
- The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.
- Transitioning from one county BHP to another county BHP due to a change in the member's county of residence.

- Transitioning from an MCP to an BHP; or,

- Transitioning from Medi-Cal FFS to the BHP.

A member, the member's authorized representatives, or the member's provider may make a direct request to an BHP for continuity of care. Members may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request. BHPs must provide reasonable assistance to members in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

Member and Provider Outreach and Education

BHPs must inform members of their continuity of care protections and must include information about these protections in member informing materials and handbooks. This information must include how the member and provider initiate a continuity of care request with the BHP. The BHP must translate these documents into threshold languages and make them available in alternative formats, upon request. BHPs must provide training to staff that come into regular contact with members about continuity of care protections.

Continued Care Criteria

After the admission criteria for a given level of care have been met, it is appropriate to retain the member at the present level of care if:

- The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan or making progress on identified problems on problem list.

- The member continues to work toward treatment goals or problems

- The member is not yet making progress but has the capacity to address his or her problems.

- The member is actively working on the goals articulated in the individualized treatment plan or working on identified problems on problem list.
- New problems have been identified that are appropriately treated at the present level of care. The current level of care is the least intensive at which the member's new problems can be addressed effectively.

Timeline Requirements

Each continuity of care request must be completed within the following timelines:

- Thirty (30) calendar days from the date the BHP received the request.

- Fifteen (15) calendar days if the member's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

- Three (3) calendar days if there is a risk of harm to the member.

BHPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided to a member under the following circumstances:

- The provider meets the continuity of care requirements.

- Services were provided after a referral was made to the BHP (this includes self-referrals made by the member); and,

- The member is determined to meet criteria for access to SMHS.

A continuity of care request is considered complete when:

- The BHP informs the member and/or the member's authorized representative, that the request has been approved; or,

- The BHP and the out-of-network provider are unable to agree to a rate and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,
- The BHP has documented quality of care issues with the provider and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,

The BHP makes a good faith effort to contact the provider, and the provider is non-responsive for thirty (30) calendar days and the BHP notifies the member and/or the member's authorized representative that the request is denied.

Continuity of Care Reporting Requirements

BHPs are required to report to DHCS all requests, and approvals, for continuity of care. The BHP must submit a continuity of care report, with the BHPs quarterly network adequacy submissions, that includes the following information:

- The date of the request;

- The member's name;

- The name of the member's pre-existing provider;

- The address/location of the provider's office; and,

- Whether the provider has agreed to the BHPs terms and conditions; and,

- The status of the request, including the deadline for deciding regarding the member's request.

Continuity of Care Requests Processed by the Administrative Services Organization (ASO)

All continuity of care requests shall be directed to the Administrative Services Organization (ASO), Optum. Optum will manage all continuity of care requests for the Behavioral Health Plan (BHP). Providers shall notify all members with existing non-BHP providers that continuity of care requests are available as the member transfers care over to the BHP. Providers are expected to assist members and work directly with Optum to ensure a smooth transfer of care. To begin the process, instruct the member to call the Access and Crisis Line and initiate the Continuity of Care request.

Requirements Following Completion of Continuity of Care Request

If the provider meets all the required conditions and the member's request is granted, the BHP must allow the member to have access to that provider for a period of up to twelve (12) months, depending on the needs of the member and the agreement made between the ASO on behalf of the BHP and the out-of-network provider. When the continuity of care agreement has been established, the BHP must work with the provider to establish a Care Plan and transition plan for the member.

Upon approval of a continuity of care request, the BHP must notify the member and/or the member's authorized representative, in writing, of the following:

- The BHPs approval of the continuity of care request.

- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period; and

- The member's right to choose a different provider from BHPs provider network.

The written notification to the member must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

- The BHPs denial of the member's continuity of care request.

- A clear explanation of the reasons for the denial.

- The availability of in-network SMHS.

- How and where to access SMHS from the BHP.

- The member's right to file an appeal based on the adverse benefit determination; and,

- The BHPs member handbook and provider directory.

At any time, members may change their provider to an in-network provider whether or not a continuity of care relationship has been established. BHPs must provide SMHS and/or refer members to appropriate network providers without delay and within established appointment time standards.

The BHP must notify the member, and/or the member's authorized representative, thirty (30) calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

Repeated Requests for Continuity of Care

After the member's continuity of care period ends, the member must choose a mental health provider in the BHPs network for SMHS. If the member later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the BHP for SMHS, the twelve (12) month continuity of care period may start over one time.

If a member changes county of residence more than once in a twelve (12) month period, the twelve (12) month continuity of care period may start over with the second BHP and third BHP, after which, the member may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the BHP should communicate with the BHP in the member's new County of residence to share information about the member's existing continuity of care request.

Validating Pre-existing Provider Relationships

An existing relationship with a provider may be established if the member has seen the out-of-network provider at least once during the twelve (12) months prior to the following:

- The member establishing residence in the county.
- Upon referral by another BHP or MCP; and/or,
- The BHP determining the member meets criteria for access to SMHS.
- A member or provider may make available information to the BHP that provides verification of their pre-existing relationship with a provider.

Following identification of a pre-existing relationship with an out-of-network provider, the BHP must contact the provider and make a good faith effort to enter a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the member.

Discharge Criteria

It may be appropriate to transfer or discharge the member from the present level of care if the following criteria are met:

- The member has achieved the goals articulated in their individualized treatment plan or resolved problems identified on the problem list, thus resolving the need(s) that justified admission to the current level of care.

- The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan or problem list. Treatment at another level of care or type of service therefore is indicated

- The member has demonstrated a lack of capacity to resolve their problem(s). Treatment at another level of care or type of service therefore is indicated;

- The member has experienced an intensification of their problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Providers should clearly document and communicate the member's readiness for discharge or need for transfer to another level of care. If the criteria apply to the existing or new problem(s), the member should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

Provider Termination of Services

Providers shall make a good effort to give written notice of a termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Providers shall report to the QA Unit and COR upon receiving any changes affecting the Provider Directory. The BHP shall update the paper Provider Directory monthly. The BHP shall update the electronic provider directory no later than thirty (30) days after receiving updated provider information. The BHP does not currently offer any physician incentive plans.

Telehealth Services

Each telehealth provider is required to be licensed in California and enrolled as a Medi-Cal provider. If the provider is not located in California, they must be affiliated with

an enrolled Medi-Cal provider group (or border community) as indicated in the Medi-Cal Provider Manual. Each telehealth provider must meet the requirements of Behavioral Health Information Notice (BHIN 23-018), BPC Section 2290.5(a)(6), or equivalent requirements under California law in which the provider is licensed.

Existing Medi-Cal covered services may be provided via telehealth modality if all the following criteria are met:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment, and that the member has a right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit

2. The member has provided verbal or written consent, at least once prior to initiating applicable health care services via telehealth, and it has been documented in the medical record

3. An explanation that the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time by the Medi-Cal member without it affecting their ability to access covered Medi-Cal services in the future,

4. The member has been provided with an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted

5. The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site

6. An explanation of the potential limitations and risks related to receiving services through telehealth as compared to an in-person visit to the extent that any limitations or risks are identified by the provider

7. The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and

8. The services provided via telehealth meet all laws regarding confidentiality of health care information and a member's right to the member's own medical information.

Medi-Cal providers have the flexibility to determine if a service is clinically appropriate for telehealth via audio-visual two-way real time communication. No limitations are placed on origination or distant sites. Providers must use the applicable billing indicators for services delivered via telehealth.

Videoconferencing Guidelines for Telehealth

Telehealth services are designed to assure timely access of routine and urgent mental health and psychiatric services to reduce emergency and acute hospital inpatient services Specialty Mental Health Provider; hereafter referred to as "telehealth provider" will perform various specialty mental health services via tele-video linkage when an on-site mental health provider is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged.

When telehealth is being utilized between two program sites, the site where the telehealth provider is located who will provide the mental health service will be termed "distant" site and the site where the mental health services are being received by the member will be termed the "originating" site. This practice also extends mental health services to members in remote areas of the county.

The standards of telehealth practice will be the same as for on-site mental health services as described in the California "*Telehealth Law of 2012*". County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telehealth services.

1. Use a secure, trusted platform for videoconferencing.

2. Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.

3. Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any member data locally, but if it must, it should be encrypted.

4. Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

5. Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in

which you practice. Just because software says its HIPAA-compliant is not enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, "all technologies" perspective.

6. It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

7. When reviewing software options, you will notice that many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.

8. County operated programs shall connect to the County's secure network when providing telehealth services as the network meets the above requirements and is a trusted platform for videoconferencing. Hardware shall be installed by the County's IT department.

NOABD Log

The BHP programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of eighteen (18), plus seven (7) years.

- All BHP programs shall maintain on site a monthly NOABD Log.
- Programs shall include the following in their NOABD Logs:
    - Date NOABD was issued.
    - Member identification number/medical record number
    - Mode of NOABD Delivery
    - Member response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known.
        - Logs to contain copies of each NOABD and "Your Rights" forms attached.

- Logs to contain documentation of inability to contact the member, if applicable.
- Log to reflect "NO NOABD ISSUED" if none are issued within a month.
- NOABD Logs must be available for review at COR or QA request.

- Monthly logs are to be submitted to QA on a quarterly basis. Dates for submission are as follows:
  - Quarter One: October 15th
  - Quarter Two: January 15th
  - Quarter Three: April 15th
  - Quarter Four: July 15th

QA has developed an Excel NOABD Log that programs can use to track monthly NOABD's. If programs choose to create their own log, it must contain all the same elements listed above. All NOABD's will be stored in the Logbook, therefore not being stored in the member's individual chart.

Missed Appointment and Follow Up Standard

County of San Diego BHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. "Missed Appointment" policies and procedures shall cover both new referrals and existing members, and at minimum, include the following standards:

For new referrals: When a new member (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

For current members: When a member (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For members who are at an elevated risk and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the member's emergency contact, or initiating a welfare check.

Additionally, the policy shall outline how the program will continue to follow up with the member (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the members' whereabouts and admittance to different levels of care throughout the County (e.g., hospital, PERT or jail admissions). All providers shall have policies and procedures in place regarding the monitoring of missed appointments for members (and/or caregivers, if applicable).

All attempts to contact a new referral and/or a current member (or caregiver, if applicable) in response to a missed appointment must be documented by the program. "Elevated risk" is to be defined by the program and/or referral source.

Prior Authorization

On August 19, 2026 the Department of Health Care Services (DHCS) released BHIN 26-030 titled 'Authorization of Outpatient Specialty Mental Health Services (SMHS). The guidance stipulates that:

Behavioral Health Plans (BHPs) shall not require prior authorization for the following services/service activities:

- Intensive Home-Based Services (IHBS)
- Crisis Intervention (CIS);
- Crisis Stabilization (CSS);
- Mental Health Services, including initial assessment;
- Targeted Case Management (TCM);
- Intensive Care Coordination (ICC);
- Peer Support Services (PSS);
- Medication Support Services (MSS);
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Individual Placement and Support (IPS) Supported Employment
- Clubhouse Services
- Parent-Child Interaction Therapy (PCIT)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- High Fidelity Wraparound (HFW)
- Enhanced Community Health Workers (E-CHW)

Prior authorization or BHP referral is required for the following outpatient services:

- Day Treatment Intensive (DTI);
- Day Rehabilitation
- Therapeutic Behavioral Services (TBS);
- Therapeutic Foster Care (TFC);
- Assertive Community Treatment (ACT)

- Forensic ACT (FACT)

Details regarding prior authorization criteria and processes can be found on the Optum website> SMH & DMC-ODS Health Plans page> *Prior Authorization* tab.

Utilization Management

Utilization Management (UM) is required for service providers across all levels of care, including outpatient, crisis residential, and case management programs. The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, medication services, and case management services. Authorization decisions are based on the access criteria delineated in Welfare and Institutions Code section 14184.402 and relevant DHCS guidance. The BHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for mental health treatment programs.

Although specific utilization review processes may vary based on the program and level of care, all providers participating in UM must establish an internal Utilization Review Committee (URC) and adhere to the minimum requirements outlined below. These requirements include standards for committee membership, clinical review, authorization decisions, documentation, and maintenance of utilization review records.

Utilization Review Criteria

Members who have been receiving services for more than two (2) years must be reviewed by the Utilization Review Committee (URC) to evaluate the clinical appropriateness and continued need for services based on the access criteria outlined in DHCS BHIN 26-002 or any superseding DHCS guidance. Other members may also be referred for utilization review based on treatment team recommendations when clinical justification is needed to support continued services. Reviews should consider whether the member continues to meet the program's target population and applicable access criteria, demonstrates benefit from services, and has an ongoing medically necessary need for treatment.

Utilization Review Committee (URC)

Each program must maintain an internal Utilization Review Committee (URC) responsible for reviewing member records and conducting the utilization review process. The committee must meet the following minimum requirements:

- **Committee Composition:** The URC must consist of at least three (3) staff members. The chairperson must be a licensed, registered, or waivered mental health clinician. At least two (2) additional members must be staff who provide direct services or clinical oversight.

- **Independence of Review:** The requesting clinician may provide clinical information and recommendations but cannot participate in authorization decisions regarding their own client.

- **Review Frequency:** The URC must review a minimum number of members quarterly, as established by the Legal Entity's policy.

- **Documentation and Review:** The committee must review the member's services, treatment plan, Utilization Management (UM) Request Form, and updated Care Plan/Client Clinical Problem List to support its determination and document the results of the review.

- **SmartCare Documentation:** Member service reviews must be conducted through SmartCare. Members who have not received services for six (6) months or longer should be considered for discharge, as appropriate.

- **UM Form Review:** The completed UM Form must be reviewed by the program manager or designee within five (5) business days. The program manager or designee must be licensed.

- **Authorization Determination:** The program manager or designee reviews the clinical recommendation and may agree with the primary provider's recommendation or recommend a different level of service. The final determination must be made following consultation and agreement between the program manager or designee and the primary provider.

- **Medical Record Maintenance:** The completed UM Form must be maintained in the member's medical record.

- **Continued Monitoring:** Members approved for ongoing services must remain on an established UM review cycle to evaluate continued eligibility and clinical appropriateness for services.

The URC operates at the program level and bases its decisions on whether the member continues to meet applicable access criteria and requires the requested level of care. The committee works collaboratively with the treating clinician to determine whether proposed services are medically necessary, appropriate to the member's current needs, and likely to support progress toward treatment goals or address identified needs documented on the *Client Clinical Problem List.*
Secondary and subsequent UM reviews must also be conducted by the program-level URC to evaluate the continued appropriateness and authorization of services.

Utilization Review Documentation and Oversight

Utilization review is a **never-billable activity**. Each program must maintain URC logs documenting utilization review activities and outcomes. These logs must be available for review by the Behavioral Health Plan (BHP) upon request. As part of the Quality Assurance Program Review (QAPR), QA Specialists will review completed UM Forms and evaluate the program's compliance with its quarterly URC review requirements. Questions regarding the utilization review process should be directed to the Quality Assurance (QA) Unit.

Utilization Review for Outpatient Level of Care Programs Serving Adults

Each program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of continuation of medically necessary treatment and level of services indicated. These decisions will be based on Welfare and Institutions Code Section 14184.402 and most recent DHCS BHIN criteria for diagnosis, impairment and interventions. All UR decisions shall be supported by chart documentation of the member's individual functioning level, symptoms, and needs.

URC review will be required as clinically determined by program protocols and at minimum, after two years of outpatient services enrollment. . The URC may only authorize up to one year of service at the same level. (Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability). .

Providers shall utilize the BHS Adult Outpatient Utilization Management Form posted on the Optum website under the SMH & DMC-ODS Health Plans page under the *UCRM* tab. This form provides an overview of overall functioning along with the primary domains reviewed to inform clinical decision-making and level-of-care recommendations.

Case Management (CM) programs shall utilize the Case Management Six-Month Review Progress Note to document medical necessity and service level of care criteria for continuing services and CM URC specific forms found on the Optum website under the SMH & DMC-ODS Health Plans page under the Forms tab.All URC Records shall be maintained and be available for review as needed by the QA unit.

Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (ACT) services require prior and ongoing authorization; this review is conducted by Optum and details including criteria, timelines and the request form can be found on the Optum website under the SMH & DMC-ODS Health Plans page under the *Prior Authorization* tab.

Utilization Review for Crisis Residential Programs

Each crisis residential program meets the utilization management requirement through the service authorization process conducted by the County's Administrative Services Organization (ASO), Optum. Referrals to crisis residential level of care can be made directly to the intake staff but do require initial authorization from Optum. Crisis residential intake staff shall submit the initial authorization request, documenting access criteria for crisis residential level of care, to Optum for review. Optum will review the initial authorization request form to identify if crisis residential services are medically necessary and respond to the provider with a final determination.

For continued stay services, the crisis residential program shall submit requests for concurrent authorization review based on the member's need. Optum will then reauthorize, as appropriate, concurrently with the members' stay based on the continued need for services.

Crisis residential programs invite members to attend their treatment team meeting when continuation of care is being discussed. Should members decline to attend the treatment meeting, staff will have input from the member prior to the meeting and will meet with the member again following the meeting to review the request for concurrent authorization determination. The treatment team meeting will be documented and submitted to Optum along with the request for concurrent authorization. The authorization determination shall be maintained in the member's hybrid chart.

If a request for authorization is incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmits with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review for Day Treatment Intensive and Day Rehabilitation Services

Utilization review of Day Treatment Intensive and Day Rehabilitation services for Medi-Cal members is delegated to Optum and managed on a twelve (12) week cycle for IOP & and a four (4) week cycle for PHP. The Day Service Request (DSR) for IOP and PHP states that the member cannot be served at a lower level of care and that a recommendation for intensive services has been made. If access or service necessity criteria are not met, the Medi-Cal member will be issued an NOABD (which must also be documented in the NOABD log) and the member rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD shall be issued by Optum. Programs are responsible to check monthly all Medi-Cal and UMDAP members for eligibility and update the MIS as appropriate. Authorizations should be filed in the medical record in the Plans section or be accessible upon request. Without authorization approval services may not be billable.

Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4. Without authorization approval services are not billable. Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4. Additional resources for IOP/PHP services, including criteria and timelines for initial and continuing authorizations, can be found on the Optum website, SMH & DMC-ODS Health Plans page> *Prior Authorization* tab.

Utilization Review for Outpatient Programs Serving Children/Youth

Child/Youth members receive treatment services that focus on the primary areas of need identified/confirmed by the member/family and conclude when those are stabilized. The focused model shall be communicated at the onset of treatment so the member/family can maximize use of sessions and be prepared for conclusion of treatment.

Members who meet the access criteria for specialty mental health services shall be eligible for up to six (6) months of treatment sessions , with the exception of services provided in STRTPs which have a three (3) month UM cycle aligned with DHCS 90-day Clinical Review requirement. This will apply to Medi-Cal members and other eligible members outlined in this handbook. Additional treatment time may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

To continue beyond limited brief sessions members shall be reviewed through a Utilization Management process and must meet eligibility criteria by indicating how the Child/Youth meets Medical Necessity (per BHIN No. 26-003 or any superseding DHCS related requirements), and by specifying how services will be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR 438.210).

The Child/Youth UM Request form can be found on the Optum website, SMH & DMC-ODS Health Plans page> *UCRM* tab. Additional resources regarding STRTPs, including the specific STRTP UM form, can be found on the Optum website> SMH & DMC-ODS Health Plans page> *MH Resources* tab.

Integration with Physical Health Care

Coordination of care between physical and behavioral health providers is necessary to optimize the overall health of a member. All providers are expected to coordinate mental health care with a member's Primary Care Physician (PCP) and should have a policy and procedure in place regarding this coordination of services. Almost all Medi-Cal members are enrolled in one of the Medi-Cal Managed Care Plans (MCPs) that are part of Healthy San Diego (HSD). To find a list of included MCPs go to the *Healthy San Diego*

website. The "Healthy San Diego Medi-Cal Managed Care Plan Contact Card" is a helpful tool to use for coordination of care and is located on the Optum Website

Contracted providers are required by the BHP to complete the *Coordination with Primary Care Physicians and Behavioral Health Services* form with the member to facilitate coordination with the member's PCP. For members that do not have a primary care physician, provider shall connect them to a primary care facility. The Coordination with PCP form should be introduced at intake and completed no later than thirty (30) days upon opening the member to program services. Users of the form shall check the appropriate box at the top of the form noting the nature of the referral. Requesting member /guardian authorization to exchange information with primary care physicians is mandatory. Please see the *Coordination with PCP Explanation Sheet* on the Optum Website> *UCRM* tab for more information.

Clinical Consultation with Primary Care

Members with less severe problems or who have been stabilized shall be referred back to their Primary Care Physician or non-specialty mental health provider within the Managed Care Plan for continuing treatment. The Transition of Care (TOC) Tool found on the Optum website on the Healthy San Diego page shall be used for these transitions. To help support treatment by the Primary Care Physician, the BHP as well as organizational providers and County operated programs shall make clinical consultation and training, including consultation and training on medications, available to a member's health care provider for members whose mental illness is not being treated by the BHP or for members who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the BHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

Pharmacy and Lab Services

Each MCP has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each member's MCP to refer the member to the appropriate pharmacy or lab. HSD website lists all the contracted pharmacy or lab services for each Medi-Cal MCP. Additionally, the member's MCP enrollment card has a phone number that providers and members can call to identify the contracted pharmacy or lab. Providers must use the health plans contacted lab vendor.

Psychiatrists may order the following lab studies without obtaining authorization from the member's Primary Care Physician: CBC and Liver function study: Electrolytes, BUN or Creatinine, Thyroid panel, Valproic acid, Carbamazapine, Tricyclic blood levels, Lithium level.

All other lab studies require authorization from the member's Primary Care Physician. It is recommended that each provider contact the member's MCP Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the member's Primary Care Physician.

Medi-Cal members who are not members of a Medi-Cal MCP may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible members with complex needs often engaged with several systems of care. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. While this benefit is provided by the member's Managed Care Plan (MCP) – it may include engagement and collaboration with our BHP system of care providers to refer members and coordinate care. BHP providers should be familiar with the basics of ECM and the Populations of Focus (described below) that are eligible for this benefit and make the appropriate referral to the member's Managed Care Plan for ECM services, when appropriate.

Enhanced Care Management is available to specific groups (aka "Populations of Focus"):

- Adults and families experiencing homelessness
- Adults, youth and children at risk for avoidable hospital or emergency department care
- Adults, youth and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization.
- Adults transitioning back to the community from a residential nursing facility
- Children and youth enrolled in California's Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s).
- Children and youth involved in child welfare (foster care)
- Adults and youth transitioning back to the community after incarceration
- Pregnant and post-partum individuals, birth equity population of focus

For additional information and definitions, please see: ECM Policy Guide Updated January 2026.pdf (ca.gov)

Managed Care Plan (MCP) Enhanced Care Management (ECM) Referral Forms / Contacts

Providers should utilize the below links for ECM referrals and contacts – all referrals should be directed to the MCP using the below forms/email contacts:

Medi-Cal Managed Care Plan	Referral Form	Email Address
Blue Shield Promise	ECM Referral Form (blueshieldca.com)	Email: ECM@blueshieldca.com
Community Health Group	ECM Referral Form (chgsd.com)	Email: ecm-cs@chgsd.com
Kaiser	ECM Referral Form (kaiserpermanente.org)	Email: RegCareCoordCaseMgmt@KP.org
Molina	ECM Referral Form (molinahealthcare.com)	Email: MHC_ECM@Molinahealthcare.com

Non-Medi-Cal Members

Non-Medi-Cal clients who meet financial eligibility requirements may have their prescriptions filled at little or no cost or the Health and Human Services Agency Pharmacy at the Health Services Complex (3851 Rosecrans Street, San Diego, California, 92110). Contracted providers shall provide medications to non-Medi-Cal members who meet financial eligibility requirements. Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services. Providers shall make every effort to enroll members in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

Physical Health Services in a Psychiatric Hospital

Healthy San Diego Recipients: The member's HSD Medi-Cal MCP is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The member's MCP also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The health plans do not require prior authorization for the initial health history and physical assessment. All other physical health services provided while a member is in a psychiatric hospital require authorization from the health plan.

Transfers from Psychiatric Hospital to Medical Hospital : Psychiatric hospitals may transfer a member to a medical hospital to address a member's medical problems. Except in an emergency, the psychiatric hospital must consult appropriate MCP staff to arrange such a transfer for physical health treatment. It is the responsibility of the MCP

to pay for transportation in such cases. The Optum Health Medical Director or Liaison and the MCP Medical Director or Liaison will resolve any disputes regarding transfers.

Medical Transportation

HSD Medi-Cal MCPs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. MCP members who call the ACL for medical transportation are referred to the Member Services Department of their MCP to arrange such services.

Home Health Care

Clients who are members of one of the HSD Medi-Cal MCPs must request in-home physical health services from their Primary Care Physician. The MCP will cover at the Medi-Cal rate home health agency services 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. The BHP will pay for services solely related to the included mental health diagnoses. The MCP Case Manager and the Primary Care Physician coordinate on-going in-home treatment. The MCP is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the MCP.