



Navigating The Challenges of Medi-Cal's Mental Health Services in California:

An Examination of Care Coordination, Referrals
and Dispute Resolution

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Table of Contents

Executive Summary	4
Introduction.....	8
Background	10
Project Findings and Recommendations.....	22
Conclusion.....	49
Endnotes.....	50
Appendix A.....	64
Appendix B.....	83
Appendix C.....	85
Appendix D.....	91
Appendix E.....	93



Executive Summary

Background and Project Goals

Medi-Cal plays a crucial role in providing mental health services in California. In 2015, over 600,000 Californians – approximately two percent of the State’s population – received mental health services paid for by Medi-Cal. While Medi-Cal plays an important role in delivering necessary mental health services to Californians, many more go without the treatment they need. They are hampered by a fragmented system in which two entities are responsible for delivering mental health services to enrollees: a Medi-Cal Health Plan (MCP) is responsible for providing non-specialty mental health services (non-SMHS), and a County Mental Health Plan (MHP) is responsible for providing specialty mental health services (SMHS). This divided mental health delivery system too often leads to enrollee confusion and challenges in obtaining services, including information about their right to mental health services or how they can resolve disputes about those services. As a result, enrollees do not receive well-coordinated care to treat their mental health conditions. Until a more integrated approach to delivering mental health services exists in California, these problems will certainly continue.

This report aims to provide insight into Medi-Cal’s fragmented mental health system, and make recommendations for improving access by providing more coordinated care and referrals between MCPs and MHPs, and ensuring that enrollees receive accurate information about their rights that allows them to dispute decisions about their care when they disagree. It begins by providing an overview of the existing system and the rules that govern it. It then provides findings and recommendations on improving care coordination and referrals between MCPs and MHPs, and ensuring that enrollees receive the required information they need to resolve disputes.

Methodology

We identified two areas of focus: (1) Coordination of Care and Referrals and (2) Dispute Resolution. We reviewed guidance and tools used to ensure compliance with both of these focus areas. First, we analyzed how Memoranda of Understanding (MOUs) are used to coordinate referrals and transitions of care between MCPs and MHPs and to establish dispute resolution standards. Second, we analyzed State guidance and audit tools used to evaluate compliance with coordination of care and dispute resolution requirements. In particular, we looked at the MHP triennial review process and MCP annual medical audits to evaluate the extent to which they ensure compliance in the two focus areas. Third, we reviewed the processes and tools in place to evaluate the quality of services to determine whether they address coordination of care, referrals, and dispute resolution issues.

Project Findings

Coordination of Care and Referral Practices

We first evaluated coordination and referral practices by analyzing MOUs entered between MCPs and MHPs and relevant State-level plan guidance. MOUs are the primary tool used to ensure that enrollees receive coordinated care from both plans and that robust referral practices are in place for enrollees to get mental health services from the appropriate plan. However, our analysis demonstrated key deficiencies in the way DHCS informs plans of their obligations and evaluates language contained in plans’ MOUs.

DHCS issues separate guidance to MCPs and MHPs about their obligations to enter into an MOU. This separate guidance sometimes provides inconsistent information as to the responsibilities of each plan in coordinating care and lacks clarity with respect to the specific details that each MOU must contain. Moreover, while DHCS provides plans with an MOU template, the language included is not required and may be modified by plans as they see fit. The MCP guidance is also not consistent with the EPSDT obligations that both the MCPs and MHPs have with regards to the provision of SMHS and non-SMHS to children under 21.

We also found significant variation in how DHCS evaluates plans' compliance with the MOU requirements. While DHCS does not appear to periodically evaluate MOUs from the MCP perspective, the department conducts a comprehensive evaluation of MHP compliance through the MHP triennial review process. During this process, DHCS reviews the MOUs and analyzes whether they address: referral protocols, information about referrals to MCPs, and referrals from MCPs for SMHS. DHCS also reviews plan documentation on MOU monitoring activities; however, plans are currently not explicitly required to agree upon a monitoring procedure when entering into a MOU. These separate and inconsistent guidance and evaluation processes give rise to wide variation among MOUs, many of which do not provide comprehensive information on coordination of care.

DHCS has issued guidance letters to inform both plans of their responsibilities to provide mental health services. Both the MHP and MCP boilerplate contract language contain provisions governing coordination of care and referrals, but the guidelines contained in the MHP boilerplate are significantly more comprehensive than those in the MCP boilerplate. Moreover, although DHCS has issued other guidance to both MCPs and MHPs, it continues to issue separate and sometimes conflicting notice to the different plans, adding unnecessary confusion about coordination of care requirements.

DHCS has also produced a Beneficiary Model Handbook for both MCPs and MHPs to conform to changes in the federal regulations. Our review of these model handbooks identified a few deficiencies with regards to care coordination. For example, while the MCP handbook clearly delineates between the mental health services offered by the MCP and those offered by the MHP, it does not provide any information about the MCP's role in facilitating members' access to SMHS. Also, while most of the actual MCP handbooks substantially complied with the legal requirements, all MHP handbooks reviewed were outdated and none discussed care coordination with MCPs in detail.

To evaluate compliance with guidance on coordination of care, DHCS conducts periodic audits of both MCPs and MHPs. DHCS audits MHPs every three years, in a process called the triennial on-site review, during which DHCS reviews MHPs' compliance with requirements on MOUs, information exchange, clinical consultation, and referrals. In reviewing all Plans of Correction (POC) submitted by non-compliant plans during the past triennial cycle, we found that only three MHPs were reportedly partially out of compliance with care coordination requirements, suggesting that DHCS currently requests documentation to ensure that MHPs have entered into MOUs, developed referral protocols, and created other written agreements with MCPs, but does not extensively analyze how these agreements are being implemented in practice.

During the annual medical audits of MCPs, DHCS evaluates whether the MCP maintains procedures for monitoring the coordination of care provided to all members. To evaluate compliance with this requirement, DHCS considers whether the MCP maintains policies and procedures that address coordination of care and whether the MCP's policies and procedures address the delivery of medically necessary services within and outside of the MCP's network. However, our review of the medical audits and of Corrective Action Plans (CAPs) submitted by non-compliant plans reveals that, while the audits provide an opportunity to evaluate MCPs' compliance with care coordination and referral practices between MCPs and MHPs, DHCS does not utilize the audit process for this end.

Finally, we reviewed the External Quality Reviews (EQRs) for all MCPs and the statewide EQR Technical Report to determine whether they evaluate coordination of care. While EQRs addressed care coordination issues in general, they did not address deficiencies specific to care coordination and referral practices between MCPs and MHPs. We also reviewed Performance Improvement Projects (PIPs) for all MCPs and found nothing directly related to care coordination or referral between MHPs and MCPs. Similarly, while some MHP EQRs and PIPs address care coordination, none were specific to coordination with MCPs. On the other hand, the majority of MHP Quality Improvement Work Plans (QIWPs) did address care coordination with MCPs, covering improvements in: MOUs and MOU monitoring, consultation and training about psychiatric services to MCP providers, information sharing practices, and tracking of referrals between plans.

Dispute Resolution

We reviewed DHCS guidance and some of the tools described above to evaluate the extent to which they cover dispute resolution requirements and practices. First, we concluded that DHCS is not actively monitoring whether MCPs and MHPs reference dispute resolution policies and procedures in their MOUs, as neither the state guidance nor the MHP Triennial Review protocol incorporate dispute resolution practices into the evaluation of MOUs. Nonetheless, our review of actual MOUs revealed that some plans do refer to dispute resolution processes in their MOUs, with a number of plans using the agreement to provide for the sharing of plans' internal grievances and appeals processes and to ensure that both plans continue providing medically necessary services while a dispute is being resolved.

We also analyzed DHCS guidance on dispute resolution to evaluate whether it reflects State and federal requirements. Both the MCP and MHP boilerplate contracts contain information about dispute resolution, but none of the boilerplates has been updated to reflect changes made to the federal regulations in July 2017. DHCS has issued separate guidance on these changes, but the MHP guidance was released almost nine months after the changes went into effect. Not only was this delay unnecessary, it led to a failure by the MHPs to timely update their policies and notices as required by the federal regulations. We also found that the notice templates included with the guidance to the MCPs and MHPs were not entirely consistent. In particular, the guidance to the MCPs does not require that MCPs provide a denial notice when the plan denies the enrollee mental health services because it determines the person is eligible for SMHS, even though such a determination meets the definition of a denial requiring the plan to issue a proper notice.

With respect to plans' member handbooks, we found that while the MHP model handbook contains detailed description of members' rights to file grievances, appeals, and fair hearings, the MCP handbook lacks this level of detail. However, only the MHP model handbook has been appropriately updated since the changes to the federal regulations went into effect. We also found that while most of the actual MCP and MHP handbooks complied with dispute resolution requirements, they do not reflect the changes in federal law.

Finally, our research shows that DHCS evaluates MHPs' compliance with dispute resolution requirements through the triennial review process, where DHCS requests plans to submit, among other things: Grievance, Appeals, and Expedited Appeals Logs; Annual Beneficiary Grievance and Appeal Reports; and documentation of continued services for enrollees pending dispute resolution. An analysis of POCs from the past triennial cycle shows that most MHPs were found out of compliance, at least partially, with some or all of the dispute resolution requirements. Furthermore, we reviewed the most recent Medical Audit Reports and CAPs for MCPs and found that eleven MCPs have been found out of compliance with dispute resolution requirements. None of these dispute resolution issues were specific to mental health or SMHS, however, the broader dispute resolution issues and solutions raised permeate all services provided by MCPs, including mental health services and referrals to MHPs.

Recommendations

Based on the findings, we have identified specific recommendations related to the State level guidance to, and oversight and monitoring of, both MCPs and MHPs. In addition, we offer specific recommendations related to plan level policies and practices, including best practices and quality improvement. These recommendations relate to both coordination of care and referrals, and enrollees' right to information related to the dispute resolution process. The report provides more in-depth evaluation and detailed recommendations on both of those issue areas. A summary of the recommendations follows:

Overarching Recommendations

- DHCS should issue joint coordinated and consistent guidance to both MCPs and MHPs on the plans' obligations related to coordination of care, referrals, and dispute resolution policies.
- DHCS should ensure both the MCP and MHP Model Enrollee Handbooks include detailed information on covered mental health services, care coordination, referrals, notices, grievances, and appeals rights and monitor plans for use of the model.
- DHCS should develop a process to comprehensively review and approve MHP QIWs, including requiring MHPs to formally evaluate policies and practices for coordination and referrals and dispute resolution with MCPs.

Recommendations on Coordination of Care and Referrals

- DHCS should provide additional guidance requiring more consistency in MOUs between MCP and MHPs, including the development of a statewide model MOU template that includes a DHCS-created screening tool to be used across the State.
- DHCS should review each MCP's compliance with MOU requirements as part of its annual medical audits and review the MHP's compliance with the MOU annually, rather than triennially.
- DHCS should require the MCPs and MHPs to develop a shared process to track referrals made from one plan to another and include that in their MOU.
- DHCS should require the MCPs and MHPs to establish a data-sharing agreement in their MOUs.

Recommendations on Dispute Resolution

- DHCS should review and approve all MCP and MHP dispute resolution policies and template notices annually, make dispute resolution reporting for the plan types more uniform, and publish detailed reports analyzing plan dispute resolution practices for both MCPs and MHPs.
- DHCS should ensure MCPs and MHPs issue notices to enrollees when a plan declines to provide requested mental health services and instead refers the enrollee to the other plan, and that the notices clearly state the enrollee options for dispute resolution.
- DHCS should require MCPs and MHPs to post dispute resolution policies on the State's website, to develop a standardized dispute resolution process checklist to ensure that all appropriate steps are taken (including a timeline for each step on the checklist), and to establish a joint internal workgroup to monitor compliance with dispute resolution requirements for shared enrollees.

Introduction

Medicaid – known as Medi-Cal in California – is a predominant provider of mental health services in California. In 2014, as part of the Affordable Care Act (ACA) implementation, California expanded the availability of mental health benefits in Medi-Cal and brought the Medi-Cal scope of benefits in line with the benefits offered in private health plans in the State.¹ While this change expanded the scope of mental health benefits available to Medi-Cal enrollees, it made delivery and access to these services more complicated. Non-specialty mental health services (non-SMHS) are now available through Medi-Cal health plans (MCPs), while specialty mental health services (SMHS) are only available through County Mental Health Plans (MHPs).² When the various entities responsible for delivering mental health services to Medi-Cal enrollees are not well coordinated, patients go without needed services or get a lower level of care than their condition requires.

This paper examines the legal framework that governs the scope of mental health services available in Medi-Cal and the delivery system that is responsible for ensuring enrollees receive those services. It highlights recent legal developments in State and federal law that impact the mental health delivery system in California, as well as the existing mechanisms to evaluate plan compliance and quality of care. It presents findings from an in-depth analysis of the systems and structures in place designed to ensure that Medi-Cal enrollees receive coordinated and comprehensive mental health services. Finally, it provides recommendations about how the State of California, MHPs, and MCPs can better coordinate between delivery systems to ensure that all enrollees receive appropriate and coordinated mental health care when they need it.

A. Project Goals

A recent study by the California Health Care Foundation estimates that one in six California adults has a mental illness, and approximately one in 24 of California adults has a serious mental illness that impacts major life activities.³ Similarly, an estimated one in 13 children in California has a serious emotional disturbance.⁴ Low-income children and adults and people of color are more likely to experience mental illness.⁵ Yet despite the prevalence of mental illness in California, access to mental health treatment lags. Two of the regions where the prevalence of mental illness is highest, i.e., the San Joaquin Valley and Inland Empire, had the fewest licensed mental health professionals to provide treatment.⁶ Statewide, less than 40% of adults with a mental illness reported accessing treatment between 2011 to 2015, and even among those who sought treatment, over 17% were not able to obtain it.⁷ Among adolescents and adults who experienced a major depressive episode, approximately two-thirds did not receive any treatment.⁸ Medi-Cal is the payer for mental health treatment for a large number of Californians—over 600,000 Californians received mental health services paid for by Medi-Cal in 2015.⁹ Nationally, Medicaid pays for almost a third of mental health treatment.¹⁰

This project is intended to help address some of the barriers that impede access to mental health treatment in Medi-Cal, and identify ways the State can move to a more integrated and effective delivery system for mental health services in Medi-Cal. Based on our prior work (described in more detail below), we identified three core areas for this project. First, we looked closely at the data collection and transmission process in place to

coordinate initial referrals and transitions of care between MCPs, which are responsible for providing non-SMHS to their Medi-Cal enrollees, and MHPs, which are responsible for providing SMHS to Medi-Cal enrollees. Second, we reviewed the Memoranda of Understanding (MOUs) between MCPs and MHPs to analyze how they are used to coordinate referrals and transitions and identify best practices in crafting strong and useful MOUs. Third, we reviewed the processes in place for ensuring that both MCPs and MHPs provide enrollees and their families with complete and accurate information about their rights to mental health care, including their rights to appeal plan decisions with which they disagree.

B. Summary of Prior Work

This project builds on two years of prior work focused on improving coordination of mental health services for Medi-Cal enrollees. In 2016, NHeLP undertook a project to research the implementation of the non-specialty mental health benefit in Medi-Cal, identify problems, and make policy recommendations to address those problems. During the course of the project, NHeLP interviewed several key informants and analyzed over 100 MOUs between MCPs and MHPs. NHeLP's report and recommendations were published in January 2017.¹¹

Then, in a separate project, NHeLP surveyed over 70 legal, policy, and family advocates around the State to determine what service was most difficult for children with special health care needs to access. The survey identified mental health care and counseling as the most difficult to access service. NHeLP convened 17 advocates from around the State to discuss what particular barriers made this service so difficult to access and to develop some initial recommendations to address those barriers. Those recommendations were published in August 2017.¹²

Background

A. Legal Framework

Under federal Medicaid law, mental health services are an optional benefit for most populations.¹³ In addition, all state Medicaid programs must provide a broad array of services, including mental health services, to enrollees under age 21 pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate of the Medicaid Act.¹⁴ Since 1995, California has implemented these provisions in part through a 1915(b) Medicaid Waiver that authorized California's counties to provide SMHS through a prepaid inpatient health plan administered by each county.¹⁵ These plans are known as MHPs in California.

1. California's 1915(b) Waiver and Specialty Mental Health

California most recently renewed its 1915(b) waiver for a five-year period starting on July 1, 2015.¹⁶ The waiver continues to allow California to provide SMHS to Medi-Cal enrollees through the MHPs. SMHS covered through the waiver include: rehabilitative mental health services (which includes mental health, medication support, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment, crisis residential treatment, and psychiatric health facility services); psychiatric inpatient hospital services; targeted case management; psychiatrist services; psychologist services; and psychiatric nursing facility services.¹⁷ The waiver also sets forth medical necessity criteria for outpatient SMHS, consistent with California regulations; the criteria dictate that in order to receive SMHS, a person must have a listed diagnosis, and meet specified impairment and intervention criteria.¹⁸

Consistent with the EPSDT mandate, California requires MHPs both to use less stringent medical necessity criteria, and to provide a broader array of services to enrollees under age 21. Specifically, MHPs must comply with federal law that requires state Medicaid programs to provide services when they are necessary to correct or ameliorate a child's illness or condition.¹⁹ Compared to the adult medical necessity standard, which requires a more narrow showing that a person's mental health condition is causing substantial impairment and that the requested intervention is likely to significantly diminish the level of impairment or prevent further deterioration, the child standard requires that services be delivered whenever they can address or improve a child's mental health condition, and the condition cannot be addressed by a physical health intervention. Moreover, MHPs must provide mental health diagnostic services and treatment to enrollees under 21 when they meet those medical necessity criteria, even when requested services are "not otherwise covered . . . specialty mental health services."²⁰ In addition to the SMHS listed above, enrollees under age 21 have access to intensive home-based services, intensive care coordination, therapeutic behavioral services, and therapeutic foster care.

2. Non-Specialty Mental Health Services (Non-SMHS) in Medi-Cal

For many years, individuals with a mental health condition who were not eligible to receive SMHS through the waiver had few options to receive non-SMHS. Enrollees could access limited services through the fee-for-service delivery system: mental health services provided by Federally Qualified Health Centers (FQHCs), and up to two

psychotherapy sessions per month for adults when prior authorized.²¹ However, in general, before 2014, MCPs had a very limited role in delivering mental health care to Medi-Cal enrollees.

Starting in 2014, MCPs took an expanded role in delivering mental health services to their enrollees. As part of the ACA, starting on January 1, 2014, California was required to provide behavioral health services, including mental health services, to the Medicaid Expansion population.²² California has chosen to align its benefits for both populations, and thus provides the same scope of behavioral health services to all Medi-Cal enrollees.²³ To implement this alignment, California required MCPs to cover the following mental health services: 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; outpatient laboratory, drugs, supplies, and supplements; and psychiatric consultation.²⁴ While DHCS has been clear that “eligibility and medical necessity criteria for Medi-Cal specialty mental health services provided by MHPs have not changed pursuant to this policy. . . . MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning.”²⁵ For this reason, the scope of services provided by the Medi-Cal plans is sometimes referred to as “mild to moderate.” Importantly, however, children under age 21 are entitled to receive any mental health services that are medically necessary, regardless of the severity of their impairment (mild, moderate, or severe).

3. Relationship between Plans Providing Specialty and Non-Specialty Mental Health Services (Non-SMHS)

As MCPs implemented this new mental health benefit, DHCS renewed its 1915(b) waiver for SMHS. This waiver clarifies the relationship between the services MHPs provide and those the MCPs provide. It specifies that treatment for Medi-Cal enrollees who do not meet the “criteria for specialty mental health services (for example, excluded diagnoses, mental health conditions resulting in mild to moderate impairment of mental, emotional or behavioral functioning as well as all non-mental health medical conditions and services) . . . may be provided through other California Medi-Cal programs – primarily the Medi-Cal Managed Care Plans (MCPs) or the Fee-for-Service Medi-Cal (FFS/MC) program.”²⁶ The “mild to moderate” language has not appeared in prior versions of the waiver.²⁷ As described in more detail below, the use of this phrase has generated significant confusion among plans, providers, and enrollees.

DHCS recently issued new guidance to MHPs clarifying the medical necessity criteria for specialty mental health: “Medi-Cal beneficiaries that meet medical necessity criteria for SMHS [specialty mental health services] are entitled to receive medically necessary SMHS from their MHP MHPs may not use alternate criteria as a basis for determining SMHS medical necessity or making referrals to the MCP or a FFS Medi-Cal provider.”²⁸ The guidance does not use the words “mild to moderate.”

Memoranda of Understanding (MOUs) between the MCPs and MHPs are the primary vehicle for ensuring enrollee access to necessary and appropriate mental health services. MHPs are required by regulation to maintain MOUs with each MCP that contain a variety of elements of the coordination of enrollees’ care, including referral protocols, clinical consultation, care management, information sharing, provision of prescription drugs and laboratory services, and emergency care and transportation.²⁹ Additionally, the MOUs with MCPs must address the coordination of physical and mental health care,³⁰ a dispute resolution process,³¹ and the provision of medically necessary services pending resolution of disputes.³²

Similarly, DHCS is required to ensure MCP contracts include a process for screening, referral, and coordination with MHPs, and MCPs develop and maintain MOUs with the MHPs.³³ In 2014, MCPs were responsible for updating,

amending, or replacing existing MOUs with MHPs to account for the expansion of mental health services that were provided by the MCPs.³⁴ Each MCP must now conduct a mental health assessment for enrollees with a potential mental health condition using a tool mutually agreed upon with the MHP to determine the appropriate care needed.³⁵ The MOU should include a process for resolving clinical and administrative differences of opinion between the MCP and MHP (including dispute resolution).³⁶ Finally, the MOU must include identified points of contact for each party responsible for managing the MOU, overseeing quality improvement, and resolving disputes.³⁷

B. Recent Legal Developments

1. Behavioral Health Parity

Over the past several years, Congress has passed successive legislation aimed at improving access to behavioral health services in the private sector by requiring private plans that offer behavioral health benefits to do so in parity with covered medical and surgical benefits.³⁸ Over time, Congress has also extended the parity requirements to some Medicaid programs.³⁹ In March of 2016, CMS issued final regulations detailing the parity rules that apply in Medicaid. These regulations created a scheme for evaluating parity that is substantially similar to the parity requirements for large group, small group, and individual health plans.⁴⁰ The regulations required states to document their compliance with the parity requirements by October of 2017.⁴¹ Many states, including California, have made their compliance plan reports available online.⁴²

California's compliance report indicated that the State had made and was making several changes in order to fully address parity. Relevant to our research here, California reported that it was changing the rules governing service authorization timelines for MHPs to match the rules used for MCPs, and that it would issue guidance to require MHPs to provide continuity of care as is provided by the MCPs.⁴³ California also reported that it would implement uniform network adequacy standards for MHPs and MCPs.⁴⁴

2. Federal Medicaid Managed Care Regulations

In 2016, CMS also published major updates to its regulations governing Medicaid managed care plans, which apply to both the MHPs and the MCPs. This new rule on Medicaid managed care modernized and revised the current regulatory framework for managed care by increasing state and plan accountability for access and quality, and strengthening enrollee protections and network adequacy requirements. The rule provides more specificity as to how states must oversee their Medicaid managed care contracts and contains specific requirements for both coordination and referrals, as well as enrollee rights to dispute resolution through grievances and appeals. Those requirements are discussed in more detail below.

C. Legal Requirements for Monitoring and Oversight of MCPs and MHPs

The federal Medicaid Agency, the Centers for Medicare & Medicaid Services (CMS), provides some general oversight of MHPs and MCPs. For example, in order to receive federal Medicaid funding for services delivered through MCPs, DHCS must demonstrate to CMS's satisfaction that the plans meet the federal definitions for Medicaid managed care plans, and that the state's contract with the plans covers all of the areas set forth in the federal regulations.⁴⁵ To ensure it receives federal funding, DHCS must also obtain prior approval by CMS before allowing a MCP to begin delivering services to Medicaid enrollees.⁴⁶ If DHCS imposes or lifts sanctions on a contracted MCP, it must notify CMS.⁴⁷ CMS may sanction a MCP after a recommendation by the state.⁴⁸ Federal regulations require the state to have a comprehensive system for monitoring Medicaid managed care plans that covers all aspects of its contracts with the plans. The regulations require the state to collect data on enrollment and disenrollment, as well as encounter data. The federal regulations also require the state to monitor the MHPs and MCPs for compliance with various legal obligations, including provision of medically necessary services under their contracts, non-discrimination against enrollees, and providing factual information to the state and enrollees.

1. Federal Requirements for Coordination and Referrals

The final 2016 Medicaid managed care rule expands on the existing requirement for plans to coordinate care for enrollees. For new enrollees, the rule adds a requirement that plans conduct a screening within the first 90 days of enrollment to identify the enrollee's needs. The rule makes clear that plans not only have an obligation to ensure each enrollee has an ongoing source of appropriate care, but also that the plan assigns a person or entity to be primarily responsible for coordinating the enrollee's services. This designee must coordinate: (1) the services that the plan provides to the enrollee; (2) care during transitions from one setting to another; (3) any services the enrollee receives from another managed care plan; (4) any carved-out services; and (5) community and social support services. The new rule clarifies that Medicaid plans must ensure that their contracted providers maintain and share enrollee records, as appropriate, while complying with applicable privacy laws.

The new rule also clarifies special procedures that plans must follow to provide coordinated care to enrollees with special health care needs. The rule does not define the term "special health care needs," but continues to require that plans have procedures to identify, assess, and design a treatment plan for enrollees with special health care needs. In addition, the rule continues to require plans to allow these enrollees to see a specialist directly, for example, through a standing appointment without referral or prior authorization of an approved number of visits, where appropriate.

The new rule adds protections requiring states to ensure that enrollees can continue seeing their providers during certain times of transition. Specifically, the rule requires states to develop transition of care policies that permit enrollees to continue seeing their current providers who are out of network with their new plans when: (1) they move into a Medicaid managed care entity from FFS Medicaid, or when they change plans; and (2) without continuity of care, the enrollee is at risk of hospitalization or institutionalization. States have discretion to set the length of time that enrollees can continue to see their current providers who are out of network with their new plan.

The rule also requires states to develop a monitoring system for all managed care programs that addresses, among other things: claims management; the enrollee support system, including encounter data reporting, medical management, utilization management, and case management; provider network management, including provider directory standards; and the availability and accessibility of services, including network adequacy standards.

In addition to the specific plan coordination obligations described above, the federal rule also requires DHCS to develop model enrollee handbooks for both MHPs and MCPs and to ensure through contracts that all plans' enrollee handbooks include certain information specified by law.⁴⁹ The model handbook and plans' enrollee handbooks must provide information about plan benefits and how and where to access any benefits provided directly by the state, including, among others: the amount, duration, and scope of benefits available; information about procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care; any restrictions on the enrollee's freedom of choice among network providers; and the extent to which, and how, enrollees may obtain benefits from out-of-network providers.

Under the same federal managed care rule, DHCS developed a MCP and MHP Model Handbook, incorporating all the information that plans are required to include under federal law. Although DHCS did publish a model handbook for MCPs, DHCS did not release accompanying guidelines for MCPs to follow when developing their own enrollee handbooks. On September 26, 2018, DHCS released the MHP Model Handbook and Information Notice.⁵⁰

2. State Requirements for Coordination and Referrals

Under State law, DHCS must perform any evaluations or reporting required by the terms and conditions of its 1115 Waiver, the Medi-Cal 2020 Waiver.⁵¹ DHCS is also responsible for ensuring all contracts with Medi-Cal MCPs include a process for screening, referral, and coordination with MHPs for providing SMHS when an enrollee's diagnosis meets the medically necessary criteria.⁵² Similarly, DHCS is responsible for ensuring that MHPs have a process for "screening, referral, and coordination with other necessary services[.]"⁵³ This authority extends to ensuring that MHPs refer (adult) Medi-Cal enrollees diagnosed with mild-to-moderate impairment of mental, emotional, or behavioral functioning to the corresponding MCP.

In exercising this authority, DHCS has required each MHP to enter into a Memorandum of Understanding (MOU), or make good faith efforts to enter into a MOU, with each MCP in the county that includes protocols for referrals between the two plans. Specifically, MOUs must address:

- "How the MHP will provide a referral to the Medi-Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and
- How the Medi-Cal managed care plan will provide a referral when the Medi-Cal managed care plan determines specialty mental health services covered by the MHP may be required."⁵⁴

Each MOU must include a determination that the MHP accepts referrals from MCP staff, providers, and members' self-referrals for determination of medical necessity for SMHS after the MCP conducts an initial mental health assessment. If during the initial assessment the MCP mental health provider determines that the enrollee meets the medical necessity criteria for SMHS, the MCP is required to refer, and the MHP is required to accept the referral for further assessment and treatment by the MHP.

The MOU must also establish a procedure for referrals from MHPs to MCPs. MHPs must refer enrollees to MCPs when the MCP provides the needed service and the MHP does not, and when the MHP has determined that the enrollee does not meet the medical necessity criteria for SMHS. DHCS requires MCPs to accept referrals from MHP staff, providers, and members' self-referrals for initial assessment. The MOU must provide that, once the MCP receives a referral from an MHP, the MCP must conduct a mental health assessment, make a determination of medical necessity for outpatient services for enrollees with mild-to-moderate impairment and, as appropriate, provide referrals for mental health providers within the MCP provider network.

Finally, MOUs between MCPs and MHPs must specify policies, procedures, and reports to oversee referral protocols and for quality improvement.⁵⁵ These policies must include regular meetings between representatives of both the MCP and MHP to review the referral and care coordination process and to monitor member engagement and utilization. Both plans must agree to conduct no less than a semi-annual review of referral and care coordination processes to improve quality of care. The policies must also include a commitment to conduct reports that track cross-system referrals, which must include at a minimum an evaluation of the number of disputes between the MCP and MHP, the disposition or outcomes of those disputes, and the number of grievances related to referrals and network access.

3. Federal Requirements for Dispute Resolution

The dispute resolution requirements in Medicaid are rooted in the constitution, federal statutory and regulatory governance, and state statutory and regulatory law and administrative guidance. It has long been recognized that Medicaid enrollees have a property interest in the continued receipt of their Medicaid benefits. Because of this interest, the Due Process Clause of the U.S. Constitution protects Medicaid enrollees' right to continued benefits, as

long as they remain eligible. The Due Process Clause prohibits government deprivations of “life, liberty, or property, without due process of law.”⁵⁶ The two key aspects of the constitutionality of the Medicaid grievances and appeals process are that enrollees receive adequate notice of state Medicaid agency actions and a meaningful opportunity to seek a hearing to review agency actions or decisions. The Supreme Court has long recognized that Medicaid enrollees rely on the Medicaid program to meet basic needs, without other options, and thus to terminate Medicaid without adequate notice and a hearing is unconstitutional.⁵⁷ The notice must be reasonably calculated, under all the circumstances, to inform the individual of the action being taken and to convey information about the right to appeal.

Federal statutory law also provides protections for Medicaid enrollees. The federal Medicaid Act and implementing regulations require states to provide enrollees with the opportunity to request a State Fair Hearing whenever a request for benefits is denied or is not acted upon with reasonable promptness.⁵⁸ An enrollee who requests a hearing prior to the effective date of the adverse action generally has the right to receive continued benefits at the previously authorized level pending the outcome of the hearing.⁵⁹ Enrollees and applicants are also entitled to cross-examine witnesses, have access to their case file, and present a case without interference.

Recent federal regulations on managed care provide additional protections for Medicaid enrollees. States must comply with these requirements for Medicaid managed care contracts starting on or after July 1, 2017.⁶⁰ The regulations require states to ensure (through contracts) that these entities have a grievance and appeal system and provide adequate notice to enrollees of decisions about or changes to their benefits.⁶¹ The regulations provide specifics as to the requirements for notice of an adverse benefit determination.⁶² They also specify procedures for the opportunity for a hearing if a state agency or plan makes an adverse benefit determination.⁶³

The new regulations require states that select health plans for enrollees and enroll them passively to provide enrollees a 90 day period to change plans, and in voluntary managed care to either change plans or elect to remain in the fee-for-service (FFS) program.⁶⁴ States must provide enrollees adequate notice as to eligibility and choice for managed care enrollment and the regulations provide specifics for the grievance and appeal opportunities that enrollees must have if they are disenrolled.⁶⁵ States must establish enrollee support systems to assist enrollees with changing plans and the grievance and appeals process for those in need of long term services and supports (LTSS).⁶⁶ The new regulations enable enrollees to continue getting services during the course of appeals of denials.⁶⁷ Enrollees must exhaust internal health plan appeal processes before pursuing a State Fair Hearing.⁶⁸ The regulations also revised the timelines for Medicaid appeals so that they are more in line with Medicare Advantage and Marketplace rules.⁶⁹

There are provisions that require all notices be clear and readily accessible, which also require states to develop, and require the relevant plan entities to implement, model enrollee handbooks and model notices. The handbooks must include specific information about all the services that enrollees are entitled to, how and where to access these benefits, and the dispute resolution processes for denials or other adverse benefit determinations. Enrollee handbooks must include information about grievance, appeal, and State Fair Hearing procedures and timeframes. This grievance and appeals information must include:

- The right to file grievances and appeals.
- The requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process.
- The right to request a State Fair Hearing after the MHP or MCP has made a determination on an enrollee’s appeal which is adverse to the enrollee.

- The fact that, when requested by the enrollee, benefits that the MHP or MCP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the enrollee.

4. State Requirements for Dispute Resolution

In 2017, California passed legislation to bring State statutes in line with the federal Medicaid managed care regulations. Thus, State law defines an “adverse benefit determination” consistent with the federal regulations.⁷⁰ The statute also clarifies that the same rules governing notices, grievances, and appeals govern all Medi-Cal plans, including MCPs, MHPs, and Drug Medi-Cal Organized Delivery System (DMC-ODS).⁷¹ The revisions to the statute bring the timelines for notices, grievances, and appeals in Medi-Cal managed care plans into compliance with the federal regulations.⁷² The statute permits DHCS to implement its provisions through sub-regulatory guidance (e.g., All-Plan Letters and Mental Health/Substance Use Disorder Services Information Notices) until January 1, 2019, which it has done.⁷³ As a result, the regulations that govern notices, grievances, appeals, and State Fair Hearings for Medi-Cal managed care enrollees are out of date, and conflict with the statute and guidance documents. The statute directs DHCS to implement its provisions in regulation no later than January 1, 2019, however, DHCS seems unlikely to meet that deadline.⁷⁴

D. Tools Used to Monitor and Oversee Plans

To ensure plans’ compliance with state and federal rules, CMS and DHCS employ a variety of mechanisms to monitor contracted MCPs and MHPs. As required by federal regulations, DHCS contracts with outside External Quality Review Organizations (EQROs) to perform some oversight functions. The 2016 updates to the federal Medicaid managed care regulations also make clear that DHCS must publicly post many of the reports it receives from plans, and EQRO findings, including the details of any corrective action required by the State for a plan to come into compliance. We have summarized features of the various tools in a chart that is attached to this paper as Appendix E. We also provide a brief summary of each tool below.

1. Audits

DHCS conducts compliance audits of both MCPs and MHPs. The audit processes, however, are governed by different authorities for the MCPs versus MHPs, and thus the scope of the audit is somewhat different between the two types of plans.

i. Medical Audits

DHCS performs annual audits of MCPs, called “medical audits” using standards and criteria established pursuant to the Knox-Keene Act.⁷⁵ DHCS uses these annual reviews to verify the MCPs’ compliance with requirements established in MCP contracts, State law, and all plan policy letters.⁷⁶ While DHCS’s authority to conduct medical audits is broad, the agency has divided the process into seven review categories: utilization management, case management and coordination of care, access and availability of care, member rights, quality management, administrative and organizational capacity, and State supported services.⁷⁷ DHCS considers the protocol its auditors use to conduct the audit proprietary; therefore, the protocol that DHCS uses to perform its audits is not publicly available.⁷⁸ To help plans prepare for these annual audits, DHCS has published technical assistance guides on some of the seven review categories.⁷⁹ The current technical assistance guides do not provide any detailed guidance on how DHCS will review compliance with the MCPs’ responsibilities to ensure appropriate referrals and transitions for members who require SMHS, or the MCPs’ obligations to inform members of the availability of services and their

appeal rights.⁸⁰ After each MCP audit, DHCS is required to publish its findings within 90 days.⁸¹ If the plan is out of compliance with any of the contractual, statutory, or administrative requirements, the MCP is required to submit a corrective action plan (CAP) detailing the steps the plan will take to ensure compliance. DHCS approves and oversees implementation of the CAP by conducting CAP submission evaluations and providing technical assistance in areas of non-compliance. DHCS also has authority to perform on-site investigations of MCPs at its discretion.⁸²

ii. Triennial Reviews

DHCS conducts on-site reviews of MHP practices on a triennial basis.⁸³ This Triennial Review is performed pursuant to DHCS's *Annual Review Protocol for Specialty Mental Health Services and Other Funded Services*.⁸⁴ The review is designed to assess compliance with State and federal laws and regulations and the MHP contract provisions.⁸⁵ Pursuant to the Annual Review Protocol for fiscal year 2017/2018, during the on-site review, reviewers are instructed to evaluate MOUs between the MHP and MCPs, including whether the MHP has a mechanism for monitoring and assessing the effectiveness of MOUs with MCPs, the MOU MHP/MCP Monitoring Meeting minutes, and any referral protocol(s) agreed upon by the MHP and the MCP.⁸⁶ These documents enable DHCS to determine whether the MHP is complying with federal and State requirements for referrals and coordination of care with MCPs. If DHCS determines that a MHP is out of compliance during an on-site review, DHCS must issue a Notice of Noncompliance, which includes findings of the on-site review and any corrective action(s) the MHP must take.⁸⁷ For all non-compliant items, the MHP must submit a Plan of Correction (POC) within 60 days that includes a description of corrective actions the plan will take, including milestones, a timeline for implementation of corrective actions, and proposed evidence of correction to submit to DHCS.⁸⁸ DHCS posts both the Notice of Noncompliance and the corresponding POC on its website.

2. Implementation Plans

Under State regulation and California's 1915(b) Waiver, all MHPs had to submit an "Implementation Plan" to DHCS before beginning their operations.⁸⁹ Implementation Plans include each MHP's policies and procedures in eleven areas, including "[s]creening, referral and coordination with other necessary services, including . . . [physical] health," and grievances and appeals.⁹⁰ Once DHCS approves the Implementation Plan, MHPs must submit changes to the Implementation Plan to DHCS for its approval.⁹¹ DHCS also reviews MHP Implementation Plans as part of the Triennial Review.⁹² As part of the Implementation Plan, MHPs must also submit their MOUs with MCPs and a description of their process for handling grievances and appeals.⁹³

3. Quality Strategy Reports

The federal Medicaid managed care regulations require each state Medicaid agency to create a written strategy to assess and improve the quality of health care and services furnished by managed care entities in the state.⁹⁴ The state must submit its written quality strategy to CMS and post it online.⁹⁵ In California, this requirement applies to both MCPs and MHPs. DHCS provides an updated Managed Care Quality Strategy Report annually and submits it for stakeholder feedback and comments every year. The last public comment period took place from March 28 to April 27, 2018, and DHCS submitted the finalized report to CMS on July 1, 2018.⁹⁶ DHCS's Quality Strategy Report covers quality strategies across all delivery systems in California, including MCPs and MHPs, and describes the State: network adequacy standards; goals and objectives for continuous quality improvement, performance targets, and improvement projects; arrangements for annual external independent reviews; and policy for transitions of care.

4. HEDIS Measures/External Accountability Sets (EAS)

Pursuant to federal regulations, states must identify performance measures and use them to evaluate plan performance.⁹⁷ DHCS does this for MCPs by establishing an “External Accountability Set” (EAS) each year.⁹⁸ For the last several years, the EAS has included several HEDIS measures created by the National Committee for Quality Assurance (NCQA), along with a few other “HEDIS-like” measures.⁹⁹ As part of its contract with DHCS, the EQRO for the MCPs validates plan data on these measures each year and includes its analysis of statewide and plan-specific performance in the External Quality Technical Report.¹⁰⁰ DHCS establishes “minimum performance levels” for MCPs on each measure, and requires plans to develop an “improvement plan” (often a formal Performance Improvement Plan described below) to address any measures that fall below the established minimum.¹⁰¹ DHCS may require plans to enter into a DHCS-approved CAP for repeated failures to meet minimum performance, or failure to meet minimum performance levels for half or more measures in a given year.¹⁰²

5. Performance Improvement Projects (PIPs)

Federal regulations mandate that each state require its contracted plans to conduct performance improvement projects (PIPs) “that focus on both clinical and nonclinical areas. . . . [and are] designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.”¹⁰³ States must ensure that contracted plans’ PIPs include four elements: (1) objective performance quality measures, (2) interventions designed to achieve improvements in access to and quality of care, (3) evaluations of those interventions based on the objective performance quality measures, and (4) activities designed to increase or maintain improvements.¹⁰⁴ States must require plans to report on their PIPs at least once per year.¹⁰⁵ States must validate plan PIPs annually.¹⁰⁶ In California, MCPs must conduct a minimum of two PIPs per year.¹⁰⁷

DHCS must approve each proposed PIP topic.¹⁰⁸ In some years, DHCS has required plans to undertake at least one PIP that addresses one of a selected list of topics.¹⁰⁹ DHCS requires MCPs to submit five modules for their PIPs: (1) PIP Initiation, (2) SMART Aim Data Collection, (3) Intervention Determination, (4) Intervention Testing, and (5) Project Summary.¹¹⁰ MCPs must get approval for the first two modules before proceeding to the subsequent modules.¹¹¹ PIPs should be carried out over 12 to 18 months, though DHCS may approve longer PIPs.¹¹² DHCS’s EQRO evaluates each completed PIP, assessing the validity and reliability of the results that the MCP reported.¹¹³ A listing of those evaluations is available on DHCS’s website.¹¹⁴

Similarly, MHPs are required to conduct a minimum of two PIPs per year.¹¹⁵ Each MHP must have at least one PIP focused on a clinical topic and one on a non-clinical topic.¹¹⁶ In addition, the Special Terms and Conditions of California’s current 1915(b) Waiver requires MHPs that are not able to provide baseline data on care timeliness, or whose timeliness falls below set performance levels, to participate in a PIP focused on timely access to care.¹¹⁷ Each year the EQRO evaluates PIPs that were underway during the last year, and reports its findings.¹¹⁸

6. Quality Improvement Work Plans (QIWP)

California regulations require MHPs to establish a Quality Management Program, developed in accordance with the contract between the MHP and DHCS.¹¹⁹ MHP contracts also require MHPs to establish and maintain a QIWP.¹²⁰ QIWPs must address improvement goals and needs identified by DHCS during the on-site Triennial Review, but are not as limited as POCs resulting from the Triennial Reviews. QIWPs also address all quality improvement and evaluation activities the MHP designs to advance access to and delivery of quality SMHS.

Because QIWPs incorporate plan deficiencies flagged by the Triennial Reviews, all corrective actions addressing referral and coordination with MCPs for providing mental health services must be included in the annual QIWP. Pursuant to the Special Terms and Conditions of California’s 1915b Waiver, both DHCS and MHPs must post QIWPs

on their respective websites. If DHCS finds MHPs in violation of the QIWP requirements, it may impose sanctions pursuant to the MHP contract.

7. External Quality Technical Reports

Federal regulation mandates that each state require its contracted plans to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under each contract.¹²¹ The federal Secretary of Health & Human Services is responsible for developing a review protocol.¹²² There are currently eight protocols available online that cover a range of topics, such as regulatory compliance, encounter data validity, and consumer and provider quality surveys.¹²³ Three of the protocols—compliance with regulations, performance measure validation, and PIP validation—are mandatory, and the other five are optional.¹²⁴ Validation means “the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.”¹²⁵ At least every three years, each plan must also undergo a more extensive external review of its compliance with access to care standards, structure and operations, and quality measurement and improvement.¹²⁶

The annual technical report compares and evaluates the plans subject to review based on these and any other EQR activities specified by the state.¹²⁷ The report must include:

- evaluation of quality, timeliness, and access to care under the plan;
- assessment of each plan’s strengths and weaknesses as well as recommendations for each plan to improve its quality performance; and
- appraisal of how well each plan responded to recommendations for quality improvement in the prior year’s report.¹²⁸

Compliance with the EQR requirements has been uneven. A 2008 report from the U.S. Department of Health & Human Services Office of Inspector General (OIG) found that over half the states contracting with EQROs received annual reports missing either required elements or information on the three mandatory EQR activities.¹²⁹

8. Consumer Surveys

DHCS requires regular satisfaction surveys of both MCP and MHP enrollees. The survey instruments administered to enrollees are different for both MCPs and MHPs.

i. MCP Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹³⁰

For many years, the EQRO for MCPs has used the CAHPS Health Plan Survey to gauge enrollee satisfaction and experience in the MCPs.¹³¹ The CAHPS Health Plan Survey is designed by the federal Agency for Healthcare Research and Quality (AHRQ) to provide insight into the patient experience with health care.¹³² The CAHPS Health Plan Survey is considered a national standard, and is used by many health care programs, including many Medicaid managed care programs, to obtain feedback about health plan enrollees’ experiences.¹³³ The current version of the survey tool includes standardized questionnaires and optional supplemental questions for adults and children enrolled in Medicaid and commercial plans.¹³⁴ The survey tool covers a range of patient experiences in health plans, including access to care, timeliness of access, provider communication, plan customer service, and overall experience.¹³⁵

ii. MHP Consumer Perception Surveys

MHPs are required to survey a sample of their enrollees twice per year, each May and November.¹³⁶ The

EQRO for MHPs must validate the survey results.¹³⁷ There are four types of forms: Adult (for ages 18-59), Older Adult (for age 60+), Youth (for ages 13-17 and transition-age youth who still receive services in child system), and Family (for parents/caregivers of youth under age 18); each survey tool is available in seven languages.¹³⁸

9. Grievance Reports

Under federal regulations, DHCS is responsible for requiring and ensuring that MCPs and MHPs maintain records of grievances and appeals.¹³⁹ The federal Medicaid managed care regulations require plan grievance and appeal reports to, at a minimum, include the following information: (1) the person's name, (2) summary of the reason for the appeal of grievance, (3) the date it was received, (4) the date the grievance or appeal was reviewed, (5) how the grievance or appeal was resolved, and (6) the date the grievance or appeal was resolved.¹⁴⁰ Based on State law and regulation, the reporting mechanism has been implemented differently for MCPs and MHPs.

i. MCP Grievance Reports

Under California's Knox-Keene Act, which is applied to the MCPs by contract and guidance, MCPs must maintain records for grievances that are pending and unresolved for 30 days or more, and report them to DHCS on a quarterly basis.¹⁴¹ The report must contain the total number of grievances filed by enrollees pending or unresolved for 30 days or more, a brief explanation of the reasons why each grievance has been pending and unresolved for 30 or more days, and the nature of the unresolved grievances.¹⁴² The MCP contract also requires plans to include problems such as untimely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests. The MCP boilerplate contract also requires the report to include the total number of grievances received; the average time it took to resolve grievances (including providing notification to the member); a listing of the zip codes, ethnicity, gender, and primary language of members who filed grievances; and the outcome of grievances received.

Under State guidance, DHCS requires MCPs to submit quarterly grievance reports that include the following data points: year, quarter, plan, client identification number, grievance/appeal category, and resolution.¹⁴³ DHCS currently requires MCPs to categorize grievance and appeals into the following categories:

- accessibility (with six subcategories),
- benefits/coverage,
- referral (with three subcategories),
- quality of care/service (with seven subcategories), and
- other.¹⁴⁴

DHCS publishes statewide summaries of these reports as part of its Medi-Cal Managed Care Performance Dashboard.

ii. MHP Annual Enrollee Grievance and Appeal Report (AGBAR)

Under State regulations, MHPs must submit an annual report to DHCS summarizing enrollee grievances, appeals, and expedited appeals filed during the prior fiscal year.¹⁴⁵ These reports must include the total number of grievances, appeals, and expedited appeals by: type, subject area category, and disposition.

Currently, DHCS requires MHPs to categorize grievances, appeals, and expedited appeals into the following subject areas:

- actions (with six subcategories),¹⁴⁶
- access (with seven subcategories),
- quality of care (with six subcategories),
- change of provider,
- confidentiality concern, and
- other (with seven sub categories).¹⁴⁷

DHCS publishes statewide and county-specific summaries of these reports every year.

Project Findings and Recommendations

To achieve our project goals, NHeLP used a variety of methods to collect data. To ascertain plans' current practices with respect to coordination and referrals between MCPs and MHPs, we launched a comprehensive online survey of both MCPs and MHPs. The MCP survey was circulated by DHCS to its list of MCP contacts (because the contact was facilitated by DHCS, we do not know the total number of individuals who received this solicitation, but it included at least one contact for each of the 22 MCPs). With assistance from DHCS, we separately reached out to 12 individuals and asked them to complete the survey on behalf of their plan. Ultimately, every MCP except one completed the survey. The survey aimed to understand the MCPs' coordination and referral processes for ensuring Medi-Cal enrollees get the mental health services they need. Ultimately, 19 individuals started the survey and 84% completed the survey.¹⁴⁸

NHeLP also surveyed all 56 MHPs in California. NHeLP sent email invitations to the County Administrator or Director for all MHPs, as listed on a roster provided by the California Behavioral Health Directors Association (CBHDA) dated January 2018 (some MHPs had more than one contact listed, in which case the email was sent to all listed contacts). NHeLP and CDHBA also sent follow-up emails and made follow-up phone calls to the MHP contacts during March and April 2018. Of the County Mental Health Plans invited to take the survey, 43 responses were collected with a completion rate of 74%. Of the 61 email invitations, 41 individuals started the survey (67%) and 32 individuals completed the survey (52%). We also supplemented the survey results with seven key informant interviews, to provide a deeper understanding of the survey results, and explore promising practices. Key informants included MCP and MHP staff and contractors, providers, and advocates.

The MHP survey also aimed to understand an MHP's coordination and referral processes focused on ensuring that Medi-Cal enrollees get the mental health services they need. The survey was developed specifically for this project and covered plan background information, plan policies and practices for initial referrals to mental health services, and plan policies and practices to coordinate care for current members whose care is transitioned to their health plans.

Neither survey used a random sample. Instead, the goal was to obtain information from as many MCPs and MHPs as possible. Therefore, the survey data are useful for understanding the concerns for the MCPs and MHPs who responded, but are not necessarily representative of all MCPs and MHPs. A copy of the survey instrument is attached to this report as Appendix B.

As part of the survey described above, we asked plans to provide us with any screening or assessment tools ("screening tools") they use to determine whether a person requires SMHS or non-SMHS. We supplemented this collection with a google search for these screening tools, and collected some from key informants. Our review of the screening tools is described in more detail below.

In 2016, we collected all of the MOUs between MCPs and MHPs through a Public Records Act (PRA) Request and performed a comprehensive analysis of them. We sent a supplementary PRA request to obtain any MOUs that had been changed or updated since 2016. DHCS produced two updated MOUs, along with six MOUs that had new addendums added after 2016. We updated our 2016 analysis of the MOUs to reflect the new MOUs.

Further, we selected various reports that are publicly available online, including the Medi-Cal Managed Care Performance Dashboard, Medi-Cal Specialty Mental Health Dashboard, Medi-Cal Quality Strategy Report, Medi-Cal External Accountability Set, MCP Performance Improvement Plans, Plan Handbooks, and MHP Quality Improvement Work Plans. We reviewed these documents, as described in more detail below, to understand the extent to which the state uses them to monitor the MCPs' and MHPs' care coordination, referral, and notice and appeal practices.

Finally, to look more closely at the information enrollees receive about their rights to benefits and to appeal decisions about their mental health services with which they disagree, we did a focused review of the policies, procedures, and enrollee information in six counties: Butte, Los Angeles, Merced, Orange, Riverside, and Sacramento. We chose these counties to represent a diversity of managed care models, geography, demographics, and size. We reviewed grievance, appeals, and expedited appeals reports since January 1, 2015; any plan policies and procedures about notices of adverse benefit determinations submitted since January 1, 2015; any plan policies and procedures about grievances submitted since January 1, 2015; any plan policies and procedures about appeals submitted since January 1, 2015; any plan policies and procedures about expedited appeals submitted since January 1, 2015; and any plan evaluation results for grievances, appeals, and State Fair Hearings submitted since January 1, 2015. We also reviewed the MCP and MHP enrollee handbooks for those six counties.

We used all of the above data to obtain a comprehensive picture of two issues. First, what are MCPs' and MHPs' policies and practices for referrals and coordination of care, and how DHCS advises and monitors MCPs and MHPs in these areas to determine their compliance with their legal and contractual obligations. Second, what are MCPs' and MHPs' policies and practices on dispute resolution and how DHCS advises and monitors MCPs and MHPs in these areas to determine their compliance with their legal and contractual obligations. Our findings and analysis in these two areas are provided in detail below.

A. Referrals & Coordination

Our review of both MCPs' and MHPs' policies and practices for referrals and coordination, and DHCS's oversight of the plans' in this arena focused on three main areas: (1) The Memoranda of Understanding that MCPs and MHPs are required to create to set out their mutual obligations; (2) The State's guidance and audit process in these areas; and (3) The plans' and State's procedures for quality review. Our findings are set forth below.

1. Memoranda of Understanding (MOUs)

As discussed in detail above, the MOU is the primary tool that MCPs and MHPs use to ensure that they are providing coordinated care and referrals so that Medi-Cal enrollees can get needed mental health services from the appropriate plan. Thus, we looked closely both at the guidance provided by the State to ensure that these MOUs are effective and at the MOUs themselves. Finally, we looked at plans' screening tools (also sometimes called assessment tools), which are the instruments plans agree to use to determine whether a person should receive SMHS or non-SMHS. Screening tools are usually, but not always, incorporated or appended to the MOUs.

i. State MOU Guidance

To evaluate MCP and MHP practices for entering into an MOU for coordination and provision of SMHS, we first analyzed the tools and procedures the State has in place to monitor plan compliance with

statutory, regulatory, and contractual requirements. Currently, DHCS separately evaluates the MCPs' and the MHPs' compliance with their responsibilities to enter into, amend, or replace MOUs.

For the MCPs, DHCS has issued guidance to summarize MCPs' responsibilities. This guidance specifies the elements that each MOU must include, such as basic requirements for each plan; covered services and populations; screening, assessment and referral; care coordination; and dispute resolution.¹⁴⁹ Besides listing the required elements, however, the guidance provides little specificity as to how each element of the MOU must be met. An MOU template is included as an attachment to the guidance and includes specific language about screening, assessment, and referral obligations, as well as language on care coordination, information exchange, and quality improvement activities (which includes reporting of cross-system referral tracking). The MOU provides little detail on how DHCS expects MCPs and MHPs to screen enrollees to determine which entity should provide their care, how they should handle and track referrals, or how the plans should coordinate care as enrollees' needs change. Moreover, DHCS states that its template is merely "provided as a guide for MCPs and MHPs to structure their MOUs . . . the specific format provided on the MOU template is not required and may be modified to account for the needs of MCPs and MHPs."¹⁵⁰

The only specific requirements contained in the guidance letter are for the MOU to reflect the MCPs' obligation to conduct an assessment for enrollees with a potential mental health condition using a screening tool mutually agreed upon with the MHP and the requirement to include in the MOU a process for resolving clinical and administrative disputes between the plans.¹⁵¹ Moreover, while DHCS collects all MOUs between MCPs and MHPs, DHCS does not appear to periodically evaluate MOUs from the MCP perspective to ensure compliance with coordination of care requirements. The guidance is also not consistent with the EPSDT obligations that both the MCPs and MHPs have to serve children under 21. The guidance provides no clarification about the provision of SMHS and non-SMHS to children under 21. The MOU guidance to the MCPs also conflicts with the guidance issued to MHPs, which specifies MHPs' requirements for ESPDT SMHS.¹⁵²

For the MHPs, DHCS's guidance on the MOUs is even more limited. There is currently no State guidance to the MHPs describing in detail the requirement to enter into an MOU with MCPs, although the requirement is mentioned in passing in three guidance letters (MHSUDS information notices) on MHPs' responsibilities in providing SMHS.¹⁵³

However, in contrast to the MCP evaluation process, DHCS currently has a robust system in place to evaluate MHP compliance with the MOU requirements through the MHP triennial review process. During the Triennial Review, DHCS requires MHPs to submit in advance the following documentation:

- MOUs with Managed Care Plans;
- MOU Monitoring Results; and
- MOU MHP/MCP Monitoring Meeting Minutes (for the previous four meetings).¹⁵⁴

The protocol also specifies that, in order to comply with coordination of care requirements, MOUs must address, at a minimum, the availability of clinical consultation (including consultation on medications) and a process for resolving disputes that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.¹⁵⁵

In addition, the Triennial Review protocol indicates that MOUs must address the referral protocol between the MHP and MCP and include information about referrals to MCPs for physical health treatment, referrals from MCPs for SMHS, case management, including exchanging medical records, and referrals to MCPs for non-SMHS.¹⁵⁶ Finally, during the Triennial Review, DHCS evaluates whether MHPs have a process in place to evaluate and monitor the MOU's effectiveness in coordination with the MCP. For this task, reviewers look at the MOU monitoring results and minutes from coordination meetings between the MHP and MCP.¹⁵⁷ Notably, however, plans are currently not required to agree upon a monitoring procedure when entering into a MOU.

ii. Analysis of Plans' MOUs

We also conducted a comprehensive review of MOUs between MHPs and MCPs for coordination of Medi-Cal mental health services. Neither DHCS nor plans post the MOUs online, so we obtained copies through a public records request. Our analysis extended to MOUs in effect in all 58 California counties and encompassed at least one MOU for each Medi-Cal MCP. Most MOUs reviewed were agreed upon or last updated between 2014 and 2015.¹⁵⁸ Most MOUs reviewed closely follow the MOU template format.¹⁵⁹

Most MOUs provide separate information for screening procedures and referral procedures, but some merge these two categories, which may cause the MOU to become unclear. Some MOUs merely mention plans' responsibility to screen or assess for mental health conditions in passing, but do not

provide an in-depth discussion of the process for screening beneficiaries for SMHS. However, the vast majority of MOUs reviewed include, as an attachment, the screening tool agreed-upon by the MCP and MHP and detailed instructions for providers to use them.

Some MOUs provide specifications for the primary care physician's responsibilities to be familiar with Diagnostic and Statistical Manual (DMS) diagnoses; to be able to rule out a mental health condition due to a general condition; to be able to identify general medical conditions that are causing or exacerbating psychological symptoms; and to conduct screening, brief intervention, and referral to treatment (SBIRT) for misuse of alcohol.

All MOUs reviewed include a statement specifying that the MHP must accept referrals from MCP staff and providers, and members' self-referral for determination of medical necessity for SMHS. In the same way, all MOUs specify that the MCP must accept referrals from the MHP, MCP care management staff and providers, and members' self-referral for initial assessment and treatment, including screening for mental health conditions treatable by the MHP. All MOUs also outline the process that MCPs and MHPs must follow after conducting the initial assessment, including the MCP's responsibility to refer the person to the MHP when it is determined that the person meets the medical necessity criteria for SMHS, and the MHP's responsibility to refer the person to the MCP when it is determined that the person's mental health condition would be responsive to physical health care-based treatment. Some MOUs specifically highlight the role of MHPs' Behavioral Health Access Teams in responding to referrals.

An example of a comprehensive MOU is the one between Alameda County Behavioral Health Care Services and Anthem. It includes a description of the MCP's responsibility to offer a Health Risk Assessment (HRA) for seniors and persons with disabilities on an annual basis and an Initial Health Assessment (IHA) for newly enrolled individuals, and notes, "[t]his [general] screen serves as the basis for further assessment, which may include case management needs, mental health and substance use, chronic physical conditions, dementia, cognitive status and the capacity to make informed decisions." The data collected as part of the HRA or IHA is then used to create the person's care plan, which guides further assessment and treatment activities.

The MOU between San Francisco Behavioral Health Services and San Francisco Health Plan is an example of an MOU that discusses with specificity how the MHPs' Behavioral Health Access Teams will respond to referrals. It stipulates that this team will:

- Determine enrollee eligibility for SMHS.
- Provide screening when enrollee requests evaluation.
- Refer to an appropriate MCP provider for non-specialty behavioral health services if the patient does not or no longer meets SMHS criteria.

The MOU between Glen County Division of Behavioral Health Plan and Blue Cross of California Partnership Plan is an example of an MOU that incorporates a flowchart for referrals between the MCP and the MHP and for referrals in certain situations. For example, this flowchart provides clear direction as to what referrals are appropriate when the enrollee needs substance use disorder services or emergency care.¹⁶⁰

While some MOUs require plans to reflect referrals in the patient's record, the majority of MOUs reviewed do not include specific requirements to directly contact the plan to which the enrollee is being referred, track referrals to ensure the enrollee is receiving appropriate care, and maintain communication with the enrollee after referral. Some MOUs, however, require MHPs to respond to all MCP provider referrals, to acknowledge the referral and documentation action plan and mark it as "accepted, modified, or denied." Finally, a few MOUs include, as an attachment, a flowchart that summarizes where beneficiaries should be referred after a screening.

The majority of the MOUs reviewed contain a separate category for coordination of care. Coordination of care activities include collaboration between plans on identifying a point of contact who will initiate, provide, and maintain ongoing care coordination and having a process in place for reviewing and updating the members' care plans. In addition, coordination of care as highlighted in the MOUs extends to activities related to transition of care for members transitioning to or from each plan's services and conducting regular meetings to review MHP and MCP referral, care coordination, and information exchange protocols and processes. Some MOUs also contain specific protocols and directions in place for sharing of information between plans and providers, in particular between MHP providers and primary care physicians.

Finally, about half of the MOUs specify that MHP providers should provide clinical consultation to MCP providers in areas such as recommended health care-based treatment for diagnosed conditions, complex diagnostic assessment of mental disorders, treatment of psychiatric symptoms precipitated by medications used to treat medical conditions, and treatment of mental disorders that are the responsibility of the MCP. Similarly, these MOUs also allow MCP providers to conduct clinical consultation to MHP providers in acquiring access to covered MCP services, treatment of physical symptoms precipitated by medications used to treat mental disorders, and complex medication interactions with medications prescribed by the primary care provider not commonly used in psychiatric specialty practice.

Most of the MOUs reviewed provide for a process to evaluate the effectiveness of the MOU on a regular basis. Several MOUs state that plans will meet annually to monitor the MOU and make changes as necessary. Some MOUs provide for a more comprehensive approach to coordination.

Beacon Health Solutions has developed a robust system to track referrals made to MHPs in its service area. Beacon contracts with many MCPs to provide non-SMHS. It uses its computer system to track the number of people it screened for medical necessity for SMHS, how many were ultimately provided non-SMHS (linked to their specific claims history), how many were referred to the MHP, and how many were referred to another county; it also tracks the number of referrals received for non-SMHS from the MHP. It can pull this information from its system for regular reports, and to identify trends over time. In addition, the system sends staff “utilization triggers” to flag that someone is accessing more services than expected, so that staff can follow-up with the person’s provider to determine whether someone should be screened again for SMHS.

The MOU between San Francisco Behavioral Health Services and San Francisco Health Plan is an example of an MOU that delineates a protocol for information sharing. It requires the MHP to “communicate with [the MCP] and/or [MCP] providers regarding the proposed treatment plan and on progress of member against treatment goals. Specific communication is required at the time of engagement in care, annually, on change of medications, and at discharge.”

iii. Analysis of Screening Tools

As part of their MOU, each MHP and MCP must agree on a common screening tool for use by clinicians or staff of both the MCPs and MHPs to determine whether an enrollee meets the criteria for SMHS or non-SMHS. These screening tools are not universal in form or use across California’s MHPs and MCPs. We reviewed 20 adult screening tools, 12 adolescent screening tools without age markers, five early childhood tools (0-5 years of age), five child screening tools (5-17 years of age), and 10 tools that are not specific to age.¹⁶¹

Adult Screening Tool:

The structure of the adult screening tools follows a series of lists from which the provider or staff filling out the form selects listed items that apply to the individual being screened and ends with a referral algorithm based on the items selected. The tools generally contain a series of two or three lists, lettered A, B, and, where applicable, C.

List A is composed of provisional diagnosis options. Of the 20 adult screening tools we reviewed, 16 of them had one of two versions of List A. One version is more symptom-focused, and includes items like persistent symptoms and impairment after two recent medication trials, behavior problems (aggressive/self-destructive/assaultive/extreme isolation), excessive ED visits or 911 calls, trauma/recent loss, significant life stressors, and homelessness/housing instability resulting from mental health condition.” The other version of list A (4 screening tools reviewed) is more diagnosis-focused, and includes items like schizophrenia/psychotic disorder, depression, impulse control, adjustment disorder, personality disorder (except antisocial personality disorder), eating disorder, pervasive development disorder (except autism), disruptive behavior/attention deficit disorder, feeding and eating disorders, elimination disorder, other disorders of infancy, childhood, adolescents, somatoform disorder, factitious disorders, dissociative disorders, paraphilia, and gender identity disorder.

List B includes information about the person’s functional impairment in life domain resulting from the mental disorder. List B includes items such as lack of independent living skills, interference with social relationships, disruptive behavioral problems with work performance and physical condition, significant problems or high risk behavior with sexuality, disruption of self-care, unable to think through social problems and anticipate consequences in decision making, legal problems or risk of incarceration, residential instability, and a tool called the

The MOU between Alameda County Behavioral Health Care Services and Anthem provides for a comprehensive coordination approach. It establishes that “[the MHP and MCP will] collaborate on quality improvement initiatives, which include but are not limited to the following:

- Regular and mutually agreed-upon meetings to review the referral and care coordination processes and to monitor member engagement and utilization.
- Semi-annual:
 - Review of referral and care coordination processes to improve quality of care
 - Reports summarizing DHCS-specified quality findings
 - Reports of systematic strengths and barriers to effective collaboration between [the MCP and MHP]
- Reports that track cross-system referrals, member engagement and service utilization per DHCS-specified requirements . . .”

World Health Organization Disability Assessment Schedule (WHODAS) score.

We observed two variants of List C, with some differences within each variant among counties. List C either contains items related to probability of deterioration/risk factors linked to mental health OR items related to substance use disorders. When List C tracks the probability of deterioration/risk factors it includes items like psychiatric hospitalization in past 6 months, criminal behavior (particularly violent crime), suicidal or violent behaviors current or in the last 6 months, transitional age youth with acute psychological episode, self-injurious behaviors that required medical attention in last 6 months, and sexual aggression with acute risk of reoffending. When List C refers to substance use disorder it contains items like drug use or alcohol addiction and/or failed Screening, Brief Intervention, and Referral to Treatment (SBIRT).

List D is not present in all screening tools. When List C refers to substance use disorders, List D is not present in any of the screening tools reviewed. Sometimes, screening tools that use list C to determine someone’s risk factors or probability of deterioration include List D to determine whether any factors related to substance use disorder are present. On those tools, List D includes items that are included on List C above, when List C is used to determine whether a person has a potential substance use disorder.

Finally, the screening form has a referral algorithm that gives guidance on how to refer a person for services based on the previous answers. The referral algorithm generally suggests the following referrals depending on how many of the factors in each of the three or four lists are present: remains in primary care provider care/therapy only with the MCP, refer to the MCP or the MCP behavioral health contractor, refer to County Mental Health Plan for assessment, and refer to county alcohol & drug program. The number of items from various lists designated for each referral pathway varies widely.

For example, an adult from Stanislaus County who meets three of the criteria in List A and none in List B would be directed to the MCP contractor, while an adult in San Joaquin who meets three of the criteria from List A would be referred to the county MHP. In neighboring Contra Costa County, an adult who met three of the criteria in List A would stay with their assigned provider or primary care provider. These three outcomes vary greatly from each other despite being based on the same structure of screening tool.

Care1st in San Diego County is an example of a plan that has developed a comprehensive yet flexible screening tool to determine whether a person should be referred for SMHS. It uses a “Severity Screening Tool for New Clients” and this tool includes much more detail on indicators for [SMHS],” and states that “if any indicators of serious impairment/disturbance in mood, behavior, and/or psychological function are met, the member may be referred for [SMHS] through the county.” This design provides much more flexibility and can help patients get the care they need without fitting into a rigid structure of checked boxes.

IEHP is an example of a plan that supplements its screening tool with an Interdisciplinary Care Team (ICT). The plan works to coordinate care with the two MHPs in its service area through regular ICT meetings. The ICT meets monthly to ensure that existing enrollees are receiving the care they need. For enrollees who present with a new need for mental health services, IEHP performs an evaluation and starts treatment as soon as possible. If the evaluation reveals a need for SMHS, IEHP providers continue to serve the enrollee until the MHP has set up an appointment in order to facilitate a seamless transfer of care. For individuals receiving psychotherapy services, IEHP tries to keep the enrollee with existing therapist regardless of need.

Child/Youth Screening Tool:

The child/youth screening tools are similar to the adult tools in that they are also typically composed of the four lists. However, lists C and D are less frequently populated than in the adult screening tools. List A for children often includes: impulsivity/hyperactivity, withdrawn/isolative, mild to moderate depression/anxiety, excessive crying, difficult to soothe, significant family stressors, CPS reports filed in the last six months, limited receptive and expressive communication skills, sleep concerns, peer relationship issues, feeding/elimination difficulties, learning difficulties, sexualized behaviors, serious medical issues/other disabilities, and may not progress developmentally as individually appropriate without mental health intervention. List B often includes: significant parent/child attachment concerns, children newborn to age 3 with at least 2 items from List A, aggression and/or frequent tantrums, neglect/abuse, self-harm (frequent head banging/risky behavior), trauma, currently in out-of-home foster care or preschool placement due to mental health issues, and separation from/loss of primary caregiver. When List C is present, it includes items related to substance use, although this is much less frequent in screening tools for children than adults. The referral algorithm follows a similar pattern to that for adults.

Our research review suggests that there is not a strong clinical reason for the screening tools’ construction. The referral algorithms in the tools do not correlate to clinical factors that suggest a need for SMHS versus non-SMHS.¹⁶²

Overall, the small and large differences in screening tools suggest that the screening tools are not well-calibrated to ensure that enrollees get the mental health services they need. A person’s clinical need for SMHS does not differ based on their county of residence. Thus, we would expect to find little variation among the tools used to determine whether people are referred for those services. Our review of the tools instead found that a person presenting with a single set of symptoms would experience widely different referrals and access to services depending on their county of residence. Moreover, these differences, particularly where different tools are used by a single MCP in different counties, are likely to cause confusion among consumers and providers. Finally, the criteria for screening and referral in these tools are largely inconsistent with the medical necessity legal standards in the regulations.

MOU Related Guidance and Evaluation Recommendations

- **DHCS should issue joint guidance to MCPs and MHPs.** Given that MOU obligations apply to both the MHPs and the MCPs,

Beacon Health Solutions is an example of an MCP that attempts to use a “no wrong door” model for screening and referrals. Beacon contracts with several MCPs around the state to provide non-SMHS. If someone presents to Beacon seeking mental health services, but ultimately needs SMHS, Beacon uses a variety of processes to ensure the person gets SMHS, depending on the person’s level of need. These include giving the person a number to call and also providing that person’s information to the MHP to follow-up; giving the person’s information to the MHP to call the person directly; and initiating a three-way call between Beacon, the person seeking care, and the MHP, to get the person into an urgent appointment within 48 hrs. In some counties where the MCPs and MHPs have closer working relationships, the process tends to be more informal because the plans collaborate as a group for each situation as it comes up. Moreover, after Beacon refers someone to the MHP, it keeps the person’s case open in its care management program for 60-90 days to ensure that the person is able to access SMHS without any barriers, including by helping the person navigate the MHP’s system as needed.

DHCS should have a single updated guidance letter that goes to both plan types, so there is no discrepancy, conflict, or lack of clarity between them.

- **DHCS should explicitly monitor MCPs’ compliance with their obligation to coordinate care with MHPs.** As is the practice for MHPs, DHCS should review and assess MCP compliance with the MOU mandate through the annual audit and hold non-compliant plans accountable by requiring corrective action plans to reflect the MOU requirements.
- **DHCS should require more transparency of MOU and screening tools.** DHCS should require plans to post their MOUs and screening tools on their websites or, in the alternative, DHCS should post the MOUs and tools on DHCS’s website.

MOU Content Recommendations

- **DHCS should promulgate a comprehensive model MOU and require MCPs and MHPs to adopt it.** Requiring plans to meet the requirements of a model MOU would ensure that certain best practices are standard for all MCPs and MHPs and would ensure the consistency required for necessary coordination of mental health services. *See Appendix A for a proposed model MOU.*
- **DHCS should require MHPs and MCPs to agree on data sharing in their MOUs.** Data is critical to ensure services provided to the same enrollee of both plans are coordinated and to ensure systems are in place to track and monitor enrollees’ care.

Screening Tools Recommendations

- **DHCS should develop and require use of a consistent screening tool.** DHCS should work with plans and providers to develop one screening tool that uses consistent and clinically-supported criteria that meets medical necessity standards. DHCS should require all plans to use its tool as part of the MOU, rather than allowing variation among plans and counties.

2. State Guidance and Audit Tools

Apart from the MOUs, DHCS has set forth MCPs’ and MHPs’ obligations to make referrals and coordinate care through a variety of tools, including plan contracts and in separate State guidance. DHCS’s primary mechanism for evaluating compliance with this guidance is the audits it regularly performs of both MCPs and MHPs.

We analyzed the guidance provided to both MCPs and MHPs. We also

examined both the audit protocols for MHPs (as discussed below, we were unable to obtain the protocol used for MCPs) and the audit results, as reflected in plan-specific reports and corrective action plans.

i. State Guidance on Coordination and Referrals

DHCS has issued guidance letters over the years to inform both MCPs and MHPs about their responsibilities to provide mental health services. That guidance became particularly important after additional mental health benefits became available through the MCPs in 2014 pursuant to the ACA's Essential Health Benefits mandate.¹⁶³

The boilerplate contract language between DHCS and the MHPs and MCPs contains provisions governing the plans' duties to coordinate care and referrals. The MHP Boilerplate Contract contains several provisions that implement the regulatory requirements of the MHPs to coordinate care with MCPs, including the MHPs' duty to enter into MOUs with the MCPs, and to coordinate care with physical health providers.¹⁶⁴ The MCP Boilerplate language is more general, simply requiring the MCPs to provide "basic case management services" to members, which includes "coordination of carved out" services.¹⁶⁵ In addition, the MCP Boilerplate has a section titled "Specialty Mental Health," which requires MCPs to refer members according to its MOU with the MHP, and to develop the MOU to coordinate services with the MHP.¹⁶⁶ In April 2017, DHCS submitted a revised MCP contract to CMS, which is meant to be retroactively effective to July 2017, pending CMS review and approval.¹⁶⁷ We have not reviewed the revised contract to see whether it includes different or more detailed provisions around coordination of care and referrals.

Although DHCS has issued and updated guidance for both MCPs and MHPs, DHCS continues to issue separate and sometimes conflicting notice to the different plan types, adding unnecessary confusion for the plans.¹⁶⁸ In the most recent guidance issued to MCPs on the plans' responsibility to provide outpatient mental health services to its enrollees, DHCS does not provide guidance that is consistent with other guidance issued to the MHPs about the responsibilities of MCPs to cover non-SMHS for adults and children.¹⁶⁹ The 2016 MHP guidance clarified that, as opposed to adults, children under 21 enrolled in Medi-Cal are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) SMHS as long as the mental health condition would not be responsive to physical health care-based treatment and the services are considered necessary to correct or ameliorate a mental illness and condition. DHCS took a similarly separate and inconsistent approach to providing guidance to the MCPs and MHPs with respect to the plans' requirements to develop MOUs, as discussed above. DHCS's continuing practice of issuing separate and inconsistent guidance on the same issues makes coordination and referrals between the MCPs and MHPs much more difficult and increases the potential for disputes to arise over obligations to provide mental health services to their shared enrollees.

Finally, DHCS has produced a model handbook for both the MCPs and the MHPs to conform to changes in the federal regulations for the content of handbooks that was effective July 1, 2017.¹⁷⁰ We reviewed both the models, which plans must use unless they get permission from DHCS to use language that is different from the model.

Because the MCP handbooks are incorporated into the MCP contracts, DHCS submitted them with the contracts to CMS for review and approval in April 2017.¹⁷¹ CMS approval is pending, and thus DHCS has not published guidance to the plans on the handbooks as of this time. We understand that DHCS is requiring plans to use the version that it submitted to CMS while approval is pending. Our review of that version identified a few key deficiencies. For example, while the model clearly delineates between the mental health services offered by the MCP and those offered by the MHP, it merely provides a link to a website where members can find the phone number for their local MHP if they are seeking SMHS.¹⁷² The model does not provide any information about the MCP's role in facilitating members' access to

SMHS.¹⁷³ The MHP Model Handbook has received CMS approval and was released in an information notice on September 26, 2018. The MHP model handbook contains a detailed description of the scope of services offered and the criteria for services.¹⁷⁴

ii. State Audits of Plans

We attempted to review the audit tools DHCS uses to evaluate MHPs' and MCPs' compliance with the guidance on their obligations related care coordination and referrals. As discussed above, DHCS regularly audits both MHPs and MCPs. It audits MHPs once every three years, in a process called the Triennial Review. It audits MCPs annually in a process called medical audits. Both MCP medical audits and MHP Triennial Reviews present a unique opportunity for DHCS to oversee care coordination practices between MHPs and MCPs and ensure that Medi-Cal enrollees with mental health needs are receiving the care they need.

We reviewed DHCS's most recent audit protocol for its Triennial Review of MHPs, which serves as a guide for DHCS reviewers and for MHPs to prepare for the on-site review portion of the audit.¹⁷⁵ The protocol is designed to assess the MHPs' compliance with a variety of the plans' obligations. As part of changes made to the protocol for fiscal year 2018-2019, DHCS created a new section entitled Care Coordination and Continuity of Care, under which the MOU, information exchange, and clinical consultation and referral requirements are merged.¹⁷⁶ The new protocol also adds several new coordination of care requirements, such as the requirements to ensure that each enrollee has an ongoing source of care and a person or entity primarily responsible for coordinating the services accessed and to coordinate SMHS with the services the enrollee receives from MCPs.¹⁷⁷ In addition, DHCS recently announced at a stakeholder meeting to review the new protocol that it will seek to place more emphasis on the review and evaluation that takes place prior to the on-site visit and will be more active in requesting and evaluating documentation to demonstrate compliance from MHPs before the on-site review. This apparent change in approach will allow DHCS to conduct a comprehensive review of coordination of care documentation in anticipation of the review, while at the same time focusing more on MHPs' actual practices during the on-site visit.

To demonstrate compliance with coordination of care requirements, DHCS asks MHPs to submit policies and procedures on coordination of care; MOUs with MCPs; MOU monitoring tools; referral protocols, forms, and tools; referral tracking mechanisms; sample referrals; and any other evidence the reviewers request in their discretion. While it is our understanding that DHCS requires plans to submit these documents, the Triennial Review protocol treats them as "suggested documentation," which may give plans the impression that they have discretion as to decide if they want or need to submit them.¹⁷⁸

When DHCS finds that an MHP is out of compliance with any of the requirements contained in the protocol, it provides the MHP with a written report with a description of each finding of non-compliance. The report includes a description of any corrective action(s) needed, and timeframes required for the MHP to come into compliance. Plans are then required to submit a POC to DHCS within 60 days after receiving the report. These POCs must include, for all items determined out of compliance, a description of corrective action, timeline for implementation, and proposed evidence of correction. DHCS posts all MHP POCs on its website.¹⁷⁹

We analyzed all reports of non-compliance and MHP POCs from the last three years, which include Triennial Reviews for all MHPs. Only three MHPs were reported as partially out of compliance with care

coordination and continuity of care requirements, suggesting that DHCS evaluates these practices only on paper, without evaluating their implementation in practice. For example, plans that have an MOU with all the required parts in place were seldom found to be out of compliance, even though DHCS did not analyze whether the MHP was actually coordinating care appropriately with MCPs pursuant to that MOU. Overall, it appears that during the triennial review process, DHCS requests documentation to ensure that MHPs have entered into MOUs, developed referral protocols, and created other written agreements with MCPs, but DHCS does not analyze how these agreements are implemented in practice, or whether they achieve the goal of providing more coordinated care and seamless referrals for enrollees.

The three MHPs found out of compliance with care coordination requirements in the last three years all involved instances where the plan either lacked a piece of required documentation, or when DHCS found that the policy submitted was not fully compliant with the plan's regulatory and contractual requirements around consultation and training.¹⁸⁰ These three reports all found a lack of necessary documentation or deficient language in the documentation provided, but did not analyze the policies' implementation or effect. Notably, no review has yet taken place using the 2018-2019 protocol, which introduced several changes to the process.

Of these three MHPs with findings of non-compliance related to coordination and referrals, only one had submitted a POC at the time this paper was published.¹⁸¹ The plan proposed to correct the deficiency identified regarding lack of process to enable clinical consultation and training for MCPs by sending a letter to all MCP physicians in the county "offering the opportunity for them to consult with [MHP] providers regarding the initiation and monitoring of psychotropic medication. [The MHP] will also collaborate with regional pharmacy representatives to provide in-service opportunities regarding commonly prescribed psychotropic medications."¹⁸² DHCS is not likely to re-evaluate compliance with the requirement until the next triennial cycle.

DHCS conducts annual medical audits of all Medi-Cal MCPs to review compliance with statutory, regulatory, and contractual requirements. DHCS divides the audits into seven categories, including one review category on Case Management and Coordination of Care. DHCS considers its audit tool proprietary and does not make it available to the public; thus, we were not able to review it. DHCS does, however, publicly publish technical assistance guides on six of the seven categories of review, which are "designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency."¹⁸³ The guides provide a list of documentation that DHCS may review during the medical audit process to evaluate compliance, such as policies and procedures, organizational charts, committee meeting minutes, monitoring reports and data logs. However, reviewers are not constrained by the guides; that is, if necessary, they may request additional documentation from the MCPs. The guides also provide examples of best practices that "some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency."¹⁸⁴

The technical assistance guide on Case Management and Coordination of Care evaluates compliance with requirements around basic case management.¹⁸⁵ Reviewers must determine whether the MCP maintains procedures for monitoring the coordination of care provided to all members, which extends to services delivered within and outside the MCP's provider network. To evaluate compliance with this requirement, DHCS considers whether the MCP maintains policies and procedures that address case management and coordination of care; whether the MCP's policies and procedures address the delivery of medically necessary services within and outside of the MCP's network, including monitoring activities

to ensure coordination of care (such as referral tracking, reports for referrals and services, etc.); and whether the MCP's policies and procedures address the provision of basic or complex case management for all members. There are four other areas evaluated under Case Management and Coordination of Care: children's services; early intervention services; initial health assessments (IHA); and complex case management.

While the medical audit is apparently intended to evaluate care coordination within the MCP's provider network and with outside providers, none of the areas covered in the technical assistance guide for this area directly address coordination of care and referrals between MCPs and county MHPs. For case management, the guidance provides the following as best practice:

the Plan regularly reviews monthly data uploaded by DHCS (e.g., encounter data, FFS claims data, TARs, etc.) to assist with the identification of members who receive carved out services (e.g., CCS, mental health, carved out prescription drugs, LTSS, etc.). The Plan utilizes this data to improve care coordination for members.¹⁸⁶

However, the guide does not include any requirement to enter into or monitor MOUs with MHPs despite the fact that MCPs share this obligation equally with MHPs. The guide also does not indicate that audit reviewers evaluate compliance with the requirement to maintain referral protocols with MHPs or assess MCP's practices concerning tracking referrals to MHPs for SMHS. It also does not prescribe that MCPs or MHPs use any particular method of tracking referrals, much less ensure that there is any follow-through on those referrals.

When DHCS finds non-compliance during the medical audits, MCPs are required to submit a CAP to DHCS, which is posted on DHCS's website.¹⁸⁷ We reviewed the 24 Medical Audit Reports and 21 CAPs that DHCS has published. Of these, eight MCPs were found at least partially out of compliance with the requirements in the medical audits related to Case Management and Coordination of Care, and submitted DHCS-approved CAPs to address the deficiencies. In all cases, however, the findings were unrelated to the MCP's relationship with the MHP, or its duty to coordinate mental health services inside and outside the plan. The findings were very broad and did not address coordination with any carved out services.

The medical audits provide an opportunity for DHCS to evaluate MCPs' compliance with care coordination and referral practices between MCPs and MHPs. Nonetheless, it appears that DHCS's audits of MCPs merely review coordination of care generally and mostly internally (for example, between primary care and specialty providers). As explained above, DHCS has provided as a best practice an example encouraging MCPs to review data uploaded by DHCS, including data on SMHS and other carved out services, in order to inform coordination practices. We found no other evidence that DHCS engages in significant oversight of coordination of care practices around mental health services.

Finally, we also reviewed the actual enrollee handbooks published by MHPs and MCPs in our six target counties in 2018. Of the 27 MCP handbooks we reviewed, most of the MCPs substantially complied with the legal requirements governing the handbooks. A few MCPs failed to fully cover one or more areas required by the regulations, or appeared outdated. Only one plan's handbook appeared to be missing crucial information about the availability of carved out SMHS. That plan's handbook referred to a "Guidebook," that supplemented the handbook, which we were not able to review; it is possible that the

missing information is covered in the Guidebook. In terms of informing beneficiaries about mental health screening, referrals, and coordination, each Medi-Cal MCP handbook included information on the scope of non-SMHS benefits afforded to the plan's enrollees. For most plans, the handbook indicated that primary care providers act as gatekeepers to specialty services and a referral from the PCP is needed to receive more specialized care.¹⁸⁸ Additionally, most plans have a provision specifying that enrollees must seek prior authorization for certain services.

Despite the clarity in the State DHCS model MHP handbook, of the six MHP handbooks we reviewed, most appeared to be outdated. They did not contain detailed information about care coordination and referrals with MCPs. All of the MHP handbooks we reviewed that were publicly available were dated 2016 or earlier. None of the MHP handbooks we reviewed discussed care coordination with MCPs, but only provided general information about accessing physical health services from MCPs, and continuity of care when a person's MHP provider stops contracting with the MHP.

State Guidance Recommendations

- **DHCS should issue coordinated and consistent guidance to both MCPs and MHPs on their coordination and referral obligations.** DHCS should provide the same guidance to both MCPs and MHPs concerning the plans' obligations to provide services, coordinate care and refer enrollees to the other plan for care and treatment. This guidance should require MCPs and MHPs to consistently track referrals made between each other and ensure that those referrals result in the person getting needed care.
- **DHCS should issue additional and consistent joint guidance to MCPs and MHPs concerning the plans' obligations to provide services to children under EPSDT.** DHCS should issue joint guidance to MCPs and MHPs about the obligations of each plan type to provide services for children under 21 under ESPDT, and such guidance should rely only on the appropriate medical necessity legal standard and not utilize screening or referral criteria based upon the severity of the child's condition.
- **DHCS should issue additional and consistent joint plan guidance on overlapping services.** DHCS must provide more clarity and specificity about the plans' obligations to provide outpatient mental health services where such service coverage by MCPs and MHPs overlaps (e.g. psychotherapy) and where the severity of the condition determines the obligation to provide the services.
- **DHCS should routinely review MHP Implementation Plans to monitor MHP policies and procedures related to care coordination and referrals.** DHCS must enforce the regulation (Title 9) requiring MHPs to obtain prior approval before they change their policies and include those approved policies in their Implementation Plan.

Audit Recommendations

- **DHCS should require MHPs to provide documentation of their care coordination processes during the triennial review process.** DHCS should change the language of the protocol to emphasize the fact that documentation requested for compliance is required, not merely suggested.
- **DHCS should evaluate the implementation and effects of MHPs' policies during the Triennial Review.** DHCS should expand the review of its new, dialogue-focused approach to the MHP audit process to include interviews with enrollees, providers, and stakeholders in the county to paint a more comprehensive picture of whether MHP care coordination practices are robust enough to ensure continuous access to mental and physical health care.
- **DHCS should annually evaluate MHPs.** While conducting annual on-site reviews might not be feasible, DHCS at a minimum should conduct annual documentation review in a process similar to the MCP medical audits process.
- **DHCS should incorporate measures to evaluate MCPs compliance with their obligations to coordinate**

mental health services with MHPs. The audit process should reflect the MHP triennial review process, which provides for substantial review of coordination practices between MCPs and MHPs and requires plans to submit all relevant documentation for evaluation.

3. Quality Review

Both DHCS and the plans have regular processes to evaluate and improve quality, broadly defined. As discussed in detail in the Background section above, DHCS contracts with two EQROs, one to evaluate quality in the MCPs, and the other to evaluate quality in the MHPs. We looked at the reports produced by the EQROs, with a particular focus on their findings on plans' PIPs, and consumer experience surveys, to understand how this process evaluates referrals and coordination of care between MCPs and MHPs. We also reviewed the MHP-created QIWPs to analyze how they account for coordination and referrals.

i. External Quality Review Process

DHCS contracted with the Health Services Advisory Group (HSAG) to conduct External Quality Review (EQR) of all Medi-Cal MCPs, as required by the federal Medicaid managed care regulations.¹⁸⁹ In April 2018, HSAG published its EQR Technical Report covering the period of July 1, 2016 to June 30, 2017.¹⁹⁰ The report summarizes HSAG's findings with respect to an independent validation performed through HEDIS Compliance Audits and non-HEDIS measures and review of aggregated information on quality, timeliness, and access to health care services that MCPs furnish to Medicaid enrollees. Notably, the EQR Technical Report aggregates information from other monitoring tools referenced throughout this report, including Triennial Reviews, Medical Audits, External Accountability Sets, HEDIS Reports, CAHPS, and PIPs. In this regard, the EQR Report summarizes findings about quality, timeliness, and access from all these other sources, but seldom provides new information or reviews different data sources. While the MCP EQR Technical Report 2016-2017 and plan-level EQRs addressed care coordination issues in general, they did not address deficiencies specific to care coordination and referral practices between MCPs and MHPs, outside of providing an overview of findings from other tools.¹⁹¹

The MCP EQR Technical Report also included summaries of the PIPs conducted by each plan. MCPs are required to have a minimum of two ongoing PIPs per DHCS Medi-Cal contract designed to have a positive effect on health outcomes and enrollee satisfaction and are focused on clinical and/or non-clinical areas that involve one of four specific components.¹⁹² One of the two PIPs must be focused on a topic from the following list chosen by DHCS: diabetes, hypertension, postpartum visits, and immunizations of two-year-olds. The MCP can select the topic of the second PIP, but must target it to an area in which the MCP needs to improve.

We reviewed the PIPs for the twenty-six MCPs in California and found nothing directly related to care coordination or referral between the MHP and MCP. A handful of PIPs addressed some aspect of care coordination or referral, but they were primarily focused on coordination by the MCP alone or between the MCP and its contracted providers.¹⁹³ While there was one PIP addressing developmental screening, no PIPs directly addressed mental health concerns.¹⁹⁴

Similar to the MCPs, MHPs must maintain at least two PIPs at a time, one clinical and one non-clinical in focus.¹⁹⁵ The most recent EQRO report reveals that, while each county is supposed to have at least two PIPs, many have not submitted or do not have active PIPs.¹⁹⁶ Of the MHP PIPs described in the report, a few address care coordination but not between the MHP and MCP; rather, the PIPs addressing care coordination primarily dealt with coordination between providers and the MHP, and a number of the care coordination PIPs addressed coordination around SUD treatment.¹⁹⁷

The EQR process also accounts for the consumer surveys administered to enrollees of MCPs and MHPs to evaluate consumer satisfaction. The CAHPS survey tool used by the MCPs asks general questions about access and timeliness of care, but does not ask any questions about coordination with carved out services.¹⁹⁸ Because the survey tool is developed for use with different types of plans around the country, it is necessarily general. Because California cannot change the survey tool or add State-specific questions to the CAHPS, we do not recommend any changes at this time.

Alameda County Behavioral Health Care Services' QIWP is an example of a QIWP that contains specific objectives aimed at improving coordination. It describes efforts to improve care coordination between the MHP, physical health care agencies, and substance use disorder agencies. Some of the actions Alameda's MHP proposes are:

- Identifying best practices in data sharing procedures and electronic health records systems used by current Behavioral Health/Primary Care collaboration projects.
- Developing a training plan and resources to implement a workshop series and collaborative focused on process improvement and coordination of care.
- Improving implementation and monitoring of current MOUs with MCPs.
- Establish data-sharing agreements with primary care providers.
- Through the Whole Care Person (WCP) pilot, developing and establishing consensus on joint outcome measures for shared members/enrollees, MCPs, MHP, and Drug Medi-Cal-Organized Delivery System (DMC-ODS).

The adult and youth MHP Consumer Perception Survey tools ask about the general experience of patients or parent/caregivers of children and youth, with their mental health services and provider experience, as well as self-reporting on the impact of those services on their quality of life.¹⁹⁹ The survey does not ask questions about whether the patient is also enrolled in a managed care plan or the patient's experience with continuity of care or referrals from the health plan to the mental health plan for SMHS or treatment.

- ii. MHP Quality Improvement Work Plans (QIWPs)
MHPs are also subject to some additional quality monitoring tools. As described in more detail above, MHPs must establish a Quality Management (QM) Program, and develop and maintain a Quality Improvement Work Plan (QIWP). The QIWP addresses the MHP's quality improvement goals, and more systematic needs identified by DHCS through the triennial oversight reviews. MHPs must evaluate their QIWP annually and update it as necessary. While MHPs are not required to address care coordination and referral practices as part of these tools, QIWPs may enable MHPs to improve coordination and referral practices.

We reviewed all of MHP QIWPs to evaluate whether they included care coordination practices.²⁰⁰ Of the QIWPs reviewed, most (seventy-one percent) address, in one way or another, care coordination with MCPs or the interface between mental health and physical health. Overall, QIWPs that address coordination between the MHP and MCPs cover improvements in: MOUs and monitoring MOU effectiveness, provision of consultation and training about psychiatric services to primary care physicians and other MCP providers, information sharing practices, number of services to consumers with dual diagnoses of mental health and substance use disorders, and the tracking of referrals from primary care providers to MHPs.²⁰¹ Many QIWPs focus on improving the referral process between primary care physicians and MHP providers. A few MHPs have incorporated into their QIWPs questionnaires for primary care providers to monitor care coordination and referral practices.²⁰²

Imperial County's QIWP is one where the MHP's Quality Management Program Committee uses an audit tool for measuring quality that takes into consideration coordination of services with primary care providers. According to the QIWP, "the [quality] review entailed assessing the appropriateness of interventions, coordination of services, and referrals to community resources." The MHP developed a protocol to improve care coordination for individuals referred to the MHP by a primary care provider. This protocol includes a summary of the MHP Intake Assessment and a letter detailing the outcome of the assessment. MHP providers are responsible for submitting both documents to the referring primary care provider after conducting the assessment. The MHP claims this protocol has improved communication between plans, as evidenced by the decrease in the number of enrollees re-referred to the MHP without meeting the medical necessity criteria.

The QIWP from Riverside County's MHP is an example of a QIWP that incorporates a questionnaire for providers to improve coordination. It proposes to ask primary care providers to fill out monthly questionnaires where they identify strengths and weaknesses of the care coordination system in place between the MHP and MCPs, as well as to identify difficulties in referring beneficiaries to the MHP.

External Quality Review Recommendations

- **DHCS should add a PIP focused on mental health access and coordination for MCPs.** DHCS should add mental health services to the list of four issue areas that MCPs are required to conduct one of their PIPs on, encouraging MCPs to focus on care coordination and access to services for patients in need of mental health services.
- **DHCS should add a PIP focused on mental health coordination for MHPs.** As with the recommendation for a mental health related PIP for MCPs, DHCS should add care coordination of mental health services to the requirements for MHPs PIPs.
- **DHCS should add a question to all of the MHP surveys to capture the enrollee's experience with coordination and referrals.** The question should ask about the enrollee's experience with the referral between the managed care plan's medical or mental health providers to determine if such referral is occurring, and how well it is working from the enrollee's perspective.

QIWP Recommendations

- **DHCS should require MHPs and QM committees to include Triennial Review findings and corrective actions with respect to care coordination with MCPs in their QIWPs.** While MHP QIWPs are not considered tools for monitoring compliance, QIWPs should reflect MHPs' proposals to address more systemic and long-term coordination issues. Thus, DHCS should require MHPs and QM committees to address Triennial Review findings and corrective actions about care coordination with MCPs in their QIWPs.
- **DHCS should require MHPs to include specific quality improvement proposals aimed at improving care coordination in their QIWPs.** Given the majority of QIWPs incorporate quality improvement proposals around care coordination with physical health agencies and plans, DHCS should require MHPs to sustain this practice to further enhance and achieve improvements.
- **DHCS should require MCPs and MHPs to agree to joint quality goals in their MOUs.** Specifically, DHCS should require MCPs to agree in their MOUs with MHPs to cooperate with MHPs on the quality improvement activities in the MHP's QIWP aimed at improving coordination of care and referrals between MCPs and MHPs.

B. Dispute Resolution

Our review of both the plans' policies and practices with respect to dispute resolution, and DHCS's oversight of the plans' in this arena focused on the same three main areas we analyzed with respect to referrals and coordination: the Memoranda of Understanding (MOUs) that MCPs and MHPs are required to create to set out their mutual

obligations; the State's guidance and audit process for dispute resolution; and the plans' and State's procedures for quality review. Our findings are set forth below.

1. MOUs

While the MOU is primarily used to ensure MCPs and MHPs provide coordinated care and referrals, they can also be used to delineate responsibilities between the plans with respect to providing information to enrollees and resolving enrollee disputes through grievances and appeals. Thus, we analyzed both the guidance and monitoring tools provided by the State to ensure that these MOUs are effective, as well as the MOUs themselves.

As discussed in more detail above, we reviewed DHCS's guidance and tools to monitor compliance with MOU requirements to evaluate whether DHCS is currently enforcing dispute resolution requirements through MOUs between MCPs and MHPs. For MCPs, both the State guidance and the accompanying MOU template are silent as to dispute resolution requirements, suggesting that DHCS does not necessarily believe that MOUs must reference activities around dispute resolution.²⁰³ Similarly, for MHPs, our review of the draft *Annual Review Protocol for Specialty Mental Health Services and Other Funded Services* for fiscal year 2018-2019, the main tool used by DHCS

to evaluate MHP compliance with MOU requirements, revealed that DHCS does not expect MHPs to incorporate dispute resolution oversight in their MOUs with MCPs.²⁰⁴

The MOU between Mono County's MHP and Anthem is an example of an MOU that specifies the dispute resolution obligations of *both* the MCP and MHP. It specifies that both the MHP and MCP "will ensure that [enrollees] are given an opportunity for reconsideration and an appeal for denied, modified or delayed services." This MOU also specifies that both plans have the responsibility to continue providing their respective services while the disputes are being resolved.

Our review of the actual MOUs entered into between MHPs and MCPs revealed that, despite the fact that plans are not required—statutorily, regulatory, or contractually—to reference obligations with respect to resolution of disputes between enrollees and plans in their MOUs, some MOUs discuss the process through which both plans agree to handle grievance, complaints, and appeals. Some MOUs provide for the sharing between plans of plans' internal processes for members and providers to register grievances and complaints. Many of these MOUs also highlight the responsibility of each plan for ensuring that medically necessary services continue to be provided while appeals are pending.²⁰⁵ Some MOUs focus solely on MHPs' obligations around dispute resolution.²⁰⁶ Other MOUs reference both MCP and MHPs responsibilities.

MOU-related Guidance and Evaluation Recommendations

- **DHCS should provide specific guidance to plans on dispute resolution requirements in MOUs.** Dispute resolution policies should be an explicit part of both State level guidance to plans concerning the MOU content and the Triennial Review protocol MOU evaluations.

MOU Content Recommendations

- **DHCS should add dispute resolution language to the MOU template.** This language should specify that: both MCPs and MHPs are responsible for giving beneficiaries the opportunity to file grievances and appeals for denial, modification, or delay of services; both plans must agree have a system in place to track all grievances and appeals related to the provision of SMHS; and both plans must develop a system to evaluate these grievances and appeals and whether action needs to be taken to address deficiencies in denial, modification, or delay of SMHS. See *Appendix A for a proposed model MOU*.

2. State Guidance and Audit Tools

DHCS has set forth MCPs' and MHPs' obligations to provide beneficiaries with information about their rights and to resolve their disputes in a variety of forms, including in their contracts and in separate guidance. DHCS's primary mechanism for evaluating compliance with this guidance is the audits it regularly performs of both MCPs and MHPs. We analyzed the guidance provided to both MCPs and MHPs. We also closely evaluated both the audit protocols for MHPs (as discussed below, we were unable to obtain the protocol used for MCPs), and the audit results, as reflected in plan-specific reports and corrective action plans.

i. State Guidance related to Dispute Resolution

DHCS's contracts with the plans provide some guidance on their responsibilities with respect to dispute resolution. The MHP Boilerplate Contract contains detailed provisions governing dispute resolution, which closely follow the requirements set forth in the federal regulations and state (Title 9) regulations.²⁰⁷ The contract has not been updated since the federal regulations were changed, however, so there are a few places where the contract is slightly out-of-date.²⁰⁸ Similarly, the MCP Boilerplate Contract contains a section on dispute resolution that is fairly detailed, but does not reflect the changes to the federal regulations that went into effect in July 2017.²⁰⁹ As discussed above, DHCS has updated the MCP Boilerplate Contract and it will be released once CMS approves it.²¹⁰

In the meantime, based on the updated federal Medicaid managed care regulations on dispute resolution that went into effect on July 1, 2017, DHCS has issued guidance to the MCPs and MHPs on their legal obligations. Guidance was issued to the MCPs (APL 17- 006) in May 2017 and MHPs (MHSUDS Info. Notice 18-10E) in March 2018. Both guidance letters included numerous template notices that must be provided in writing to enrollees when adverse benefit determinations are made.

The guidance letter should have been issued jointly to both plan types in early 2017, in order to provide ample time for plans to update their policies and practices, and to ensure that consistent guidance was issued to the plans. In fact, DHCS did not issue guidance to MHPs until almost 9 months after the law's changes went into effect. Not only was this delay unnecessary, we believe it led to a failure by the MHPs to update their policies and notices as required by the federal regulations.

The notice templates included with the guidance to the MCPs and MHPs were also not entirely consistent, especially with respect to referral of enrollees from the MCPs to the MHPs. The MHP template notices includes a model "Delivery System Notice" (MHSUDS Info No. 18-10E, Enclosure 4) for situations where members/enrollees are denied mental health services and informed that their needs are the responsibility of the other plan (i.e., in the case of the MHP model notice, it would tell the enrollee to seek mental health services from the MCP).

The guidance to the MCPs, on the other hand, does not require the MCPs to provide the same denial notice when the plan denies the enrollee mental health services because it determines the severity of the condition qualifies the person for SMHS from the MHP and not the MCP. The existing MCP model notice for the exact same determination instructs MCPs that this situation does not require a denial notice. These notices from DHCS are inconsistent and the MCP model notice should be changed to state that such a determination meets the definition of a benefits denial, requiring the plan to issue a proper notice.

Furthermore, as discussed above, DHCS has issued guidance to require the MCPs to submit quarterly grievance reports, while the MHPs submit annual reports called Annual Beneficiary Grievance and Appeal Reports (ABGARs).²¹¹ The data collected in these reports is significantly different, and also categorized differently, making it hard to compare data from MCPs and MHPs.²¹² For example, the reporting template for MCPs, unlike the template for MHPs, does not distinguish between grievances and appeals, or regular and expedited complaints—they are all reported together.

Moreover, while both MCPs and MHPs track grievances received by category, the categories are different between the two plan types, and none of the existing categories for either MCPs or MHPs explicitly captures any problems related to screenings, referrals, or care coordination for mental health services. The reports also do not have a category for complaints about the grievance and appeal process itself. Any complaints about either screening, referral, and coordination issues or issues with the grievance process would likely fall into the catch-all “other” category. Thus, the grievance reports, as they exist now, are not well calibrated to identify screening, referral, and coordination problems between MCPs and MHPs, or problems with the grievance process. Moreover, whereas DHCS collects information about the number of denial or termination of service notices that the MHPs send out, it does not appear to collect any such data from MCPs in order to provide comparison data for the number of grievances and appeals filed.

DHCS does not report the data it collects in a comprehensive or consistent way. While DHCS includes some statewide summary data on the quarterly Medi-Cal Managed Care Performance Dashboard, DHCS does not publicly report any plan-specific grievance data for MCPs. DHCS does publish each MHP’s ABGAR every year. However, DHCS does not publicly report any analysis it performs of the grievance data it receives for MCPs or MHPs. While DHCS widely reports that it uses grievance data to monitor plans, it is unclear what analysis it performs and what it does with its analysis.

Finally, DHCS has produced a model handbook for both the MCPs and the MHPs to conform to changes in the federal regulations in the content of handbooks that was effective July 1, 2017.²¹³ We reviewed both the models, which plans must use unless they get permission from DHCS to use language different from the model.

Because the handbooks are incorporated into the MCP contracts, DHCS submitted them with the contracts to CMS for review and approval in April 2017.²¹⁴ CMS approval is pending, and thus DHCS has not published guidance to the plans on the handbooks yet. We understand that DHCS is requiring plans to use the version that was submitted to CMS while approval is pending. Our review of that version found that while its description of the dispute resolution requirements was accurate, it was lacking in detail.²¹⁵ The MHP Model Handbook was released in an information notice on September 26, 2018. The model handbook contains fairly detailed descriptions of members’ rights to file grievances, appeals, and fair hearings.²¹⁶

ii. Six County Policies and Procedures on Dispute Resolution

As discussed above, we sought to review MCP and MHP policies and procedures for dispute resolution in six counties: Butte, Los Angeles, Merced, Orange, Riverside, and Sacramento. We sought these policies and procedures to help us evaluate how the plans are complying with the new managed care dispute resolution rules that went into effect on July 1, 2017, and to determine whether DHCS is effectively monitoring the plans for compliance with these rules. We used a variety of methods to obtain the policies and procedures: internet searches, informal requests to plans, and formal PRA requests to

DHCS. Unfortunately, these methods provided limited results. We obtained no relevant documents from the MHPs in the six target counties, and relevant documents from only 14 of the 18 MCPs that operate in those counties.

Because we could not review any of the MHP dispute resolution documents for the six target counties, we were unable to determine if those MHPs were in compliance with the requirements governing dispute resolution. Of the documents we received from the MCPs operating in these six target counties, we obtained and reviewed six plan specific grievance and appeal policies covering at least one plan in all of the target counties. All of the plan policies obtained and reviewed were updated in 2017. Despite differences in how the policies are written, all of the policies reviewed contain the specific grievance and appeal rule changes that are newly required of plans based on changes to State and federal law that took effect in July 2017. Therefore, the MCP policies appear to comply with the new managed care dispute resolution rules that apply to all Medi-Cal plans.

One tool DHCS uses to review MHP's policies and procedures to ensure that they reflect DHCS guidance is requiring MHPs to obtain approval of their Implementation Plans, including for any changes to the Implementation Plan. We were not able to review any of our target counties' Implementation Plans. For two of the counties, the most recent Triennial Review resulted in corrective action, because the MHP's Implementation Plans were 10 or more years out of date.²¹⁷ These findings suggest that DHCS's current process for monitoring and reviewing MHP Implementation Plans is not adequate to ensure that MHPs have appropriate policies in place for dispute resolution.

Finally, we also reviewed the actual enrollee handbooks published by MHPs and MCPs in our six target counties in 2018. Of the actual MCP handbooks we reviewed, most of the MCPs substantially complied with the legal requirements governing handbooks. A few MCPs failed to fully cover one or more areas required by the regulations, or appeared outdated. In terms of dispute resolution information, specifically, three MCPs did not make clear that enrollees must usually go through the plan's internal appeal process before requesting a State Fair Hearing—a new federal requirement that went into effect in July 2017. Each plan provides information on the appeals and grievance processes. Additionally, each plan except one informs enrollees about the State Fair Hearing process. However, this information is typically in the middle or towards the end of the enrollee handbook. The length of the patient handbooks and location of the appeals and grievance information may limit enrollees' knowledge of this information. Further, most plans state that help is available in filing a complaint or appeals, but only offer an internal member services phone number, which could dissuade those needing help from filing a complaint or appeal. Some plans provide information on the availability of the DHCS ombudsman office, but few plans relate this information to potential help with a complaint, appeal, or State Fair Hearing.

While most MCPs' plan handbooks provided some timeline and procedural information to enrollees, the information lacks clarity and plans do not explicitly state that there is a plan level exhaustion requirement. Instead, plans use vague language that informs enrollees that they may ask for a State Fair Hearing within ninety days or one hundred twenty days (discrepancy based on days) of receiving a notice of action from the plan. Further, it seems that some plans are utilizing old language with about accessing State Fair Hearings. Regarding filing a complaint and a subsequent appeal internally with the plans, there are discrepancies between the various plans regarding if and what the timeframe should be. Some plans offer that a complaint can be filed at any time, while others set a 180-day limit. For appeals, a discrepancy between a 60-day and 90-day limit exists.

Despite the clarity in the model MHP handbook, of the actual MHP handbooks we reviewed, most appeared to be outdated. The MHP handbooks we reviewed did include fairly comprehensive information about notice rights, grievances, appeals, and State Fair Hearings, though the information generally did not reflect changes implemented as a result of the updated federal regulations, or explain that enrollees are entitled to notice when they are referred or stepped down to the MCPs. Since DHCS only released its Model MHP Handbook in September 2018, the fact that MHP handbooks are not up-to-date may not be surprising, but regardless of DHCS's delay in publishing a model, MHPs are subject to the revised handbook requirements that went into effect in July 2017.²¹⁸

iii. State Audits of Plans

We attempted to review the audit tools DHCS uses to evaluate MHPs and MCPs to assess their compliance with the guidance described above regarding their obligations for dispute resolution. As discussed above, DHCS regularly audits both MHPs and MCPs. It audits MHPs once every three years through the Triennial Review and MCPs annually through medical audits. Both MCP Medical Audit Reviews and MHP Triennial Reviews present a unique opportunity for DHCS to oversee care coordination practices between MHPs and MCPs and ensure that Medi-Cal enrollees with mental health needs are receiving the care they need.

We reviewed DHCS's proposed audit protocol for its Triennial Review of MHPs for 2018-19, which will serve as a guide for DHCS reviewers and for MHPs to prepare for the on-site review portion of the audit.²¹⁹ In the current protocol, DHCS will review MHP compliance with its guidance described above, including by analyzing MHPs' implementation of their own policies. To do this review, DHCS requests plans to submit policies and procedures highlighting dispute resolution practices, including: MHP enrollee handbooks; Grievance, Appeals, Expedited Appeals Logs; Annual Beneficiary Grievance and Appeal Reports; written notices of appeal resolution; notification letter templates; sample written notices to providers; documentation of continued services for enrollees pending appeals and/or State Fair Hearings; and any other evidence deemed appropriate by the review team.²²⁰ Importantly, during the triennial review process, DHCS also reviews whether the MHP has a procedure in place to transmit issues identified as a result of the grievance, appeal, or expedited appeal processes to the Quality Improvement Committee, which must in turn consider these issues and evaluate whether their inclusion in the plan's QIWP is warranted.²²¹ Notably, as discussed previously under Coordination and Referrals, the protocol treats this documentation merely as "suggested documentation," which may indicate to plans that while not submitting documentation may result in a finding of non-compliance, plans can demonstrate compliance by submitting only the documentation they consider necessary.

The protocol, under Handling Grievances and Appeals, includes review of specific practices for record keeping, monitoring, and review of grievances and appeals. The protocol requires MHPs to submit to DHCS their ABGAR as part of the review process, and also recommends that they submit documentation such as grievance, appeals, and expedited appeals log(s), and any other evidence deemed appropriate by the review team.²²²

We analyzed all reports of non-compliance and MHP POCs from the last three years, which include Triennial Reviews for all MHPs, to determine patterns of plan compliance with dispute resolution requirements.²²³ Notably, most of the requirements related to dispute resolution described in the Triennial Review protocol were newly implemented as part of the 2018-2019 protocol. At the time of this report, no oversight review had been conducted under the 2018-2019 protocol. Thus, we reviewed MHP

Triennial Review reports and POCs based on previous years' protocols, which included less rigorous evaluation of MHPs' compliance with dispute resolution requirements.²²⁴

For the three years we reviewed, 29 MHPs (52%) were found out of compliance, at least partially, with dispute resolution requirements during the triennial review process.²²⁵ Non-compliant findings were made in a wide range of areas, but the areas with the highest number of plans not complying were: failure to maintain a grievance, appeals, or expedited appeals log (or not entering required information); grievances, appeals, or expedited appeals not resolved within the established timeframes; not providing written acknowledgment or notification of disposition to enrollees; not notifying providers of disposition; and defective Notices of Appeal Resolution. A more detailed summary of these findings can be found in Appendix D to this report.

The MHPs found deficient in their dispute resolution practices addressed the identified defective dispute resolution issues in their required POCs in varying levels of detail. Most plans simply mentioned that they would begin complying with the requirements without specifying how they would achieve improvements and many proposed to resolve the deficiencies by updating the plans' policies and procedures to reflect the requirements. Other POCs were more detailed about proposed corrective actions. For example, some plans described performing an upgrade on their computer Grievance and Appeals Log to insure that all required elements are properly recorded within one day of receiving the complaint.²²⁶ Similarly, to correct deficiencies in timeliness, some plans have proposed developing a spreadsheet that would track and monitor adherence to all grievance and appeals resolution timeliness requirements.²²⁷ Finally, some POCs stated that the MHP would begin reviewing grievance reports on a monthly basis to ensure data accuracy; these reports would then be reconciled with the annual reports at the end of the year.²²⁸

For the MCPs, as discussed above, DHCS does not publish its annual audit protocol. Thus, we were not able to review its method of evaluating MCP compliance with dispute resolution requirements. In addition, DHCS has not published a technical assistance guide for the audit section on "Member Rights," which we assume would include its review of MCP compliance with dispute resolution rules.²²⁹ Thus, we do not have sufficient information to evaluate how DHCS reviews compliance with these requirements in the audit process.

We reviewed the most recent Medical Audit Reports and CAPs that DHCS has published for the MCPs.²³⁰ MCPs are required to provide a CAP upon the completion of a DHCS Medical Audit or any other monitoring activity where findings are identified. DHCS conducts CAP submission evaluations and provides technical assistance to ensure compliance.

In the reports and CAPs, DHCS identified deficiencies for 11 MCPs directly related to dispute resolution requirements.²³¹ None of these dispute resolution issues was specific to mental health or SMHS, however, the broader dispute resolution issues and solutions raised permeate all services provided by MCPs, including mental health services and referrals to MHPs for SMHS.

For example, one plan had findings related to its notice letters for prior authorization denials, modifications, or delays. In that case, DHCS found that the MCP's notices contained an insufficient explanation of the reason for the decision, or in some cases used language that was too complex for a member to understand.²³² To alleviate this problem, the plan reported that it created an internal

workgroup to develop clear and concise language and develop an audit tool to conduct random and routine monthly audits of components of the notice letters to ensure compliance.²³³ Under the “member rights” category, review, findings included issues such as MCPs failing to ensure grievances were captured and accurately reported.²³⁴ In some other cases, DHCS found instances of MCPs failing to consistently implement their procedures for expedited grievance classification and processing, including failing to ensure that expedited grievances were timely addressed (within 24 hours).²³⁵

The solutions for the majority of these deficiencies was creating policies and procedures (or amending existing policies and procedures) aimed at compliance with the MCPs’ contractual and other legal obligations. There were a couple of plans that had sufficient policies and procedures in place, where DHCS identified a need for improved compliance with their existing policies; in these cases, plans’ CAPs included remedies such as developing audit tools for grievance reviews, checklists for grievance investigations and follow-up processes, and staff training on grievance and appeal procedures.²³⁶ Where DHCS identified deficient noticing practices, some plans created template notice letters to attempt to improve clarity about the reasons for decisions. More often than not, these changes resulted in DHCS closing its findings as to the deficiencies.²³⁷

Based on this review of the medical audit reports for MCPS and their CAPs, it does appear that DHCS reviews MCP compliance with dispute resolution requirements quite thoroughly. In addition, it appears that DHCS analyzes not only the MCPs’ policies and procedures with respect to dispute resolution, but also how those policies are implemented in practice. The department works with MCPs to develop targeted corrective action to address identified deficiencies.

State Guidance Recommendations

- **DHCS should amend the MCP template notice to make clear that MCPs must issue notices when they decline to provide requested mental health services and instead refer someone to the MHP.** DHCS should issue a template notice to state that, based on the plan’s assessment and denial, a proper denial notice is required in such situations and instruct the MCP to issue such a notice in instances where there are delivery system denials by the MCP.
- **DHCS should issue joint coordinated and consistent guidance to both MCPs and MHPs on the plans’ obligations to comply with dispute resolution rules that apply to both plan types.** This guidance should include template notices with language that is consistent for both MCPs and MHPs.
- **DHCS should collect and approve all MCP and MHP dispute resolution policies annually.** A more regular and careful review will allow DHCS to confirm that the policies conform to current law and contractual requirements.
- **DHCS should post MCP and MHP dispute resolution policies on the State’s website.** Publicly posting these policies will both promote transparency and provide consumer assistance advocates and enrollees with additional information about their rights.
- **DHCS should make dispute resolution reporting more uniform for MCPs and MHPs.** Both MCPs and MHPs should report separately on notices issued by type, grievances, appeals, expedited grievances, and expedited appeals.
- **DHCS should provide detailed reports and analysis of plan dispute resolution for both MCPs and MHPs that are published on its website.** These reports should explain how the analysis is used to monitor plans and provide them with technical assistance.
- **The MCP Model Handbook should be amended to include detailed information on coordination and referrals with respect to carved out services, especially mental health services.** DHCS should ensure that

the Model Handbook for MCPs contains this information, similar to the information included in the MHP Model Handbook.

- **The MCP Model Handbook should be amended to include detailed information on notice, grievances, and appeals rights.** The MHP Model Handbook contains a clear and detailed explanation of enrollees' rights in these areas. DHCS should amend the Model Handbook for MCPs to be consistent.

Audit Recommendations

- **DHCS should review the implementation of dispute resolution policies in its MCP and MHP audits.** This review should examine the notices issued by the MCPs and MHPs, along with the percentage of successful grievances and appeals.
- **DHCS should require MCPs and MHPs to develop internal workgroups to monitor compliance with dispute resolution requirements.** These workgroups should develop policies and procedures that ensure grievance and appeal processes and notices are functioning properly.
- **DHCS should work with MCPs and MHPs to develop a standardized dispute resolution process checklist to ensure that all appropriate steps are taken (including a timeline for each step on the checklist).** A standard checklist will increase compliance and consistency for both MCPs and MHPs.

3. Quality Review

Both DHCS and the plans have regular processes to evaluate and improve quality, broadly defined. As discussed in detail above, DHCS contracts with two EQROs, one to evaluate quality in the MCPs, and the other to evaluate quality in the MHPs. We looked at the reports produced by the EQROs, with a particular focus on their findings on plans' PIPs, and consumer experience surveys, to understand how this process evaluates plans' provision of information about and implementation of dispute resolution procedures. We also looked at the MHP-created QIWP to analyze how they account for information and dispute resolution.

i. External Quality Review Process

As explained above, in April 2018 the HSAG published its EQR Technical Report covering the period of July 1, 2016 to June 30, 2017.²³⁸ The report summarizes HSAG's findings by aggregating information from other monitoring tools referenced throughout this report, including Medical Audits, External Accountability Sets, HEDIS Reports, CAHPS, and PIPs. The EQR Report summarizes quality, timeliness, and access findings from all these sources, but seldom reveals new information. With respect to grievances, appeals, and expedited appeals, the EQR Report, again, merely references findings from other tools and provides limited recommendations.

We reviewed all MCP-specific EQRs available and found limited information. Only one EQR addresses issues related to grievances, appeals, and expedited appeals. Anthem Blue Cross Partnership Plan's EQR discusses opportunities for the plan to improve dispute resolution policies and practices, but focuses solely on the results from Anthem's Seniors and Persons with Disabilities (SPD) Medical Survey. Furthermore, the EQR does not reveal which deficiencies were highlighted by the SPD survey; it merely recommends that Anthem "[w]ork with DHCS to ensure that the MCP resolves all deficiencies from the . . . SPD Medical Survey, particularly in the area of Grievances and Appeals within the Member Rights category."

We also reviewed the same PIPs for MCPs and MHPs discussed in the referral and care coordination findings for anything related to dispute resolution. None of the PIPs addressed any issues around dispute resolution. Thus, it does not appear that the PIP process is currently focused on improving dispute resolution for patients receiving care through MCPs and MHPs.

We also reviewed the consumer survey tools used to collect information about the experience of MCP and MHP enrollees. The CAHPS health plan survey does not ask any questions about dispute resolution or denials of care.²³⁹ For the reasons discussed above, we do not recommend any changes to the CAHPS Survey. As described above, the MHP adult and child/youth survey tool only asks about the patient or parent/caregiver's experience with the mental health services provided by the mental health plan as well as quality of life questions. The adult survey asks very basic question about whether the adult was given information about his/her rights.²⁴⁰ The youth survey for families/caregivers and the youth teen survey do not even ask that basic question.²⁴¹ None of the surveys ask about whether patients were notified of their right to file a grievance or appeal, or given a notice in writing when their services were denied, terminated, reduced or not provided timely.

ii. QIWs

Finally, we reviewed the MHP QIWs. As explained in more detail above, QIWs address quality improvement goals as determined by the MHP, and more systemic needs identified by DHCS through the triennial oversight reviews. The MHP contract requires plans to include in their QIWs "evidence of the monitoring activities including, but not limited to: review of enrollee grievances, appeals, expedited appeals, fair hearings, provider appeals and clinical records review."²⁴² MHPs may utilize these tools to enable improvements in internal grievance and appeals processes and ensure compliance with federal and State requirements. In addition, DHCS may ask MHPs that it finds out of compliance with dispute resolution requirements during the triennial review process to include corrective action proposals in their QIWs as part of their POCs. We reviewed all of the MHP QIWs to evaluate whether they include information and proposed courses of action for grievances, appeals, and expedited appeals policies, practices, and procedures.²⁴³ Almost all of the MHP QIWs (96%) address dispute resolution issues, which demonstrates that MHPs regard dispute resolution as a priority for quality improvement.

The majority of QIWs address grievance and appeals issues under broader discussions about enrollee satisfaction.²⁴⁴ The vast majority of QIWs have set as a goal consistent evaluation of grievances, appeals, and expedited appeals, and ensuring that the plan is complying with timeliness requirements.²⁴⁵ Many QIWs establishing quarterly or semi-annual evaluations performed by a quality improvement team or, in some cases, specifically-designed Grievance Committees, followed by annual reports to be submitted to the MHP Quality Improvement Committee.²⁴⁶ Some QIWs are concerned with improvements around provider appeals and provider notification of resolutions, which, as discussed above, is an area where the Triennial Reviews have identified major deficiencies.²⁴⁷ Surprisingly few QIWs address issues related to notices, meaning that the QIWs are not currently used regularly to maintain oversight of whether notices are issued properly or contain the required content, including whenever the MHP determines that an enrollee does not meet the medical necessity criteria for SMHS.²⁴⁸

Quality Recommendations

- **DHCS should comprehensively review and approve QIWs.** DHCS should engage in more meaningful and comprehensive review of QIWs on an annual basis and ensure that QIWs address systemic dispute resolution problems identified during the triennial review process.
- **DHCS should require MHPs to formally evaluate the QIWs and include dispute resolution findings.** This evaluation should inform future quality improvement activities to be reflected in the QIWs, and should not be limited to enrollee grievances, appeals, and expedited appeals, but should also include ongoing evaluation

of grievances and appeals brought by providers and an analysis of whether the MHP is informing providers of grievances and appeals resolutions.

- **DHCS should encourage MHPs to use their QIWs to propose improvements around issuance of notices of adverse benefits determinations.** MHPs should use their QIWs to ensure that notices are properly issued to enrollees who are denied services or whose services are delayed or modified, and ensure that the notices include all of the required information.

Conclusion

The current delivery system for mental health services in Medi-Cal is bifurcated, which causes significant challenges both to ensuring that Medi-Cal enrollees and their families know where and how to access mental services when they need them, and to providing coordinated access to those services without gaps or delays. In 2020, the 1915(b) Medi-Cal waiver that governs the bifurcated delivery system for SMHS through MHPs will expire and needs to be renewed or modified, if the state seeks to continue it. Between now and then, California has a unique opportunity to improve its delivery systems to ensure that all enrollees receive appropriate and coordinated mental health care when they need it. The recommendations contained in this report are intended to guide the State and its MCPs and MHPs to implement best practices to make delivery of mental health services in Medi-Cal more effective and efficient, so that no one goes without needed care.

Endnotes

- ¹ Senate Bill XI 1 (Hernandez, Chapter 4, Statutes of 2013) (encoded at Cal. Welf. & Inst. Code § 14132.03).
- ² For the small number of Medi-Cal beneficiaries who are not enrolled in an MCP, but receive care through fee-for-service Medi-Cal, non-specialty mental health services are delivered through the fee-for-service system, rather than the MCPs.
- ³ Cal. Health Care Found., *Mental Health in California: For Too Many, Care Not There* 4 (2018), <https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf>.
- ⁴ *Id.*
- ⁵ *Id.* at 6-10.
- ⁶ *Id.* at 5, 44.
- ⁷ *See id.* at 15-16.
- ⁸ *Id.* at 17-18.
- ⁹ Cal. Health Care Found., *supra* note 3, at 29.
- ¹⁰ *Id.* at 26.
- ¹¹ Kim Lewis & Abbi Coursolle, Nat'l Health Law Prog., *Issue Brief: Mental Health Services in Medi-Cal* (2017), <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/Mental-Health-Services-in-Medi-Cal>.
- ¹² Kim Lewis & Abbi Coursolle, Nat'l Health Law Prog., *Access to Mental Health Services for Children with Special Health Care Needs: Analysis and Recommendations* (2017), <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/access-to-mental-health-services-for-children-with-special-health-care-needs>. This work was funded by the Lucile Packard Foundation for Children's Health.
- ¹³ Most mental health services are provided pursuant to the rehabilitative services option (42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130) or other licensed practitioner option (42 U.S.C. § 1396d(a)(6); 42 C.F.R. 440.60). Some services may also be delivered as part of broader optional benefits, such as pharmacy benefits (42 U.S.C. §§ 1396d(a)(12), 1396r-8; 42 C.F.R. § 440.120), or targeted case management (42 U.S.C. § 1396n(g)).
- ¹⁴ 42 U.S.C. 1396d(r); CAL. WELF. & INST. CODE § 14132(v); *see also* Cal. Dep't Health Care Servs., All Plan Letter 14-017 (Dec. 12, 2014) [hereinafter APL 14-017], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2014/APL14-017.pdf>.
- ¹⁵ The pre-paid inpatient health plan or PIHP model was phased in between 1995 and 1998. *See* Sarah Arnquist & Peter Harbage, *A Complex Case: Public Mental Health Delivery and Financing in California* 15-18 (2013) (describing this history), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf>.
- ¹⁶ Letter from Hye Sun Lee, Ctrs. Medicare & Medicaid Servs., to Mari Cantwell, Cal. Dep't Health Care Servs. (June 24, 2015) [hereinafter 1915(b) Waiver Approval & STC], http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf.

- ¹⁷ CAL. CODE REGS., tit. 9, § 1810.247.
- ¹⁸ Cal. Dep't Health Care Servs., Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 21-24 (2015) [hereinafter California 1915(b) Proposal], [http://www.dhcs.ca.gov/services/MH/Documents/1915\(%20b\)_SMHS_Waiver.pdf](http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf).
- ¹⁹ See CAL. WELF. & INST. CODE § 14059.5; see also CAL. CODE REGS. tit. 9, § 1810.215 (requiring MHPs to comply with 22 C.C.R. §§ 51340(e)(3) & (f) and 42 U.S.C. § 1396d(r)); see also Cal. Dep't Health Care Servs., MHSUDS Information Notice No. 16-061 at 2-3 (Dec. 9, 2016) [hereinafter MHSUDS Notice 16-061], http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf.
- ²⁰ CAL. CODE REGS., tit. 9, § 1810.215.
- ²¹ See Cal. Dept. Health Care Servs., All Plan Letter 13-021 (Dec. 13, 2013) [hereinafter APL 13-021], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf>; see also Don Kingdon et al., Cal. Health Care Found., *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions* 3 (2016), <https://www.chcf.org/wp-content/uploads/2016/08/CircleMediCalMentalHealth.pdf>.
- ²² 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5) (benefits for expansion population must include essential health benefits (behavioral health services are an essential health benefit per 42 U.S.C. § 18022(b)(1)(E)); see also Michelle Lilienfeld, Nat'l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), <http://www.healthlaw.org/about/staff/michelle-lilienfeld/all-publications/alternative-benefit-plans-for-the-medicaid-expansion-population>.
- ²³ California, *State Plan Amendment # 13-035* (2014), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf>; see also Lilienfeld, *supra* note 22, at 2-3 (discussing benefit alignment).
- ²⁴ APL 13-021, *supra* note 21, at 4. These services are also covered in fee-for-service for beneficiaries who are not enrolled in a Medi-Cal plan. See CAL. WELF. & INST. CODE § 14132.03.
- ²⁵ APL 13-021, *supra* note 21, at 3-4.
- ²⁶ California 1915(b) Proposal, *supra* note 18, at 24.
- ²⁷ See *id.*
- ²⁸ MHSUDS Notice 16-061, *supra* note 19, at 2-3.
- ²⁹ CAL. CODE REGS., tit. 9, § 1810.370.
- ³⁰ *Id.* § 1810.415
- ³¹ *Id.* § 1850.505
- ³² *Id.* § 1850.525
- ³³ CAL. WELF. & INST. CODE § 14681; Cal. Dept. Health Care Servs., All Plan Letter 13-018 (Nov. 27, 2013) [hereinafter APL 13-018], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>; Cal. Dep't of Health Care Servs., *Sample Contract Boilerplate for County Mental Health Plans* at Ex. A, Attach. 11 (discussing responsibilities with respect to case management and care coordination) [hereinafter MHP Boilerplate Contract], <http://www.dhcs.ca.gov/services/MH/Documents/Attachment%202%20MHP%20Contract%20Boilerplate.pdf>; *id.* at Ex. A, Attach. 12 (discussing MHPs responsibility to coordinate with local health departments).
- ³⁴ MHSUDS Notice 16-061, *supra* note 19, at 2.

³⁵ *Id.* at 3.

³⁶ *Id.* at 4.

³⁷ *Id.*

³⁸ See, e.g., Mental Health Parity Act of 1996, Pub. L. 104-204, title VII, § 702(a), 110 Stat. 2944 (1996) (codified as amended at 29 U.S.C. § 1185a); Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, div. C, title V, § 512(a), (g)(1)(A), 122 Stat. 3881, 3892 (2008) (codified at 29 U.S.C. § 1185a); see also Amanda K. Sarata, Cong. Research Serv., *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010* at 3 (2011), <http://www.ncsl.org/documents/health/MHparity%26mandates.pdf>. For a comprehensive description of the rules that apply to large group, small group, and individual health plans, see Elizabeth Edwards, Nat'l Health Law Prog., *Mental Health Parity and Addiction Equity Act of 2008* (2014), <http://www.healthlaw.org/about/staff/elizabeth-edwards/elizabeth-edwards-publications/issue-brief-mhpaea2008>.

³⁹ 42 U.S.C. §§ 1396u-2(b)(8), 1396u-7(b)(6), 1397cc(f)(2); see CMS, State Health Official Letter (Jan. 16, 2013) (SHO # 13-001) (describing the legislative history), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>; see also Ctrs. for Medicare & Medicaid Servs., *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (2017), <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>; Elizabeth Edwards & Abbi Coursolle, Nat'l Health Law Prog., *Fact Sheet: Mental Health Parity Compliance in Medicaid* (2018) (describing the guidance in detail), <http://www.healthlaw.org/publications/browse-all-publications/fact-sheet-mental-health-parity-compliance-medicaid>.

⁴⁰ Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. 18389, 18390 (Mar. 30, 2016).

⁴¹ 42 C.F.R. § 438.930 (states using MCOs); *id.* § 440.395(e)(4) (ABPs); *id.* § 457.496(g) (CHIPs).

⁴² See Cal. Dep't Health Care Servs., *Medicaid Mental Healthy Parity and Addiction Equity Act Compliance Plan* (2017), http://www.dhcs.ca.gov/formsandpubs/Documents/Parity_Compliance_Plan_9.29.2017.pdf.

⁴³ See *id.* at 29, 33.

⁴⁴ *Id.* at 32.

⁴⁵ *Id.* § 438.806(a); see also Ctrs. Medicare & Medicaid Servs., *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval* (2017), <https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf>.

⁴⁶ 42 C.F.R. § 438.806(b).

⁴⁷ *Id.* § 438.724.

⁴⁸ *Id.* § 438.730.

⁴⁹ 42 C.F.R. § 438.10(c).

⁵⁰ Cal. Dep't Health Care Servs., *Mental Health / Substance Use Disorder Services Information Notice 18-043* (Sep. 26, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-043_Beneficiary_Handbook/MHSUDS_Information_Note_18-043_Beneficiary_Handbook_Information_Note.pdf.

⁵¹ CAL. WELF. & INST. CODE § 14184.21.

⁵² *Id.* § 14681; APL 13-018, *supra* note 33.

⁵³ CAL. WELF. & INST. CODE § 14683.

⁵⁴ CAL. CODE REGS. tit. 9 § 1810.370(a)(1).

- ⁵⁵ APL 13-018, *supra* note 33.
- ⁵⁶ U.S. CONST., amend. XIV, § 1.
- ⁵⁷ *Goldberg v. Kelly*, 397 U.S. 254 (1970) (holding that when welfare benefits are terminated, the enrollee has due process rights to an effective notice and pre-termination hearing); see also 42 C.F.R. § 431.205(d).
- ⁵⁸ See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250; *id.* § 438, SubPart F (dispute resolution requirements for managed care systems); see also *id.* at § 431.205(d) (explicitly requiring hearing system to meet *Goldberg* standards).
- ⁵⁹ *Goldberg*, 397 U.S. at 267; see also 42 C.F.R. § 431.230.
- ⁶⁰ 42 C.F.R. §§ 438.100, 438.56.
- ⁶¹ *Id.* §§ 438.228, 438.400-438.424.
- ⁶² *Id.* §§ 438.404, 438.210; see also *id.* § 438.10.
- ⁶³ *Id.* §§ 438.200, 431.220 431.244.
- ⁶⁴ *Id.* § 438.54.
- ⁶⁵ *Id.* § 438.56.
- ⁶⁶ 42 C.F.R. § 438.71.
- ⁶⁷ *Id.* § 438.420.
- ⁶⁸ *Id.* §§ 438.402, 438.408.
- ⁶⁹ *Id.*
- ⁷⁰ CAL WELF. & INST. CODE § 10950(g)(1).
- ⁷¹ See *id.* § 10950(g)(2).
- ⁷² See *id.* §§ 10951, 10951.5.
- ⁷³ See *id.* § 10951(e); Cal. Dep't Health Care Servs., All Plan Letter 17-006 (May 9, 2017) [hereinafter APL 17-006], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>; Cal. Dep't Health Care Servs., Mental Health / Substance Use Disorder Information Notice 18-010E (Mar. 27, 2018), http://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf.
- ⁷⁴ CAL WELF. & INST. CODE § 10951(f).
- ⁷⁵ *Id.* § 14456.
- ⁷⁶ See *id.*
- ⁷⁷ Medical Audits and Corrective Action Plans, Cal. Dept. Health Care Servs., <https://www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx> (last visited Sep. 21, 2018).
- ⁷⁸ See Health Servs. Accountability Group, Medi-Cal Managed Care External Quality Review Technical Report: July 1, 2016–June 30, 2017 at 16 (2017) [hereinafter EQR Tech. Rep.], https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2016-17_EQR_Technical_Report_F1.pdf.
- ⁷⁹ Technical Assistance Guides, Cal. Dept. Health Care Servs., <https://www.dhcs.ca.gov/services/Pages/TechnicalAssistanceGuides.aspx> (last visited Sep. 21, 2018).
- ⁸⁰ See *id.* Notably, however, the department has yet to publish a guide for the Member Rights category, which would presumably include review of plans' grievances and appeals policies and practices.

- ⁸¹ CAL. WELF. & INST. CODE § 14456.
- ⁸² *Id.* § 14457.
- ⁸³ See *id.* § 5614; CAL. CODE REGS., tit. 9, § 1810.380(a).
- ⁸⁴ See System and Chart Reviews, Cal. Dept. Health Care Servs., https://www.dhcs.ca.gov/services/MH/Pages/POC_MH_System_and_Chart_Reviews.aspx (last visited Sep. 21, 2018).
- ⁸⁵ Cal. Dep't Health Care Servs., Mental Health / Substance Use Disorder Information Notice 17-050 (Sep. 28, 2017), https://www.dhcs.ca.gov/Documents/MHSUDS_Info_Notice_17-050_Annual_Review_FY_17-18.pdf.
- ⁸⁶ Cal. Dep't Health Care Servs., *Draft Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Fiscal Year 2018-2019* at 72-74 (2018) [hereinafter Draft MHP Review Protocol 18-19] (on file with NHeLP). While DHCS has not released the final protocol as of the publication of this report, we understand that it will not contain substantive changes compared to this draft.
- ⁸⁷ See CAL. CODE REGS., tit. 9, § 1810.380(b), (c).
- ⁸⁸ *Id.* § 1810.380(c); Draft MHP Review Protocol 18-19, *supra* note 86, at 3.
- ⁸⁹ See CAL. CODE REGS., tit. 9, § 1810.310; California 1915(b) Proposal, *supra* note 18, at 100; see also Cal. Dep't Health Care Servs., Mental Health / Substance Use Disorder Information Notice 97-06 (Mar. 14, 1997) [hereinafter MHSUDS Notice 97-06], <https://www.dhcs.ca.gov/services/MH/Documents/Attachment%2014%20%20DMH%20Information%20Notice%2097-06%20Implementation%20Plans.pdf>.
- ⁹⁰ CAL. CODE REGS. tit. 9, § 1810.310(a)(2), (3).
- ⁹¹ *Id.* § 1810.310(c).
- ⁹² See Draft MHP Review Protocol 18-19, *supra* note 86, at 6.
- ⁹³ MHSUDS Notice 97-06, *supra* note 89, at 3, 6.
- ⁹⁴ 42 C.F.R. § 438.340.
- ⁹⁵ *Id.* § 438.340(c)(3), (d).
- ⁹⁶ Cal. Dep't Health Care Servs., *Medi-Cal Managed Care Quality Strategy Report* (2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf>.
- ⁹⁷ 42 C.F.R. § 438.330(c)(1).
- ⁹⁸ Cal. Dep't Health Care Servs., *Medi-Cal Managed Care – Quality Improvement & Performance Measurement Reports: External Accountability Sets (EAS)*, <https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx> (last visited Sep. 24, 2018).
- ⁹⁹ See, e.g., EQR Tech. Rep., *supra* note 78, at 24.
- ¹⁰⁰ See *id.* at 23-37.
- ¹⁰¹ *Id.* at 27.
- ¹⁰² *Id.*
- ¹⁰³ 42 C.F.R. § 438.330(d).
- ¹⁰⁴ *Id.* § 438.330(d)(2).
- ¹⁰⁵ *Id.* § 438.330(d)(3).
- ¹⁰⁶ *Id.* § 438.358(b)(1).

- ¹⁰⁷ Cal. Dept. Health Care Servs., All Plan Letter 17-014 (Sep. 11, 2017) [hereinafter APL 17-014], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-014.pdf>; see also Cal. Dep't Health Care Servs., *Medi-Cal Managed Care Quality Strategy Annual Assessment 27* (2017), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/2017_Medi-Cal_Managed_Care_Quality_Strategy_Annual_Assessment.pdf.
- ¹⁰⁸ APL 17-014, *supra* note 107, at 8-9.
- ¹⁰⁹ EQR Tech. Rep., *supra* note 78, at 65-66.
- ¹¹⁰ See *id.* at 66; see also APL 17-014, *supra* note 107, at 9.
- ¹¹¹ APL 17-014, *supra* note 107, at 9.
- ¹¹² *Id.*
- ¹¹³ *Id.*
- ¹¹⁴ Medi-Cal Managed Care – Quality Improvement & Performance Measurement Reports Page, Cal. Dep't Health Care Servs., <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTTR.aspx> (last visited Oct. 1, 2018).
- ¹¹⁵ See California External Quality Review Organization, Cal. Dep't Health Care Servs., http://www.dhcs.ca.gov/services/MH/Pages/CAL_EQRO_PIP.aspx (last visited Sep. 20, 2018).
- ¹¹⁶ *Id.*
- ¹¹⁷ 1915(b) Waiver Approval & STC, *supra* note 16, at ¶ 5.
- ¹¹⁸ See California External Quality Review Organization, *supra* note 115; see also Reports and Summaries Page, Behavioral Health Concepts, Inc., http://www.caleqro.com/mh-egro#!mh-reports_and_summaries (last visited Oct. 1, 2018).
- ¹¹⁹ See CAL. CODE REGS., tit. 9, § 1810.440(a).
- ¹²⁰ MHP Boilerplate Contract, *supra* note 33, at Ex. A, Attach I § 22(J).
- ¹²¹ 42 C.F.R. § 438.350.
- ¹²² *Id.* § 438.352.
- ¹²³ Quality of Care External Quality Review, Ctrs. Medicare & Medicaid Servs., <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html> (last visited Oct. 2, 2018).
- ¹²⁴ See *id.*; 42 C.F.R. § 438.358(b).
- ¹²⁵ Ctrs. Medicare & Medicaid Servs., *Quality, External Quality Review Protocols: Introduction* 7 (2012).
- ¹²⁶ 42 C.F.R. § 438.358(b).
- ¹²⁷ *Id.* § 438.358(c). Reports must also include detailed explanation of the methodology for data collection, aggregation and analysis for each required EQR activity and validation of quality measures and may include other optional activities.
- ¹²⁸ *Id.* § 438.364(a).
- ¹²⁹ U.S. Dep't Health & Hum. Servs., *External Quality Reviews in Medicaid Managed Care* 11 (2008), <http://oig.hhs.gov/oei/reports/oei-01-06-00510.pdf>.
- ¹³⁰ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
- ¹³¹ See, e.g., APL 17-014, *supra* note 107.

- ¹³² About CAHPS, Agency Healthcare Res. & Qual., <https://www.ahrq.gov/cahps/about-cahps/index.html> (last visited Oct. 2, 2018).
- ¹³³ See CAHPS Health Plan Survey, Agency Healthcare Res. & Qual., <https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html> (last visited Oct. 2, 2018).
- ¹³⁴ *Id.*
- ¹³⁵ See *id.*
- ¹³⁶ CAL. CODE REGS., tit. 9, § 3530.40; see also Cal. Dep’t Health Care Servs., Mental Health / Substance Use Disorder Services Information Notice 18-013 (May 7, 2018) [hereinafter MHSUDS Notice 18-013], https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_Information_Notice_18-013_Spring_2018_CPS-FINAL.pdf.
- ¹³⁷ See CAL. CODE REGS., tit. 9, § 3530.40.
- ¹³⁸ Cal. Dep’t Health Care Servs., *Instructions for Consumer Perception Survey Data Collection 1* (2018) [hereinafter MHP Consumer Perception Survey], https://www.dhcs.ca.gov/services/MH/Documents/FMORB/CPS_Instructions_Spring2018.pdf.
- ¹³⁹ 42 C.F.R. § 438.416.
- ¹⁴⁰ *Id.* § 438.416(b).
- ¹⁴¹ See, e.g., Cal. Dep’t Health Care Servs., *COHS Boilerplate Contract*, at Ex. A, Attach. 14 § 3(B) (2013) [hereinafter MCP Boilerplate Contract] (incorporating Cal. Health & Safety Code § 1368 and 28 C.C.R. § 1300.68(f)), <https://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.
- ¹⁴² See *id.*
- ¹⁴³ Cal. Dep’t Health Care Servs., All Plan Letter 14-013, at 2 (Nov. 3, 2014) [hereinafter APL 14-013], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-013.pdf>.
- ¹⁴⁴ See *id.* at Attach. 1.
- ¹⁴⁵ CAL. CODE REGS., tit. 9, § 1810.375(a).
- ¹⁴⁶ “Action” was the term previous used in the federal regulations to describe what is now known as an “adverse benefit determination.”
- ¹⁴⁷ Cal. Dep’t of Health Care Servs., *Annual Medi-Cal Beneficiary Grievance and Appeal Report 1* (2017) [hereinafter ABGAR], https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/ABGAR_Final_2016-17.pdf.
- ¹⁴⁸ For a more detailed description of the survey results, please see Appendix C.
- ¹⁴⁹ Cal. Dep’t Health Care Servs., All Plan Letter 18-015 (Sep. 19, 2018) [hereinafter APL 18-015], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-015.pdf>.
- ¹⁵⁰ *Id.* at 2. For the MOU template, Cal. Dep’t Health Care Servs., Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and County Mental Health Plans (2018) [hereinafter MOU Template], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-015Att2.pdf>.
- ¹⁵¹ APL 18-015, *supra* note 149, at 4.
- ¹⁵² See generally MHSUDS Notice 16-061, *supra* note 19.
- ¹⁵³ See Cal. Dep’t Health Care Servs., Mental Health / Substance Use Disorder Services Information Notice 14-020 (May 29, 2014), <https://www.dhcs.ca.gov/formsandpubs/Documents/14-020.pdf>; I. Dep’t Health Care Servs., Mental Health / Substance Use Disorder Services Information Notice 15-015 (Apr. 16, 2015), https://www.dhcs.ca.gov/formsandpubs/Documents/IN_15_015.pdf; MHSUDS Notice 16-016, *supra* note 19.

- ¹⁵⁴ Cal. Dep't Health Care Servs., *MHP Triennial Review Preparation Checklist, Fiscal Year 2017/2018* (2017) [hereinafter MHP Triennial Review Checklist] (on file with NHeLP).
- ¹⁵⁵ *Id.*
- ¹⁵⁶ For the regulatory requirements, see CAL. CODE REGS., tit. 9, § 1810.370.
- ¹⁵⁷ MHP Triennial Review Checklist, *supra* note 154; see also Draft MHP Review Protocol 18-19, *supra* note 86, at 73.
- ¹⁵⁸ We submitted a PRA request for MOUs that had been updated since 2015, but the information we received demonstrated that the vast majority of MOUs agreed upon between 2014 and 2015 continue in effect as of 2018. Of all the MOUs reviewed, only the MOU entered between the San Francisco County Department of Public Health and San Francisco Health Plan had been updated as recently as 2017. A 2016 addendum was incorporated into the MOUs entered into between Health Net Community Solutions and MHPs in the counties of Kern, Sacramento, San Diego, San Joaquin, and Stanislaus. This addendum addresses coverage and coordination of medically necessary Behavioral Health Treatment (BHT) services for beneficiaries under 21 and did not update or modify the language in the original MOUs dated April 2017 in any significant way.
- ¹⁵⁹ See MOU Template, *supra* note 150.
- ¹⁶⁰ *MOU between Glen County Division of Behavioral Health Plan and Blue Cross of California Partnership Plan* (2014) (on file with NHeLP).
- ¹⁶¹ Some screening tools were sent directly to us from surveyed MHPs and MCPs. Other screening tools were gathered through our review of MOUs. Finally, other screening tools were found using online search tools. Some, but not all, MHPs and MCPs use different screening tools for adults and children. For example, Beacon Health Solutions, which contracts with 25 counties to provide non-specialty mental health services, uses different screening tools for adults and children. While there was some difference among the screening tools in counties where the MCP contracts with Beacon Health Strategies, however, the general structure is the same.
- ¹⁶² For example, both the children and adult screening tools uses a time period of six months as the cut off for meeting a list criteria like violent crime in the last six months, self-injurious behavior in the last six months, or psychiatric hospitalization in the last six month. However, this six-month time is not consistent with research on rates of recidivism or rehospitalization. Rather, the research shows that risk of reoffending in criminal activity combined with mental illness remains for a year or longer with many studies tracking recidivism among people with and without mental illness through four or more years with the likelihood of reincarceration increasing each year. See, e.g., Amy Blank Wilson et al., *Examining the Impact of Mental Illness and Substance Use on Recidivism in a County Jail*, 34 *INTERNAT'L J. LAW & PSYCH.* 264 (2011); Jacques Baillargeon et al., *Risk of Reincarceration Among Prisoners with Co-Occurring Severe Mental Illness and Substance Use Disorders*, 37 *ADMIN. & POLY MENTAL HEALTH* 367 (2010). Studies of the risk of re-hospitalization for psychiatric patients typically included up to a year with some extending longer; research suggests that although follow-up at six months is not important, inclusion criteria should be longer to provide a better picture of mental health needs. See Raluca Sfetcu et al., *Overview of Post-Discharge Predictors for Psychiatric Re-Hospitalisations: a Systematic Review of the Literature*, 17 *BMC PSYCH.* 227 (2016).
- ¹⁶³ See CAL. WELF. & INST. CODE § 14132.03.
- ¹⁶⁴ MHP Boilerplate Contract, *supra* note 33, at Ex. A, Attach. I §§ 2(E), 22(E).
- ¹⁶⁵ MCP Boilerplate Contract, *supra* note 141, at Ex. A, Attach. 11 § 2(A)(6).
- ¹⁶⁶ *Id.* at Ex. A, Attach. 11 § 7.

- ¹⁶⁷ See Cal. Dep't Health Care Servs., *Stakeholder Advisory Committee: July 19, 2017*, at 14 (2017) [hereinafter July 2017 SAC], https://www.dhcs.ca.gov/services/Documents/071917_SAC_MeetingSummary.pdf.
- ¹⁶⁸ See Cal. Dep't Health Care Servs., All Plan Letter 17-018 (Oct. 27, 2017) [hereinafter APL 17-018], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf>; MHSUDS Notice 16-061, *supra* note 19.
- ¹⁶⁹ Compare APL 17-018 *supra* note 168 with MHSUDS Notice 16-061, *supra* note 19.
- ¹⁷⁰ 42 C.F.R. § 438.10(c)(4)(ii).
- ¹⁷¹ See July 2017 SAC, *supra* note 167, at 14.
- ¹⁷² See, e.g., Cal. Dep't Health Care Servs., *Model Member Handbook: Non-COHS Counties 40* (2017) [hereinafter MCP Model Handbook], https://www.healthcareoptions.dhcs.ca.gov/sites/default/files/Documents/DHCSModelHandbook_WEB_112117.pdf.
- ¹⁷³ See *id.*
- ¹⁷⁴ See Cal. Dep't Health Care Servs., *Mental Health Plan Beneficiary Handbook 42-56* (2018) [hereinafter MHP Model Handbook], https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-043_Beneficiary_Handbook/MHP_Beneficiary_Handbook.pdf.
- ¹⁷⁵ See Draft MHP Review Protocol 18-19, *supra* note 86. As discussed above, while DHCS has not released the final protocol as of the publication of this report, we understand that it will not contain substantive changes compared to this draft.
- ¹⁷⁶ See *id.* at 33-40.
- ¹⁷⁷ *Id.*
- ¹⁷⁸ See MHP Triennial Review Checklist, *supra* note 154. Under the proposed 2018-2019 protocol, DHCS will continue to use the same documentation to evaluate compliance with the proposed requirements. See *generally* Draft MHP Review Protocol 18-19, *supra* note 86. In addition, the department has announced that it will seek to place more emphasis on the review and evaluation that takes place prior to the on-site visit and will be more active in requesting and evaluating documentation to demonstrate compliance from MHPs before the on-site review.
- ¹⁷⁹ See Medi-Cal Specialty Mental Health Services Plans of Correction, Cal. Dep't Health Care Servs., https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last visited Oct. 2, 2018). DHCS is required to make these postings pursuant to the 1915(b) Waiver. See 1915(b) Waiver Approval & STC, *supra* note 16, at ¶ 4.
- ¹⁸⁰ Cal. Dep't Health Care Servs., *Fiscal Year 2016/2017 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services King County Mental Health Plan Review: Findings Report, October 17-20* (2016), https://www.dhcs.ca.gov/Documents/FY_2016_-2017_System_Report_Kings_County.pdf; Cal. Dep't Health Care Servs., *Fiscal Year 2017/2018 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services Kings County Mental Health Plan Review: Findings Report 19* (2018), [https://www.dhcs.ca.gov/services/MH/Documents/DelNorteSystemReport_FY17-18_FINAL_Icedits7-28%202018\(arial12\).pdf](https://www.dhcs.ca.gov/services/MH/Documents/DelNorteSystemReport_FY17-18_FINAL_Icedits7-28%202018(arial12).pdf); Cal. Dep't Health Care Servs., *Fiscal Year 2017/2018 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services Inyo County Mental Health Plan Review: Findings Report 14* (2018), https://www.dhcs.ca.gov/services/MH/Documents/FY_2017_18_System_Report_Inyo.pdf.
- ¹⁸¹ See *generally* Cal. Dep't Health Care Servs., *Kings County Plan of Corrections 2016/2017* (2018), https://www.dhcs.ca.gov/services/MH/Documents/MHPPPOC%20FY%202017-18/Kings_County_Plan_of_Correction_FY_2016-17.pdf.

- ¹⁸² *Id.* at page 9. The triennial reports for Del Norte and Inyo counties both were released over 60 days ago, but no POC has been posted online as of the date this report was published.
- ¹⁸³ Technical Assistance Guides, *supra* note 79.
- ¹⁸⁴ See al. Dep't Health Care Servs., *Technical Assistance Guide for Medical Audits, Category 2: Case Management and Coordination of Care 4* (2017), https://www.dhcs.ca.gov/services/Documents/MCQMD/CCTechnicalAssistanceGuide_05-22-17.pdf.
- ¹⁸⁵ *Id.* at 5-6.
- ¹⁸⁶ *Id.* at 6.
- ¹⁸⁷ See Medical Audits and Corrective Action Plan, *supra* note 77.
- ¹⁸⁸ As required by federal law, all plans have an exemption for emergency care and family planning care to the referral requirements.
- ¹⁸⁹ See 42 C.F.R. § 438.358.
- ¹⁹⁰ See generally EQR Tech. Rep., *supra* note 78.
- ¹⁹¹ See *id.*
- ¹⁹² 42 C.F.R. section §438.330 (d).
- ¹⁹³ See EQR Tech. Rep., *supra* note 78, at 69-72. For example, Anthem Blue Cross Partnership Plan's postpartum PIP addressing provider side coordination efforts (*id.* at 230); CenCal Health's diabetes care PIP focused on coordination of beneficiary outreach and appointment scheduling assistance (*id.* at 393); Contra Costa Health Plan's postpartum PIP using public health nurses for care coordination function (*id.* at 468); Family Mosaic Project's caregiver engagement PIP focused on increasing caregiver attendance at care coordination meetings and primary care connections PIP focused on primary care connections focused on procedures for care coordinators referring beneficiaries and families to primary care providers (*id.* at 481-83); Health Net Community Solutions, Inc.'s hemoglobin A1c PIP focused on the lack of protocols for provider outreach to enrollees for hemoglobin testing (*id.* at 570); Inland Empire Health Plan's pap smear testing rate PIP focused on developing protocols for identifying patients who need screening and treatment (*id.* at 641); San Francisco Health Plan's postpartum PIP focused on care coordination and referral and patient experience PIP that was abandoned, but involved using three way calls with Medi-Cal Managed Care representations, the Managed Care Plan, and the enrollee to try to increase enrollee satisfaction and decrease confusion (*id.* at 849-51).
- ¹⁹⁴ One of Gold Coast Health Plan's PIPs focused on developmental screening for children and was aimed at increasing the percentage of standardized child developmental screening tools completed for children eight to eleven months of age. *id.* at 504.
- ¹⁹⁵ California External Quality Review Organization, *supra* note 115; APL 17-014, *supra* note 107, at 8-9.
- ¹⁹⁶ Behavioral Health Concepts, *2016-2017 Medi-Cal Specialty Mental Health External Quality Review Statewide Report 71* (2017), <https://caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202016-2017%20Reports/CalEQRO%20Statewide%20Annual%20Report%20FY16-17.pdf>.
- ¹⁹⁷ See e.g., Amador County Behavioral Health, *Quality Improvement Program 2016-2017 Work Plan Evaluation 9* (2017) (describing clinical PIP aimed at meeting the needs of youth with co-occurring mental health and substance use disorders), <https://www.amadorgov.org/home/showdocument?id=28177>.
- ¹⁹⁸ See generally CAHPS Health Plan Survey, *supra* note 133.
- ¹⁹⁹ See MHP Consumer Perception Survey, *supra* note 138.

- ²⁰⁰ All counties are represented in these 56 QIWP. The counties of Placer and Sierra have developed a joint QIWP, as have the counties of Sutter and Yuba. See Mental Health Plan Quality Improvement Plans, Cal. Dep't Health Care Servs., https://www.dhcs.ca.gov/services/MH/Pages/MHP_QI_Plans.aspx (last visited Sep. 28, 2018).
- ²⁰¹ See, e.g., El Dorado County Health & Hum. Servs. Agency, *Mental Health Division Annual Quality Improvement Work Plan Fiscal Year 2018-19*, at 7 (2018), <https://edcgov.us/Government/MentalHealth/QI/Documents/FY%2018-19%20Approved%20EDC%20QI%20Work%20Plan%2007-1-18.pdf>; Cty. Imperial, *Quality Improvement Work Plan FY 2017-2018* (2018), <http://www.co.imperial.ca.us/behavioralhealth/otherpdfs/QI%20Work%20Plan%2017-18.pdf>; Tulare County Health & Hum. Servs. Agency, *Quality Improvement Work Plan FY 2017-2018* (2018), http://hhsawebdocs.tchsa.org/Questys.CMx.HHSAWebdocs/File.ashx?id=4518&v=1&x=pdf&r=HHSA_Webdocs.
- ²⁰² See, e.g., Cty. Imperial, *supra* note 201, at 47.
- ²⁰³ APL 18-015, *supra* note 149; see also MOU Template, *supra* note 150.
- ²⁰⁴ See Draft MHP Review Protocol 18-19, *supra* note 86, at 70. See *id.* § B.
- ²⁰⁵ See, e.g., *MOU between Madera County Mental Health Plan and CalViva* (2015) (on file with NHeLP); *MOU between El Dorado County Mental Health Plan and Kaiser Permanente, LLC* (2015) (on file with NHeLP).
- ²⁰⁶ See, e.g., *MOU between Kern Behavioral Health and Recovery Services and Kern Health Systems* (2014) (on file with NHeLP).
- ²⁰⁷ See MHP Boilerplate Contract, *supra* note 33, at Ex. A, Attach. I § 15.
- ²⁰⁸ See *id.*
- ²⁰⁹ See MCP Boilerplate Contract, *supra* note 141, at Ex. A, Attach. 14.
- ²¹⁰ See July 2017 SAC, *supra* note 167, at 14.
- ²¹¹ Compare APL 14-013, *supra* note 143, at 2, with CAL. CODE REGS. tit. 9, § 1810.375(a).
- ²¹² See sources cited *supra* note 211; see also ABGAR, *supra* note 147, at 1.
- ²¹³ 42 C.F.R. § 438.10(c)(4)(ii).
- ²¹⁴ See July 2017 SAC, *supra* note 167, at 14.
- ²¹⁵ See *id.*
- ²¹⁶ See MHP Model Handbook, *supra* note 174, at 42-56.
- ²¹⁷ Specifically, the state's 2015-16 System Review of Butte County's MHP notes that the County's Implementation Plan had not been updated since 2001, and required the County to take corrective action. Cal. Dep't Health Care Servs., *Fiscal Year (FY) 2015/2016 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services: Butte County Mental Health Plan Review* 14 (2016), https://www.dhcs.ca.gov/services/MH/Documents/FY_2015-16_System_Review_Report_Butte.pdf. The state's 2017-18 System Review of Sacramento County's MHP notes that the county's Implementation Plan had not been updated since 2007, and required the County to take corrective action. Cal. Dep't Health Care Servs., *Fiscal Year (FY) 2017/2018 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services: Sacramento County Mental Health Plan Review* 4 (2018), <https://www.dhcs.ca.gov/services/MH/Documents/FY-17-18-Sacramento-County-Findings-Report.pdf>.
- ²¹⁸ 42 C.F.R. § 438.10(c)(4)(ii).
- ²¹⁹ See Draft MHP Review Protocol 18-19, *supra* note 86. As discussed above, while at the time this report was published, the final protocol was not yet available, we understand it will not change substantially from this draft.

- ²²⁰ *Id.* at § F. In its 2017-2018 Preparation Checklist, DHCS requests that MHPs submit “Evaluation Results [for] Grievances, Appeals, and Fair Hearings” prior to the on-site review. See MHP Triennial Review Checklist, *supra* note 154. We understand that, while the MHP contract requires plans to evaluate enrollee grievances, appeals, and fair hearings at least annually, DHCS does not impose a specific mechanism for plans to conduct these assessments. As such, it is up to the plans to determine what evidence it will submit to demonstrate compliance. DHCS informed us that most plans submit their QIWP as evidence that they are conducting evaluations of grievances, appeals, and fair hearings. For more information about the QIWPs and how they address dispute resolution concerns, see Section X.
- ²²¹ Draft MHP Review Protocol 18-19, *supra* note 86, at 94.
- ²²² *Id.* at 99.
- ²²³ See Medi-Cal Specialty Mental Health Services Plans of Correction, *supra* note 179.
- ²²⁴ Specifically, the POCs we reviewed evaluated dispute resolution requirements under Section C (Cal. Dep’t Health Care Servs., *Draft Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Fiscal Year 2015-2016* (2015), https://www.dhcs.ca.gov/formsandpubs/Documents/15-042_Enc1_RvwProtocol.pdf), and Section D (Cal. Dep’t Health Care Servs., *Draft Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Fiscal Year 2016-2017* (2016), https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_16-045_Enc1.pdf & Cal. Dep’t Health Care Servs., *Draft Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Fiscal Year 2017-2018* (2017), https://www.dhcs.ca.gov/Documents/Enclosure_1_Annual_Review_Protocol_SMHS_Other_Funded_Programs_FY_17-18.pdf) on Beneficiary Protection. There was not any significant difference between the protocols for reviewing dispute resolution compliance under these three different annual protocols. We conducted our review with the understanding that going forward, oversight is likely to improve under the new protocol for fiscal year 2018-2019.
- ²²⁵ See Appendix D for a table explaining how these numbers were calculated.
- ²²⁶ See Cal. Dep’t Health Care Servs., *Santa Cruz County Plan of Correction for Triennial Review 3-4* (2018), https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Santa_Cruz_County_Plan_of_Correction_2018-Redacted.pdf.
- ²²⁷ See Cal. Dep’t Health Care Servs., *Ventura Mental Health Plan Review March 27-30, 2017: Items Out of Compliance with Plan of Correction 7-10* (2017), https://www.dhcs.ca.gov/services/MH/Documents/FY_2016-17_Plan_of_Correction_Ventura_County.pdf.
- ²²⁸ See, e.g., Cal. Dep’t Health Care Servs., *Merced Mental Health Plan Review March 27-30, 2017: Items Out of Compliance with Plan of Correction 3* (2017), https://www.dhcs.ca.gov/services/MH/Documents/MHPPOC%20FY%202017-18/MERCED_POC_Report_FY_16-17_Finalv3-Redacted.pdf; Cal. Dep’t Health Care Servs., *Marin Behavioral Health & Recovery Services Response to FY 2016/2017 Annual Review of Consolidated Specialty Mental Health Services and Other Funded Services Mental Health Plan Review Findings Report 6* (2017), https://www.dhcs.ca.gov/services/MH/Documents/MHPPOC%20FY%202017-18/Marin_County_UPDATED_POC_FY_2016-17.pdf.
- ²²⁹ See Technical Assistance Guides, *supra* note 79.
- ²³⁰ Medical Audits and Corrective Action Plans, *supra* note 77.
- ²³¹ See Medi-Cal Specialty Mental Health Services Plans of Correction, *supra* note 179.
- ²³² Cal. Dep’t Health Care Servs., *Medical Review: CalOptima 7* (2017), <https://www.dhcs.ca.gov/services/Documents/MMCD/2017CalOptimaMedicalAuditReport.pdf>.

- ²³³ Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: CalOptima 1-2* (2018) [hereinafter CalOptima CAP], <https://www.dhcs.ca.gov/services/Documents/MMCD/2017CalOptimaMedicalAuditCAPCloseout.pdf>.
- ²³⁴ See, e.g., Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: Kaiser 26-27* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/2016KaiserMedicalAuditCAPCloseout.pdf>; Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: Partnership Health Plan 9-11* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/2017PHCMedicalAuditCAPCloseout.pdf>; Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: California Health & Wellness Plan 27-28* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/2016CAHWMedicalAuditCAPCloseout.pdf>.
- ²³⁵ See, e.g., Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: Santa Clara Family Health Plan 32-33* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/2017SCFHPMedicalAuditCAPCloseout.pdf>.
- ²³⁶ See, e.g., Cal. Dep't Health Care Servs., *Corrective Action Plan Response Form: California Health & Wellness Plan 27-28* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/2016CAHWMedicalAuditCAPCloseout.pdf>.
- ²³⁷ See *id.* at 1-2; CalOptima CAP, *supra* note 233, at 1-2.
- ²³⁸ See generally EQR TECH. REP., *supra* note 78.
- ²³⁹ See CAHPS Health Plan Survey, *supra* note 133.
- ²⁴⁰ Cal. Dep't Health Care Servs., *MHSIP Consumer Survey: Adult Survey 1* (2018) ("I was given information about my rights."), https://www.cibhs.org/sites/main/files/file-attachments/adult_with_qol-english.pdf.
- ²⁴¹ See Cal. Dep't Health Care Servs., *Youth Services Survey for Youth* (2018), <https://www.cibhs.org/sites/main/files/file-attachments/youth-english.pdf>.
- ²⁴² MHP Boilerplate Contract, *supra* note 33, at Ex. A, Attach. I.
- ²⁴³ We reviewed 56 QIWP, representing all counties in the state. The counties of Placer and Sierra have developed a joint QIWP, as have the counties of Sutter and Yuba. See Mental Health Plan Quality Improvement Plans, *supra* note 200.
- ²⁴⁴ See, e.g., Alpine County Behavioral Health Services, *Quality Improvement Work Plan Fiscal Year 2017/2018* at 10 (2017) (proposing, as part of the activities related to monitoring client satisfaction, to monitor all processed enrollee grievances, appeals, and expedited appeals by ongoing review of the plan's log, and noting that if the review uncovers significant trends, that "may influence the need for policy changes or other system-level issues"), <http://www.alpinecountyca.gov/DocumentCenter/View/1846>.
- ²⁴⁵ See, e.g., Butte Cnty. Dep't Behav. Health, *Quality Assurance and Performance Improvement Work Plan FY 17-18* at 13 (2017), <http://www.buttecounty.net/Portals/5/Administration/QMD/QAPIWorkPlanFY1718.pdf>; Sacramento Cnty. Div. Behav. Health Servs., *Quality Management Program Annual Work Plan - Fiscal Year 17/18* at 11 (2017), <http://www.dhs.saccounty.net/BHS/Documents/Reports--Workplans/RT-QM-Program-Annual-Work-Plan-FY2017-18.pdf>.
- ²⁴⁶ See, e.g., Butte Cnty. Dep't Behav. Health, *supra* note 245, at 13; Cnty. Of Marin, *Quality Improvement Work Plan FY 2017-2018* at 3 (2017), https://www.marinhhs.org/sites/default/files/files/servicepages/2017_10/qi_workplan_fy17-18_final.pdf.
- ²⁴⁷ See, e.g., San Mateo County Behavioral Health & Recovery Servs., *Quality Improvement Work Plan July 2017-June 2018* at 5 (2017) (setting a goal of ensuring that "providers are informed of the resolution of all grievances and given a copy of the letter within 90 days of the grievance file date"), <http://www.smchealth.org/sites/main/files/file-attachments/qualityimprovementworkplan2017-18.pdf>.

²⁴⁸ For an example of an MHP that did address notice requirements in its QIWP, see *Cty. Imperial*, *supra* note 201, at 90 (stating that the quality improvement team is responsible for ensuring that the enrollee is properly advised of denials, authorization limits, or service reductions and that the NOA includes information about how to appeal the plan's decision).

Appendix A: Model Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING
BY AND AMONG
MEDI-CAL MANAGED CARE PLAN AND COUNTY MENTAL HEALTH PLAN

This Memorandum of Understanding (MOU) is between (NAME OF MCP) and (NAME OF MHP). This MOU specifies the division of procedures/processes and responsibilities between the two agencies.

Purpose: To address the coordination between (NAME OF MCP) and (NAME OF MHP) in the delivery of Medi-Cal-covered, behavioral/mental health services to Medi-Cal beneficiaries enrolled with (NAME OF MCP) and to comply with Department of Health Care Services (DHCS) regulatory requirements regarding behavioral health.

Terms: The term of this Agreement begins on January 1, 20XX and ends on December 31, 20XX.

CATEGORY	MCP	MHP
BASIC RESPONSIBILITIES		
BASIC RESPONSIBILITIES	Coordination and coverage of behavioral and physical health services for members who meet medical necessity criteria for services covered by Medi-Cal. MCP is contracted by DHCS to ensure the delivery of physical health care services and mental health services through a credentialed and contracted provider network. Behavioral health services are rendered within the primary care physician's (PCP) scope of practice and through a managed behavioral health care organization for medically necessary outpatient mental health services. MCP will refer to and coordinate with the MHP.	Coverage and provision of specialty mental health services for members who meet medical necessity and service necessity criteria for Medi-Cal Specialty Mental Health Services (SMHS). MHP is contracted by DHCS to select and credential its provider network, negotiate rates, authorize specialty mental health services, and provide payment for services rendered by specialty mental health providers. MHP will refer to and coordinate with the MCP.

**Appendix A:
Model Memorandum of Understanding (continued)**

RESPONSIBILITIES WITH RESPECT TO PROVIDER NETWORKS		
<p>NETWORK MANAGEMENT (IF APPLICABLE)</p>	<p>MCP has contracted with (NAME OF CONTRACTOR) to administer the Outpatient Mental Health Benefit.</p> <p>MCP contracts with (NAME OF CONTRACTOR) to provide the provider network and utilization management services for the Outpatient Mental Health Benefit.</p> <p>For the purpose of this MOU, MCP is the primary contact with the MHP and may involve (NAME OF CONTRACTOR) in meetings with the MHP, as necessary.</p> <p>(NAME OF CONTRACTOR) contact information: xxx-xxx-xxxx _____ _____</p>	<p>MHP has contracted with (NAME OF CONTRACTOR) to administer the Specialty Mental Health Services (IF APPLICABLE)</p>
<p>PROVIDER NETWORKS</p>	<p>MCP will maintain a current list of contract provider on its website, which can be accessed by the MHP, and will specify which contractors also contract with the MHP.</p> <p>IF APPLICABLE: (NAME OF CONTRACTOR) will maintain a current list of contract providers on its website, which can be accessed by the MHP.</p>	<p>MHP will provide a current list of contract providers to the MCP upon agreement of MOU, as additions or deletions occur, and as otherwise needed. The MHP will encourage its contracted providers to also contract with the MCP when appropriate.</p>
<p>CREDENTIALING</p>	<p>MCP requires that MCP Providers and the MHP utilize National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards.</p>	<p>Conforming to the standards of the National Committee on Quality Assurance, MHP will complete a credentialing process for its individual and group practitioner providers.</p> <p>MHP will involve the MCP in the process of developing, monitoring and updating credentialing elements at least annually so that the MCP may validate the MHP credentialing process.</p> <p>It is recognized that the the county's Community Behavioral Health clinics are presently certified and re-certified through a site-specific State Short-Doyle certification process.</p>

**Appendix A:
Model Memorandum of Understanding (continued)**

OVERSIGHT RESPONSIBILITIES, DISPUTE RESOLUTION, GRIEVANCES AND APPEALS		
LIAISON	<p>Medical Director or designee will:</p> <ol style="list-style-type: none"> 1. Coordinate activities with MHP and inform MCP and/or MCP Providers about services offered by MHP. MCP Providers include delegated medical groups, clinics, and clinicians contracted with MCP to provide health care services to MCP members. 2. Identify and resolve any systemic issues including recommended changes to the Memorandum of Understanding (MOU) or the processes defined herein. 3. Represent MCP and/or MCP Providers in the dispute resolution process. 4. Oversee the MCP's process for tracking referrals to the MHP. <p>Designated MCP liaison staff will meet at least quarterly with MHP liaison staff to ensure that the terms of the MOU are operationalized and operating effectively and efficiently.</p>	<p>MHP Director or designee will:</p> <ol style="list-style-type: none"> 1. Coordinate activities with MCP and/or MCP Providers and notify MHP staff of their roles and responsibilities. 2. Identify and resolve any systemic issues, including recommended changes to the MOU or the processes defined herein. 3. Represent MHP in the dispute resolution process. 4. Oversee the MHP's process for tracking referrals to the MCP. <p>Designated MHP liaison staff will meet at least quarterly with MCP liaison staff to ensure that the terms of the MOU are operationalized effectively and efficiently.</p>

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>OVERSIGHT RESPONSIBILITIES</p>	<p>MCP and MHP mental health Medi-Cal oversight team will be comprised of representatives of the MCP and MHP responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.</p> <p>MCP will have an oversight team comprised of a Medical Director as well as representatives from various internal departments such as: Quality Improvement, Information Technology, and Finance.</p> <p>Mental Health Service requests or disputes will be reviewed internally or by delegated subcontractor (whichever current process is in-place) and will be provided by licensed medical and/or mental health professionals, with current and unrestricted licensure to provide program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.</p> <p>MCP and MHP will establish a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information.</p> <p>The MCP Multidisciplinary Clinical Team will be led by the MHP Liaison and will include members from the Quality Improvement Division, Authorization Team, Substance Use Disorder Division and other designated licensed mental health professionals. The members will meet quarterly with MCP Multidisciplinary Clinical Team members or more frequently as needed by mutual agreement</p>	<p>MCP and MHP mental health Medi-Cal oversight team comprised of representatives of the MCP and MHP responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.</p> <p>The MHP Oversight Team will be led by the MHP Liaison and include members of the Quality Improvement, Substance Use Disorder, Finance and Information Technology Divisions. The members will meet quarterly with MCP Oversight Team members or more frequently as needed by mutual agreement.</p> <p>MCP and MHP will establish a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information.</p> <p>MHP will have an oversight team comprised of a Medical Director as well as representatives from Utilization Management, Quality Improvement, Claims, Member Services, and Provider Relations</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

DISPUTE RESOLUTION	<p>Both MCP and MHP agree to participate in a dispute resolution process that includes:</p> <p>Administrative and Clinical</p> <p>First Level Review</p> <ol style="list-style-type: none"> 1. The resolution process must be initiated within 45 calendar days of the disputed event. 2. Each Plan will appoint a representative, designated by the Plan, to reach and implement resolution decisions. 3. The representatives together will arrive at proposed resolution of the dispute within 10 business days. 4. If the representatives are unable to reach a joint decision, or if the proposed resolution is not acceptable to both Plans, a second level review may be initiated by either Plan. <p>Second Level Review</p> <ol style="list-style-type: none"> 1. The second level review must be initiated within 10 business days after a first level decision. 2. Each Plan will use its Medical Director, or the Medical Director's designees as a 2nd level reviewer. 3. The second level reviews will reach a joint resolution within 10 business days. 4. If the second level reviewers cannot reach a joint decision, or if the decision is not acceptable to both Plans, a third party review may be initiated by either Plan. <p>Third Party Review by either #1 or California DHCS State level dispute resolution process</p> <ol style="list-style-type: none"> 1. Current regulations specify that if the local dispute resolution process is not able to resolve the dispute, that either Plan may request dispute resolution by a state-level process staffed by the DHCS. <p>If the dispute involves MCP continuing to provide services to the enrollee, which the MCP staff believes required SMHS from the MHP, the MHP shall identify and provide the MCP with the name and phone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the MCP provider responsible for the enrollee's care.</p> <p>If the dispute involves an urgent need for services, an expedited dispute resolution process must be initiated and all levels of review must be completed within 7 business days.</p> <p>Provision of Services During Resolution Process</p> <p>Both Plans agree to provide services to the beneficiary during the dispute resolution process in accordance with current regulations.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

<p>PROVISION OF MEDICALLY NECESSARY SERVICES PENDING RESOLUTION OF DISPUTE</p>	<p>Pursuant to CCR, Title 9, Section 1850.525, an unresolved pending dispute between the MHP and MCP shall not delay the provision of medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to a MCP beneficiary. The following applies until the dispute is resolved:</p> <p>The parties may agree to an arrangement satisfactory to both parties regarding how the services under dispute will be provided; or when the dispute concerns the MCP's contention that the MHP is required to deliver SMHS or Short-Doyle Mental Health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, the MCP shall be responsible for providing and managing the care of the member under the terms of the contract with DHCS until the dispute is resolved. When the dispute concerns the MHP's contention that the MCP is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological or radioisotope services required to diagnose or treat the mental illness, the MHP is responsible to provide or arrange and pay for the disputed services to the beneficiary until the dispute is resolved.</p>	<p>A dispute between the MHP and the MCP shall not delay the provision of medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries pending resolution of the dispute.</p> <p>The parties may agree to an arrangement satisfactory to both parties regarding how the services under dispute will be provided; or when the dispute concerns the MHP's contention that the MCP is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.</p> <p>The County MHP shall identify and provide the MCP with the name and telephone number a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the MCP provider responsible for the beneficiary's care.</p> <p>When the dispute concerns the MHP's contention that the MCP is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological or radioisotope services required to diagnose or treat the mental illness, the County MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

<p>GRIEVANCES AND APPEALS</p>	<p>Enrollees have all grievance and appeal rights granted under the current DHCS contract requirements and federal and state law.</p> <p>Enrollees contacting the MCP with complaints regarding their experience with MHP or its providers are referred immediately to the MHP so their concern can be investigated and resolved. MCP has a process in place to track such MHP complaints for evaluation during the quarterly and annual reviews Medical Directors and/or liaisons review.</p> <p>MCP has in place a written process for the submittal, processing and resolution of all member grievances and complaints which is inclusive of any aspect of the health care services or provision of services.</p> <p>MCP will coordinate and share the established complaint and grievance process for its members with the MHP.</p> <p>MCP will ensure that members and providers are given an opportunity for reconsideration and an appeal for denied, modified or delayed services</p> <p>MCP will ensure that beneficiaries continue receiving medically necessary services while an appeal is pending.</p> <p>MCP and MHP will agree on a system to track grievances and appeals related to denial, modification, or delay of mental health services.</p> <p>MCP and MHP will meet annually to evaluate grievances and appeals tracked.</p>	<p>Enrollees have all grievance and appeal rights granted under the current DHCS contract requirements and federal and state law..</p> <p>MHP is responsible for addressing member complaints related to the care and services provided to those enrollees by its staff or provider network.</p> <p>MHP will ensure that MCP members and providers are given an opportunity for reconsideration and an appeal for denied, modified, or delayed services.</p> <p>MHP will ensure that beneficiaries continue receiving medically necessary services while an appeal is pending.</p> <p>MCP and MHP will agree on a system to track grievances and appeals related to denial, modification, or delay of mental health services.</p> <p>MCP and MHP will meet annually to evaluate grievances and appeals tracked.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

COVERED SERVICES AND MEDICAL NECESSITY		
COVERED SERVICES	<p>MCP arranges for Medi-Cal covered physical and mental health care benefits within a managed care model as outlined in current DHCS contract and regulations. PCPs are delegated to provide and/or arrange for covered services.</p> <p>PCPs are responsible for the provision of mental health services within the scope of PCP practice.</p> <p>The mental health services covered, when medically necessary include:</p> <ol style="list-style-type: none"> 1. Diagnostic of mental health condition(s) and determination of treatment plan. <ol style="list-style-type: none"> a. Assessments are conducted by a licensed mental health professional as specified in the Medi-Cal Provider Manual. 2. Individual and group mental health evaluation and treatment (psychotherapy). 3. Psychological testing, when clinically indicated to evaluate a mental health condition(s). 4. Outpatient services for the purposes of monitoring drug therapy. 5. Outpatient laboratory, drugs, supplies, and supplements (excluding medications excluded by DHCS from managed care plan coverage). 6. Psychiatric consultation. 7. Medically necessary treatment for mental health conditions for children, or for adults where the condition result in mild or moderate impairment, but are not limited to: <ol style="list-style-type: none"> a. Basic education, counseling, referral, and linkage to mental health and other services b. Treatment/medications for: Mental health conditions that would be responsive to physical health care-based treatment and those conditions that do not meet MHP medical necessity criteria. <p>MCP also provides for medical case management.</p>	<p>Medi-Cal covered SMHS are those defined in Title 9, CCR, Section 1810.247 and include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Rehabilitative mental health services <ol style="list-style-type: none"> a. Assessment b. Plan development c. Therapy d. Collateral services e. Medication support 2. Day treatment intensive and day rehabilitation 3. Crisis intervention 4. Crisis stabilization 5. Adult residential treatment services 6. Crisis residential services 7. Psychiatric or Psychologist services 8. Targeted care management 9. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, including Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Behavioral Services and Therapeutic Foster Care 10. Psychiatric inpatient hospital services <p>MHP provides and maintains responsibility for:</p> <ol style="list-style-type: none"> 1. Treatment for mental health conditions that would not be responsive to physical health care-based treatment. 2. Medication-induced psychiatric reactions from medications prescribed by the MCP providers to the extent that those reactions meet Medi-Cal criteria for medical and service necessity.

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>MEDICAL NECESSITY</p>	<p>MCP covers certain, medically necessary, outpatient mental health assessment and services to adult members with mild to moderate impairment of mental, emotional, or behavioral functioning as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), that are outside of the PCP's scope of practice.</p> <p>Medically necessary services for adults are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These services include:</p> <ol style="list-style-type: none"> 1. Diagnose a mental health condition and determine a treatment plan. 2. Provide medically necessary treatment for mental health conditions that result in mild to moderate impairment. 3. Refer adults and children to MHP for SMHS when member appears to meet criteria for service. <p>For children under age 21, the MCP must cover all non-SMHS, regardless of severity of the child's impairment, when medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.</p>	<p>A. Pursuant to Title 9, CCR §1830.205, an adult beneficiary must meet the following criteria to receive outpatient Medi-Cal SMHS:</p> <ol style="list-style-type: none"> 1. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present. 2. Impairment: The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis: <ol style="list-style-type: none"> a. A significant impairment in an important area of life functioning; b. A reasonable probability of significant deterioration in an important area of life functioning; or, 3. Intervention: The proposed intervention is focused on addressing the impairment resulting from the covered diagnosis with the expectation that the proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning. In addition, the beneficiary's condition would not be responsive to physical health care based treatment <p>B. Pursuant to Section 14059.5 of the Welfare and Institutions Code, and existing state guidance, medical necessity criteria for beneficiaries under the age of 21 are met when all of the following exist:</p> <ol style="list-style-type: none"> 1. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present; 2. The beneficiary has a condition that would not be responsive to physical health care-based treatment and, 3. The services are necessary to correct or ameliorate a mental illness or condition discovered by the screening services.
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**Appendix A:
Model Memorandum of Understanding (continued)**

SCREENING AND REFERRAL PROCESS		
SCREENING ASSESSMENT	<p>MCP and MHP have agreed-upon screening and assessment processes and use DHCS-provided screening tool in compliance with federal and state requirements. See Attachment for Screening Tool. Within attachment are process directions and screening tools for child and adult members. Instructions that accompany the screening tools ensure consistency in the process.</p> <p>Any MCP staff, PCP, provider can complete a mental health screening using the DHCS screening tool. The screening tool is designed to identify beneficiaries who may be eligible for SMHS as well as services that can be provided by a PCP or a mental health provider contracted by the MCP. After completing a mental health screening using the tool, MCP staff, PCP, or provider will enter the results of the screening in an agreed-upon tracking document or software.</p> <p>MCP offers a Health Risk Assessment (HRA) for Seniors and Persons with Disabilities (SPD) beneficiaries annually and an Initial Health Assessment (IHA) for newly enrolled beneficiaries. The HRA and IHA screen for current health and functional risks, including behavioral health needs. These screens serve as the basis for further assessment, which may include case management needs, mental health and substance use, chronic physical conditions, dementia, cognitive status, and the capacity to make informed decisions.</p> <p>Data from the HRA and IHA is used to create the care plan, which guides further assessment and treatment activities. MCP behavioral health providers are responsible for performing assessment within the scope of their licensure to aid them in developing their treatment plan; provide referrals; guide treatment decisions.</p> <p>MCP PCPs are responsible for the following types of diagnostic assessments:</p> <ol style="list-style-type: none"> 1. Basic Assessments: PCPs are expected to be familiar with the full range of ICD-9/ICD-10 diagnoses, including diagnosis of mental disorder. 2. To rule out General Medical Conditions Causing Psychological Symptoms. 3. To rule out Mental Disorders Due to a General Medical Condition and Substance Related Disorders. 4. Identify general medical conditions that are causing or exacerbating psychological symptoms. 5. Conduct screening, brief intervention and referral to treatment (SBIRT) for misuse of alcohol for beneficiaries over 18 annually. 6. Conduct EPSDT screenings for beneficiaries under 21 as required. 	<p>MCP and MHP have agreed-upon screening and assessment processes and use DHCS-provided screening tool in compliance. See Attachment for Screening Tool. Within attachment are process directions and screening tools for child and adult members. Instructions that accompany the screening tools ensure consistency in the process.</p> <p>Any MHP staff or provider can complete a mental health screening using the DHCS screening tool. The screening tool is designed to identify beneficiaries who may be eligible for SMHS as well as services that can be provided by a PCP or a mental health provider contracted by the MCP. After completing a mental health screening using the tool, the MHP staff or provider will enter the results of the screening in an agreed-upon tracking document or software.</p> <p>MHP is responsible for assessments involving:</p> <ol style="list-style-type: none"> 1. The resolution of diagnostic dilemmas not resolved by consultation if the diagnostic conclusion has a bearing on the PCP's treatment plan or if the diagnostic conclusion is needed to determine appropriateness for SMHS. 2. Stability level if the result is needed to determine appropriateness for SMHS. 3. The need for SMHS

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>REFERRALS AND AUTHORIZATION OF SERVICES</p>	<p>If it is determined by MCP providers that the beneficiary meets SMHS medical necessity criteria, MCP staff or their providers refers the beneficiary to MHP for further assessment and treatment. At the point of referral, staff secures beneficiary acceptance of the referral and informed consent. MCP providers are responsible for directly contacting MHP to ensure referral acceptance. The MCP shall notate the referral in an agreed-upon tracking document or software.</p> <p>If the MHP determines a beneficiary does not meet medical necessity criteria for SMHS, after conducting a full assessment, MCP staff or their providers refers the beneficiary to a contracted mental health provider.</p> <p>MCP and their providers accept referrals from MHP. When a beneficiary is ineligible for MHP programs, the MCP may refer beneficiary to community-based programs. MCP maintains a current list of community-based programs and assist beneficiaries with access.</p> <p>Referrals to MHP by MCP staff occur when:</p> <ol style="list-style-type: none"> 1. An assessment is needed by MHP to confirm or arrive at a diagnosis. 2. Medically necessity criteria for SMHS is met (Check Medical Necessity criteria information above) <p>When an MCP assessment leads to a referral to the MHP, the report includes relevant available information regarding the patient's diagnosis and need for service. The MCP shall notate receipt of the referral in an agreed-upon tracking document or software, and document next steps, including the beneficiary's first appointment with an MCP provider.</p>	<p>MHP accepts referrals from MCP staff, providers, and beneficiaries' self-referral (or referral from beneficiary's authorized representative) or through referral by another person or organization, for determination of medical necessity for SMHS. The MHP shall notate receipt of the referral in an agreed-upon tracking document or software, and document next steps, including the beneficiary's first appointment with an MHP provider.</p> <p>When MHP determines that an MCP beneficiary is ineligible for MHP-covered services, the MHP refers the beneficiary to the MCP primary care provider for services covered by the MCP or to other source of care for services not covered by the MHP. At the point of referral, staff secures beneficiary acceptance and informed consent. MHP providers are responsible for directly contacting MCP provider to ensure referral acceptance. The MHP shall notate the referral in an agreed-upon tracking document or software.</p> <p>All referrals from the MHP or its service providers are made to MCP and the identified primary care provider of the beneficiary, which can be obtained by calling the MCP or checking the plan's website portal. When a MHP assessment leads to a referral to the MCP and/or one of its providers, the report includes relevant available information regarding the patient's diagnosis and need for service.</p> <p>MHP assists in providing member referrals to providers, provider referral agencies and/or other sources of care for services not covered by the MHP.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

CARE COORDINATION		
<p>CLINICAL CONSULTATION</p>	<p>MCP will monitor the process for MHP providers to receive physical health consultation about MCP members.</p> <p>MCP will inform PCPs on how to access MHP consult/liason services.</p> <p>MCP and/or MCP Providers will participate in case consultation with MHP providers as appropriate and mutually develop treatment plans.</p> <p>MCP providers and plan staff are available to consult with MHP staff and/or PCPs about beneficiary's physical health conditions and outpatient mental health needs. MHP and MCP behavioral health providers are available to provide clinical consultation to PCPs as requested for both medication management and consult on the mental health condition managed by the PCP.</p> <p>Clinical consultation includes but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Acquiring access to covered MCP medical services. 2. Treatment of physical symptoms precipitated by medications used to treat mental disorders. 3. Treatment of complicated sub-syndrome medical symptoms. 4. Complex medication interactions with medications prescribed by PCPs not commonly used in psychiatric specialty practices. <p>MCP provides clinical consultation and training to MHP or other providers of mental health services regarding a beneficiary's physical condition. Such consultation includes consultation by MCP to MHP on medications prescribed by an MCP provider for a MHP client.</p>	<p>MHP providers will participate in case consultation with MCP and/or MCP providers as appropriate and mutually develop treatment plans.</p> <p>MHP provides consultation to MCP administrative staff for acquiring access to MHP services.</p> <p>MHP provides clinical consultation to MCP providers regarding SMHS. Clinical consultation includes but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Recommended physical health care-based primary mental health treatment for diagnosed conditions. 2. Complex diagnostic assessment of mental disorders (e.g. multiple, co-occurring diagnoses; atypical symptom patterns). 3. Treatment of stabilized but serious and debilitating mental disorders. 4. Complex psychotropic medication practices (medication interactions, polypharmacy, and use of psychotropic medication). 5. Consultation regarding the coordination with pharmacies and MCP as appropriate to assist beneficiaries in receiving prescription drugs and laboratory services prescribed. 6. Treatment for complicated sub-syndrome psychiatric symptoms. 7. Treatment of psychiatric symptoms precipitated by medications used to treat medical conditions. 8. Clinical consultation regarding beneficiary's physical health condition and medications being treated by MHP.
<p>INFORMATION EXCHANGE</p>	<p>The MCP and MHP shall have policies and procedures that ensure timely sharing of information. The policies and procedures shall describe agreed upon roles and responsibilities for sharing protected health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3), and in compliance with HIPAA and other State and federal privacy laws. Such information may include, but is not limited to, beneficiary demographic information, diagnosis, treatment plan, medications prescribed, laboratory results, referrals/discharges to/from inpatient and crisis services, and known changes in condition that may adversely impact the beneficiary's health and/or welfare. Both the MCP and MHP shall make best efforts to secure releases from beneficiaries as necessary to facilitate the exchange of information, in particular, to allow the MCP and MHP to track referrals and transitions of care.</p>	

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>MEDICAL RECORD CONFIDENTIALITY</p>	<p>MCP will maintain the confidentiality of medical records in accordance with all applicable state and federal laws and regulations.</p> <p>MCP will assist in improving communication between MCP providers and MHP about clients they have in common.</p> <p>When a MCP member accesses the services of the MHP in addition to the PCP, the PCP will request written consent from the member to share information with the MHP provider regarding:</p> <ol style="list-style-type: none"> 1. Medical condition 2. Current Medications prescribed by the PCP <p>The written consent to release information must be signed by the MCP member or authorized person and kept in the MCP member's record file.</p> <p>MCP and contracted providers are prohibited from releasing medical information, even to persons authorized to receive that information, that is related to the patient's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting the information submits to the provider, plan or contractor, a written, signed request that describes the following:</p> <ol style="list-style-type: none"> 1. The information requested 2. Intended use or uses 3. The length of time during which the information will be kept before being destroyed or disposed of 4. A statement that the information will not be used for other purposes and will be destroyed within the designated time frame. <p>(MOU SHOULD CONTAIN A SAMPLE RELEASE FORM)</p> <p>MCP will comply with applicable portions of the Confidentiality of Medical Information Act (California Civil Code 56 through 56.37) the Patient Access to Health Records Act (California Health and Safety Code 123100, et esq) and the Health Insurance Portability and Accountability Act (Code of federal regulations Title 45 Parts 160 and 154)</p> <p>MCP will provide MHP with a copy of MCP Policy and Procedure regarding Medical Records and Other Protected Health Information</p>	<p>MHP will maintain the confidentiality of medical records in accordance with all applicable state and federal laws and regulations.</p> <p>MHP will assist in improving communication between MCP Providers and MHP about clients they have in common.</p> <p>MHP providers will send a written treatment plan and update to the PCP and to the referring behaviorist (if applicable), at the following milestones:</p> <ol style="list-style-type: none"> 1. on engaging the patient into a treatment program 2. on discharging the patient from treatment 3. at the time of any medication changes 4. annually, for ongoing treatment <p>Protected Health Information (PHI) created by the MHP is primarily protected by:</p> <ol style="list-style-type: none"> 1. the California Welfare & Institutions (W&I) Code section 5328; 2. HIPAA, and 3. the Code of Federal Regulations section 42 CFR Part II. <p>As HIPAA regulations state, because the California W&I Code often has stricter privacy protections than HIPAA, the MHP must follow the stricter W&I Code rules concerning mental health information.</p> <p>MHP will request written authorization to release information from MCP members at the time that they seek treatment from a MHP provider to share relevant information with the PCP regarding:</p> <ol style="list-style-type: none"> 1. MCP member's mental health and/or substance use disorder condition 2. Current medications prescribed by the MHP provider 3. Readiness for transition back to the Managed Care Plan; and 4. Other relevant information pertaining to the provision of services or appropriate referrals. <p>The written Authorization to Release Information form must be signed by the MCP member or authorized person and kept in the MCP member's record file. Requirements of the MHP's Authorization to release information are:</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

	<p>MCP is responsible for training all MCP staff on policies and procedures regarding PHI.</p> <p>MCP will not transmit any Electronic Mail (Email) containing confidential data of MHP members such as PHI, and Personal Confidential Information (PCI) or other confidential data to MHP or anyone else including state agencies unless transmission is secure.</p> <p>MCP will notify MHP within 24 hours during a work week of any security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use of disclosure of data in violation of any Federal or State laws or regulations.</p>	<p>It must be documented on either the MHP's official Authorization to Release Information form or on another authorization/consent form that includes all the elements required by HIPAA and the Welfare & Institutions Code and 42 CFR Part 2.</p> <p>All required areas of the authorization form must be completed or the authorization is not valid.</p> <p>The authorization to release information must be signed and dated by either the patient or legal representative.</p> <p>Once a written authorization to release information is present, the MHP will respond to a request for information from the MCP concerning provision of services or appropriate referrals within one business day.</p> <p>In certain situations such as psychiatric crises or emergencies, private health information may be released without written consent to qualified professionals who have medical or psychological responsibility for the member.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

<p>CARE / CASE COORDINATION</p>	<p>MCP and/or MCP providers will ensure adequate clinical information is provided to MHP on referrals to MHP.</p> <p>MCP and/or MCP providers will communicate with MHP providers on the proposed treatment plan when clinically indicated.</p> <p>Case coordination for the treatment of specialty and nonspecialty behavioral health diagnoses with overlapping responsibilities will be handled in accordance with the processes set forth.</p> <p>Coordination includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. An identified point of contact from each party that initiate, provides and maintains ongoing care coordination protocols as mutually agreed upon by both plans. 2. Coordination of care for inpatient mental health treatment provided by MHP including a notification process between MHP and MCP within 24 hours of admission and discharge to arrange for appropriate follow-up services. Coordination also includes processes for reviewing and updating beneficiaries' care plan when clinically indicated. 3. Coordination of transportation services required for the beneficiary to access SMHS. 4. Transition of care for beneficiaries transitioning to or from each plan's services. 5. Regular meetings to review referral, care coordination, and information exchange protocols and processes. <p>Communications will be as needed, but no less than quarterly for each member.</p>	<p>MHP will respond to all MCP and/or MCP provider referrals by fax or phone, to acknowledge referral and document action plan (accepted, modified, denied).</p> <p>MHP will communicate with MCP and/or MCP providers regarding the proposed treatment plan and on progress of member against treatment goals. Specific communication is required at the time of engagement in care (initial treatment plan), annually (for ongoing care), on change of medications, and at discharge (containing recommended follow-up).</p> <p>Case coordination for the treatment of specialty and nonspecialty behavioral health diagnoses with overlapping responsibilities will be handled in accordance the attached document.</p> <p>Coordination includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. An identified point of contact from each party that initiate, provides and maintains ongoing care coordination protocols as mutually agreed upon by both plans. 2. Coordination of care for inpatient mental health treatment provided by MHP including a notification process between MHP and MCP within 24 hours of admission and discharge to arrange for appropriate follow-up services. Coordination also includes processes for reviewing and updating beneficiaries' care plan when clinically indicated. 3. Working with the MCP to ensure that beneficiaries have transportation as necessary to access MHP services. 4. Transition of care for beneficiaries transitioning to or from each plan's services. 5. Regular meetings to review referral, care coordination, and information exchange protocols and processes. <p>Communications will be as needed, but no less than quarterly for each member.</p>
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**Appendix A:
Model Memorandum of Understanding (continued)**

RESPONSIBILITIES FOR SPECIFIC SERVICES		
EMERGENCY ROOM SERVICES AND CARE	Professionals can access 24/7 emergency services for member by contacting the MCP Triage Resource Center/Psychiatric Emergency Center/Crisis Stabilization Unit at xxx- xxx-xxxx.	Members in need of urgent and emergency psychiatric care that are identified by the MCP, including person-to-person telephone transfers, to be referred to the county crisis program during their call center hours. A toll free telephone crisis hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available 24 hours a day.
HOSPITAL SERVICES	<p>MCP covers professional services and associated room charges for hospital outpatient department services consistent with medical necessity and contracts. Separate billable outpatient services related to electroconvulsive therapy, such as anesthesiologist services, are also the contractual responsibility of the MCP.</p> <p>MCP covers all medically necessary professional services in accordance to Title 9, Section 1820.205, Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services, to meet the physical health care needs of beneficiaries who are admitted to the psychiatric ward of a general acute care hospital or a freestanding licenses psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations.</p> <p>MCP is not required to cover and pay for room and board charges or mental health services associated with a beneficiary's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.</p> <p>MHP and MCP, working with hospital providers, coordinate discharge planning from inpatient facilities based on a beneficiary's needs.</p>	<p>MHP is responsible for psychiatric inpatient services as described in Title 9, Section 1810.345 and 1810.350(b) and (c), including direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address beneficiary's medical problems based on changes in the beneficiary's mental health or medical condition.</p> <p>When medical necessity criteria are met and services are approved by the MHP, the MHP and contracted providers will provide hospital based specialty mental health ancillary services, which include, but are not limited to electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI) that are received by an MCP beneficiary admitted to a psychiatric inpatient hospital other than routine services.</p> <p>MHP contracted providers perform medical histories and physical examinations required for hospital admissions for mental health services for beneficiaries unless otherwise covered by the hospital's per diem rate.</p> <p>MHP is not responsible to provide or arrange and pay for the services excluded from coverage by the MHP under Title 9, Section 1810.355. The MHP is responsible for the mental health authorization for psychiatric inpatient hospital services.</p> <p>MHP and MCP, working with hospital providers, coordinate discharge planning from inpatient facilities based on a beneficiary's needs.</p>
NURSING FACILITY SERVICES	MCP or its delegated medical groups will arrange and pay for nursing home services for MCP members for the month of admission plus one month. MCP will arrange for disenrollment from managed care if the member needs nursing facility services for a longer period of time.	MHP will provide all medically necessary SMHS for MCP members required in Nursing Facility settings and Institutes for Mental Disease (IMDs) to the extent covered by Medi-Cal but not covered by the MCP. This would include case management as appropriate for disenrolled MCP members who meet specialty behavioral health medical necessity criteria.

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>TRANSPORTATION SERVICES</p>	<p>MCP or its delegated medical groups will arrange and pay for all medically necessary emergency and non-emergency medical transportation services, and non-medical transportation services of members as described in Title 22, CCR Section 51323 and the MCP contract, including emergency and non-emergency medical transportation services required by members to access covered behavioral health services, except as described under MHP responsibilities.</p> <p>MCP or its delegated medical groups will arrange and pay for transportation of members needing transportation for a medical condition from a psychiatric inpatient hospital or other 24-hour facility for behavioral health care to an inpatient hospital as required to address the member's physical health.</p>	<p>MHP will arrange and pay for transportation of MHP members from one psychiatric inpatient hospital to another psychiatric hospital or another type of 24-hour facility for behavioral health care only when the MHP arranges the transfer in order to use a facility with lower costs, and the transfer is not indicated for medical (physical health) reasons.</p>
<p>PHARMACEUTICAL SERVICES AND PRESCRIPTION DRUGS</p>	<p>MCP will cover medically necessary medications, except those carved-out medications that are covered through the Fee-for-Service Medi-Cal program, per State regulations.</p> <p>MCP providers will monitor the effects and side effects of psychotropic medication prescribed for those beneficiaries whose psychiatric conditions are under treatment by their PCPs.</p> <p>MCP and MHP will meet to discuss addition of new psychotropic medication to the formulary.</p> <p>MCP will ensure that MHP prescribers are included in the MCP pharmacy provider network for the limited purpose of prescribing related medications for MCP members who are also MHP members.</p> <p>MCP will share with MHP a list of participating pharmacies and update the information as it changes.</p> <p>MCP will provide a new formulary annually and inform MHP of formulary changes specific to behavioral health providers, and of any changes of psychotropic medications.</p> <p>MCP providers will prescribe medically necessary medications for the treatment of physical conditions and behavioral health conditions treated through primary care.</p>	<p>MCP and MHP will meet to discuss addition of new psychotropic medication to the formulary.</p> <p>MHP providers will prescribe and monitor the effects and side effects of psychotropic medications for those beneficiaries under treatment by MHP providers.</p> <p>MHP will give MCP a list of prescribing providers with Drug Enforcement Administration (DEA) numbers, addresses and phone numbers, and update the list on a bi-annual basis. This list will be provided in either a written or electronic format.</p> <p>MHP will participate in the development of Utilization standards for pharmacy services.</p> <p>MHP will inform its providers of carved-out psychotropic medications and mechanisms by which patients may obtain such medication.</p> <p>MHP providers will prescribe non-psychotropic medication for SFHP members only in consultation and with approval of members' SFHP PCP.</p> <p>Prescriptions for controlled medications should be done only in consultation with PCP.</p>

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>LABORATORY, RADIOLOGY, AND RADIOISOTOPE SERVICES</p>	<p>MCP will provide lists of contracted laboratories to the MHP.</p> <p>MCP and/or MCP Providers will be responsible for outpatient laboratory services for psychiatric medication monitoring. These services include tests to determine a baseline assessment before prescribing psychiatric treatment medications or to monitor side effects from psychiatric treatment medications.</p> <p>MCP and/or MCP Providers will arrange for and order laboratory tests necessary for the treatment of physical conditions.</p>	<p>MHP and MCP will work together to develop a process for assuring that behavioral health providers can order laboratory tests through contracted laboratories for laboratory tests needed in connection with the administration and management of psychotropic treatment medication.</p>
<p>HOME HEALTH SERVICES</p>	<p>The MCP PCP may request home health services for members with behavioral health diagnoses being treated by the PCP for a physical condition. MCP will authorize service based on medical necessity.</p>	<p>If MHP determines that a MCP enrollee requires medically necessary SMHS in the home setting, MHP will arrange and pay for these services.</p>
<p>SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES</p>	<p>MCP and/ or its delegated entity will refer members with developmental disabilities to Regional Centers for non-medical services such as respite care, out of home placement, supportive living services, etc. if such services are needed.</p> <p>A separate MOU with the Regional Center must be in place to govern this relationship between the MCP and RC that defines the duties of each entity.</p>	<p>MHP will refer members under its care with developmental disabilities to Regional Centers for non-medical services such as respite care, out of home placement, supportive living services, etc. if such services are needed. Services will be paid for by Regional Centers. As appropriate, MHP will inform the MCP Provider of such referral.</p> <p>A separate MOU with the Regional Center must be in place between the MHP and the RC that defines the duties of each entity.</p>
<p>REPORTING, QUALITY IMPROVEMENT, AND MOU EVALUATION</p>		
<p>REPORTING AND QUALITY IMPROVEMENT</p>	<p>MCP and MHP collaborate on quality improvement initiatives, which include but are not limited to the following:</p> <ol style="list-style-type: none"> 1. Regular and mutually agreed-upon meetings to review the referral and care coordination process and to monitor beneficiary engagement and utilization, including beneficiary's dispute resolution process. 2. Semi-annual: <ol style="list-style-type: none"> a. Review of referral and care coordination process to improve quality of care b. Reports summarizing DHCS-specified quality findings c. Reports of systemic strengths and barriers to effective collaboration between the MCP and MHP 3. Reports that track cross-system referrals, member engagement and service utilization per DHCS-specified requirements. Reports include, but are not limited to: number of disputes between MCP and MHP, disposition/outcomes of MCP/MHP disputes, number of grievances related to referrals and network access with disposition/outcomes of those grievances, utilization of mental health services by beneficiaries through each agency, quality strategies to address duplication of services. 4. Participation in DHCS-led performance measures and quality improvement initiatives. 	

**Appendix A:
Model Memorandum of Understanding (continued)**

<p>MONITORING, AMENDMENTS, AND UPDATES</p>	<p>MCP and MHP Medical Directors and/or liaisons will meet on annual basis to evaluate potential changes to the MOU. These meeting will take place prior to the end of the term of the MOU.</p> <p>During the annual meeting, MCP and MHP Medical Directors and/or liaisons will conduct a review of the effectiveness of the MOU and would make any necessary changes. If no changes are needed, the current MOU will be extended for an additional period of one year (from January 1 to December 31)</p> <p>Under no circumstances will the MOU be automatically renewed if the annual meeting between MCP and MHP Medical Directors and/or liaisons has yet to take place.</p>

Managed Care Plan

Date

Mental Health Plan

Date

Appendix B:

Survey Questions for MCP & MHP

Survey of Medi-Cal Health Plans on Mental Health Screening, Referral, and Coordination Practices

1. Please provide your plan and contract information
2. Questions about initial screening and referrals of people seeking mental health services.
3. Do you use (or require your contracted providers to use) a screening tool to determine whether a person needs (i.e. meets the medical necessity criteria for) specialty mental health services or non-specialty mental health services?
4. If someone seeks mental services, but you (or your contracted provider) determines that the person needs specialty mental health services, what do you do (or instruct your contracted provider to do) to refer that person to get those services? (Check all that apply)
5. When you (or your contracted providers) refer someone to the MHP for specialty mental health services, do you keep track of those referrals?
6. If you answered yes to the previous question, what type of system do you (or your contracted providers) use to keep track?
7. Do you use (or require your contracted providers to use) a tool to determine whether a person who is receiving your services no longer needs (i.e. meets the medical necessity criteria for) non-specialty mental health services and instead should be referred for specialty mental health services?
8. When you (or your contracted providers) refer someone to the MHP for specialty mental health services, do you (or do you instruct your contracted providers to) provide any follow-up to ensure the person follows through on the referral?
9. If someone has been receiving non-specialty mental services, but you (or your contracted provider) determine that the person's condition has changed such that s/he needs specialty mental health services, what do you do (or instruct your contracted provider to do) to refer that person to get those services? (Check all that apply)
10. When you (or your contracted providers) refer an MCP client to step-up to the MHP to receive specialty mental health services, do you keep track of those referrals?
11. If you answered yes to the previous question, what type of system do you (or your contracted providers) use to keep track?

**Appendix B:
Survey Questions for MCP & MHP (continued)**

Survey of County Mental Health Plans on Screening, Referral, and Coordination Practices

1. Please provide your contact information
2. Please provide the county or counties in which your MHP operates (please answer the survey separately for each county if different counties have different practices).
3. Do you use (or require your contracted providers to use) a screening tool to determine whether a person needs (i.e. meets the medical necessity criteria for) specialty mental health services or non-specialty mental health services?
4. If someone seeks mental services, but you (or your contracted provider) determines that the person needs non-specialty mental health services, what do you do (or instruct your contracted provider to do) to refer that person to get those services? (Check all that apply)
5. When you (or your contracted providers) refer someone to the MCP for non-specialty mental health services, do you keep track of those referrals?
6. If you answered yes to the previous question, what type of system do you (or your contracted providers) use to keep track?
7. Do you use (or require your contracted providers to use) a tool to determine whether a person who is receiving your services no longer needs (i.e. meets the medical necessity criteria for) specialty mental health services and instead should be referred for non-specialty mental health services?
8. When you (or your contracted providers) refer someone to the MCP for non-specialty mental health services, do you (or do you instruct your contracted providers to) provide any follow-up to ensure the person follows through on the referral?
9. If someone has been receiving specialty mental services, but you (or your contracted provider) determine that the person's condition has changed such that s/he needs non-specialty mental health services, what do you do (or instruct your contracted provider to do) to refer that person to get those services? (Check all that apply)
10. When you (or your contracted providers) refer an MHP client to step-down to the MCP to receive non-specialty mental health services, do you keep track of those referrals?
11. If you answered yes to the previous question, what type of system do you (or your contracted providers) use to keep track?

Appendix C: Survey of MCPs & MHPs: Highlights

MHP Survey Findings

Overview

We surveyed all 58 County MHPs in California. The survey aimed to understand the MHPs' coordination and referral processes aimed at ensuring that Medi-Cal beneficiaries get the mental health services they need.

Survey Design

The survey was developed specifically for this project and covered:

- Plan background information,
- Plan policies and practices for initial referrals to mental health services, and
- Plan policies and practices to coordinate care for current members whose care is transitioned to their health plans (MCPs).

Survey Sample and Administration

This survey did not use a random sample. Instead, the goal was to obtain information from as many MHPs as possible. Therefore, the survey data are useful for understanding the concerns for the 43 MHPs who responded, but are not necessarily representative of all MHPs.

The survey was administered online from February 1 to May 7, 2018. We also surveyed all 56 MHPs in California. NHeLP sent email invitations to the County Administrator or Director for all MHPs, as listed on a roster provided by the California Behavioral Health Directors Association (CBHDA) dated January 2018 (some MHPs had more than one contact listed, in which case the email was sent to all listed contacts). NHeLP and CDHBA also sent follow-up emails and made follow-up phone calls to the MHP contacts during March and April 2018. Of the MHPs invited to take the survey, 43 responses were collected with a completion rate of 74%. Of the 61 email invitations, 41 individuals started the survey (67%) and 32 individuals completed the survey (52%). We also supplemented the survey results with seven key informant interviews, to provide a deeper understanding of the survey results, and explore promising practices. Key informants included MCP and MHP staff and contractors, providers, and advocates.

Key Findings: Initial Referrals

Of the MHPs that responded, 77.14% reported that they use a screening tool to determine whether a person needs (i.e. meets the medical necessity criteria for) specialty mental health services or non-specialty mental health services, and 22.86% reported that they do not use a screening tool. Our review of the screening tools provided is the report.

**Appendix C:
Survey of MCPs & MHPs: Highlights (continued)**

Respondents described the ways they initiate referrals to non-SMHS when someone seeks care from an MHP, but does not meet criteria for SMHS. Most MHPs use multiple referral methods. In addition, four respondents noted that they have ongoing collaborative relationships with MCP staff and providers and work together to identify appropriate services for beneficiaries in this situation. Three respondents noted that the MHP provides services even if a person does not meet criteria for SMHS. Two MHPs noted that they are able to schedule appointments with MCP providers directly.

Table 1. If someone seeks mental services, but you determine that the person needs non-specialty mental health services, what do you do to refer that person to get those services?

ANSWER CHOICES	NUMBER OF RESPONSES	PERCENT
Tell the person to seek services from the MCP	18	51.43%
Give them the MCP's customer service number	20	57.14%
Provide the person's information directly to the MCP to follow-up	16	45.71%
Initiate a three-way call with the MCP and the person to provide a "warm hand off"	11	31.43%
Work with the MCP directly to schedule an appointment for the person	12	34.29%
Other (please explain)	18	51.43%

N = 34 (respondents could choose all answers that apply)

When asked whether they track referrals made to the MCP for individuals requesting services who do not meet the criteria for SMHS, 17.14% (6 MHPs) indicated that they do not keep track of these referrals. Another 17.14% of respondents (6 MHPs) indicated that they keep track only in the aggregate. The majority of MHPs (18 MHPs, or 51.43% of respondents) indicated that they keep track at the individual level. For those MHPs that kept track of referrals, either individually or in the aggregate, about a third used a manual tracking process, another third used an automated or computerized tracking system, and another third used some other process. Other processes included relying on the MCP to track referrals, and regular meetings with the MCP to discuss referrals.

Key Findings: Continuity of Care

Of the MHPs that responded, much fewer, only 53.13% reported that they use a screening tool to determine whether a person needs (i.e. meets the medical necessity criteria for) SMHS or non-SMHS when they are determining whether to step someone down to the MCP for care, and 46.88% reported that they do not use a screening tool. Our review of the screening tools provided is in the report.

Respondents described the ways they refer MHP enrollees who no longer meet criteria for SMHS to their MCP. Most MHPs use multiple referral methods. In addition, three respondents noted that they have ongoing collaborative relationships with MCP staff and providers and work together to identify appropriate services for beneficiaries in this situation. Three respondents also noted that the MHP provides services even if a person does

**Appendix C:
Survey of MCPs & MHPs: Highlights (continued)**

not meet criteria for SMHS. One MHP sends staff to attend the first meeting with a MCP-funded provider with the person whose care is transitioning to provide a warm hand-off.

Table 2. If someone has been receiving specialty mental services, but you determine that the person’s condition has changed such that s/he needs non-specialty mental health services, what do you do to refer that person to get those services?

ANSWER CHOICES	NUMBER OF RESPONSES	PERCENT
Tell the person to seek services from the MCP	12	37.50%
Give them the MCP’s customer service number	11	34.38%
Provide the person’s information directly to the MCP to follow-up	16	50.00%
Initiate a three-way call with the MCP and the person to provide a “warm hand off”	10	31.25%
Work with the MCP directly to schedule an appointment for the person	8	25.00%
Other (please explain)	21	65.63%

N = 31 (respondents could choose all answers that apply)

When asked whether they track referrals made to the MCP for individuals receiving services who no longer meet the criteria for SMHS, 25% (8 MHPs) indicated that they do not keep track of these referrals. Another 9.38% of respondents (3 MHPs) indicated that they keep track only in the aggregate. The majority of MHPs (18 MHPs, or 56.25% of respondents) indicated that they keep track at the individual level. For those MHPs that kept track of referrals, either individually or in the aggregate, 40% used an automated or computerized tracking system, 32% used a manual tracking process, and 28% used some other process. Other processes included tracking through the plan’s EHR system, or relying on the MCP’s tracking process.

MCP Survey Findings

Overview

NHeLP surveyed all 58 County’s Medi-Cal MCPs in California for a total of 22 MCPs. The survey aimed to understand the MCPs coordination and referral processes aimed at ensuring that Medi-Cal beneficiaries get the mental health services they need.

Survey Design

The survey was developed specifically for this project and covered:

- Plan background information,
- Plan policies and practices for initial referrals to mental health services, and
- Plan policies and practices to coordinate care for current members whose care is transitioned to the MHPs.

Appendix C: Survey of MCPs & MHPs: Highlights (continued)

Survey Sample and Administration

This survey did not use a random sample. Instead, the goal was to obtain information from as many MCPs as possible. Therefore, the survey data are useful for understanding the concerns for the MCPs who responded, but are not necessarily representative of all MCPs. However, all California counties have representation in this survey.

The MCP survey was circulated by DHCS to its list of MCP contacts (because the contact was facilitated by DHCS, we do not know the total number of individuals who received this solicitation, but it included at least one contact for each of the 22 MCPs). With assistance from DHCS, we separately reached out to 12 individuals and asked them to complete the survey on behalf of their plan. Ultimately, every MCP except one completed the survey. The survey aimed to understand the MCPs' coordination and referral processes for ensuring Medi-Cal enrollees get the mental health services they need. Ultimately, 19 individuals started the survey and 84% completed the survey.

Key Findings: Initial Referrals

Of the MCPs that responded, 66.67% reported that they use or require contracted providers to use a screening tool to determine whether a person needs specialty mental health services or non-specialty mental health services. Conversely, 33.33% reported that they did not use or require the use of a screening tool. Our review of the screening tools provided is in the report.

Respondents described the ways they initiate referrals to the MHPs for SMHS when someone seeks care from an MCP, but does not meet criteria for MCP care. Most MCPs use multiple referral methods. In addition, 6 out of the 11 "other" respondents note that they often assist in care coordination in any way that they can. 2 of the 11 respondents also note that their referral process depends on the urgency, circumstances, and the acuity of the patient's situation. Interestingly, one respondent noted that they hold "Interdisciplinary Care Team" meetings on an ad hoc basis with county partners to discuss case coordination and verify medical necessity.

Table 1. If someone seeks mental services, but you determine that the person needs specialty mental health services, what do you do to refer that person to get those services?

ANSWER CHOICES	NUMBER OF RESPONSES	PERCENT
Tell the person to seek services from the MCP	9	50.00%
Give them the MCP's customer service number	12	66.67%
Provide the person's information directly to the MCP to follow-up	11	61.11%
Initiate a three-way call with the MCP and the person to provide a "warm hand off"	10	55.56%
Work with the MCP directly to schedule an appointment for the person	12	66.67%
Other (please explain)	11	61.11%

N = 18 (respondents could choose all answers that apply)

**Appendix C:
Survey of MCPs & MHPs: Highlights (continued)**

When asked whether they track referrals made to the MHP for individuals requesting services who do not meet the criteria for MCPs, 6.25% (1 MCPs) indicated that they do not keep track of these referrals. Another 27.78% of respondents (5 MCPs) indicated that they keep track only in the aggregate. The majority of MCPs (12 MCPs, or 66.67% of respondents) indicated that they keep track at the individual level. For those MCPs that kept track of referrals, either individually or in the aggregate, 41.18% (7 MCPs) used a manual tracking process, 41.18% (7 MCPs) used an automated or computerized tracking system, and 17.65 (3 MCPs) used some other process. Other processes included a combined system of manual and automated, or using a note function in the Medical Management System and manually tracked using a spreadsheet or referrals are documented on individual records.

Key Findings: Continuity of Care

Of the MCPs that responded, 50% reported that they use a screening tool to determine whether a person needs (i.e. meets the medical necessity criteria for) SMHS or non-SMHS when they are determining whether to step someone up to the MHP for care, and 50% reported that they do not use a screening tool. Our review of the screening tools provided is in the report.

Respondents described the ways they refer MCP enrollees who now meet criteria for SMHS to their MHP. Most MCPs reported providing follow-up to ensure follow through on referrals and 12 described their methods of tracking referrals. However, 18.75% (3 MCPs) respondents note that they do not provide follow-up to track referrals.

Table 2. If someone has been receiving non-specialty mental services, but you determine that the person’s condition has changed such that s/he needs specialty mental health services, what do you do to refer that person to get those services?

ANSWER CHOICES	NUMBER OF RESPONSES	PERCENT
Tell the person to seek services from the MCP	7	43.75%
Give them the MCP’s customer service number	8	50.00%
Provide the person’s information directly to the MCP to follow-up	11	68.75%
Initiate a three-way call with the MCP and the person to provide a “warm hand off”	8	50.00%
Work with the MCP directly to schedule an appointment for the person	11	68.75%
Other (please explain)	8	50.00%

N = 16 (respondents could choose all answers that apply)

When asked whether they track referrals made to the MHP for individuals receiving services who no longer meet the criteria for MCP care, 18.75% (3 MCPs) indicated that they do not keep track of these referrals. Another 37.50% of respondents (6 MCPs) indicated that they keep track only in the aggregate. The same amount of MCPs (6 MCPs, or 37.50% of respondents) indicated that they keep track at the individual level. For those MCPs that kept track of

Appendix C: Survey of MCPs & MHPs: Highlights (continued)

referrals, either individually or in the aggregate, 46.15% used an automated or computerized tracking system, 38.46% used a manual tracking process, and 15.38% used some other process. Other processes included a combined method or tracking through the member record within the MMS and spreadsheets.

Conclusions

Although most MCPs and MHPs are providing screening, tracking, and follow-up there is still room for improvement. Many written responses indicate that processes are more complex than indicated in the survey. This is shown through the responses that indicate that both the MHP and the MCP try to tailor their approach to referral and follow-up. This is, in theory, a good practice. Further research is needed to determine if this method is successful for beneficiaries going between MCPs and MHPs as we only surveyed plans. Some studies show that beneficiaries who are referred to treatment for mental health issues do not attend referral appointments¹. Best practices that can be taken from this include individualized plans for referral and follow-up, and a “warm handoff” practice or integrated care teams that coordinate care. Our recommendations are to adopt a standardize practice of screenings, referrals, and follow-ups across MHPs and MCPs. In addition, we recommend a closed loop process to ensuring that beneficiaries are not lost in the shuffle of referrals.

¹ Andrew Moscrop, Dan Siskind, Richard Stevens; Mental health of young adult patients who do not attend appointments in primary care: a retrospective cohort study, *Family Practice*, Volume 29, Issue 1, 1 February 2012, Pages 24–29

Appendix D: Table of Issues Identified in Triennial Review Oversight

	No logs (or defective)	Logs not matching Annual Report	Grievances or Appeals not resolved within established timeframes	No written acknowledgment or notification of disposition sent to beneficiaries	Issues not sent to Quality Improvement Committee	No notification of final dispositions sent to providers	Deffective Notices of Appeal Resolution	Grievances and Appeals not logged in within one day of receipt	Issues with beneficiary problem resolution process	Plan not ensuring services are continued while State Fair Hearing is pending
Calaveras						x				
Tehama			x							
Del Norte			x	x						
Sacramento				x						
Inyo			x				x			
Fresno	x									
Santa Cruz	x			x						
San Joaquin	x									
Solano								x		
Kings				x						
Merced				x						
Alameda									x	
Santa Barbara			x							

Appendix D:
Table of Issues Identified in Triennial Review Oversight (continued)

	No logs (or defective)	Logs not matching Annual Report	Grievances or Appeals not resolved within established timeframes	No written acknowledgment or notification of disposition sent to beneficiaries	Issues not sent to Quality Improvement Committee	No notification of final dispositions sent to providers	Deffective Notices of Appeal Resolution	Grievances and Appeals not logged in within one day of receipt	Issues with beneficiary problem resolution process	Plan not ensuring services are continued while State Fair Hearing is pending
San Mateo						x				
Humboldt						x				
Ventura			x	x						
Contra Costa	x	x	x	x						
Sonoma	x		x	x						
San Francisco			x	x						
San Benito						x				
Marin			x							
Shasta			x							
El Dorado	x	x	x	x	x		x			
Madera			x	x		x	x			x
San Luis Obispo	x									
Butte			x							x
Imperial			x							
Riverside		x					x			
Siskiyou			x							
Total	7	3	15	11	1	5	4	1	1	2

Appendix E: Tools Used to Monitor Plans

	Governing Law	Applies to	How Frequent	Who generates	Process	Result	Public posting Req'd	Contains elements related to coordination and referrals between MCPs and MHPs	Contains elements related to Due Process
Medical Audit	WIC §14456	MCPs	Annual	DHCS	DHCS performs onsite review of plan policies and procedures	DHCS report is publicly posted; plans must create a corrective action plan (CAP) when non-compliance is identified	X		X
Triennial Review	WIC § 5614; 9 CCR § 1810.380	MHPs	Triennial	DHCS	DHCS performs onsite review of plan policies and procedures	DHCS report is publicly posted; plans must create a plan of correction (POC) when non-compliance is identified		X	X
Quality Strategy Report	42 CFR § 438.340	MCPs, MHPs	Annual	DHCS	DHCS must submit to CMS	DHCS aggregates data relevant to eleven areas specified in the regulation and analyzes them in an annual report	X		X

**Appendix E:
Tools Used to Monitor Plans (continued)**

	Governing Law	Applies to	How Frequent	Who generates	Process	Result	Public posting Req'd	Contains elements related to coordination and referrals between MCPs and MHPs	Contains elements related to Due Process
Managed Care Program Reports	42 CFR § 438.66	MCPs, MHPs	Annual	DHCS	DHCS must submit to CMS	DHCS is to evaluate each managed care plan in 10 areas specified in the regulation and produce an annual report summarizing its findings	X		
HEDIS Measures / External Accountability Set	42 CFR § 438.330(c) (1)	MCPs, MHPs	Annual	Plans	Plans must provide to EQRO for validation	EQRO validates plan measures and publishes results in External Quality Technical Report (MCPs) / External Quality Statewide Report (MHPs)	X		
Health Plan Grievance Reports	42 CFR § 438.416; APL 17-006	MCPs	Quarterly	Plans	Plans must submit to DHCS	DHCS aggregates data and publishes quarterly in its Medi-Cal Managed Care Performance Dashboard			X

**Appendix E:
Tools Used to Monitor Plans (continued)**

	Governing Law	Applies to	How Frequent	Who generates	Process	Result	Public posting Req'd	Contains elements related to coordination and referrals between MCPs and MHPs	Contains elements related to Due Process
Annual Beneficiary Grievance and Appeal Report (AGBAR)	42 CFR § 438.416; 9 CCR § 1810.375(a)	MHPs	Annual	Plans	Plans must submit to DHCS	DHCS reviews the AGBAR as part of the Triennial Review; plans must develop a POC to address any non-compliance determined by the review.			X
Implementation Plans	9 CCR § 1810.310	MHPs	Before operations and updated when changed	Plans	DHCS must approve	DHCS reviews the Implementation Plan including any proposed changes and must approve (explicitly or tacitly by not disapproving in 30 days) before changes are effective	No	X	X
PIPs	42 CFR § 438.330(d); 42 CFR § 438.350	MCPs, MHPs	Annual	Plans	Plans must provide to EQRO for validation	EQRO evaluates and validates PIPs annually and includes its analysis in External Quality Technical Report (MCPs) / External Quality Statewide Report (MHPs)	X	Some plans	X

**Appendix E:
Tools Used to Monitor Plans (continued)**

	Governing Law	Applies to	How Frequent	Who generates	Process	Result	Public posting Req'd	Contains elements related to coordination and referrals between MCPs and MHPs	Contains elements related to Due Process
QI/WPs	1915(b) Waiver Terms & Conditions ¶ 4; 9 CCR § 1810.440	MHPs	Annual	MHPs	Plans must review and update their plans annually	Plans must publicly post their plans	X	Some plans	X
External Quality Technical Reports	42 CFR § 438.350	MCPs, MHPs	Annual	EQRO	EQRO creates for DHCS	The EQRO obtains data and evaluates it to determine plan compliance in three areas, using a protocol developed by CMS, and also reviews additional areas as directed by the state, and publishes its findings in an annual report	X		

**Appendix E:
Tools Used to Monitor Plans (continued)**

	Governing Law	Applies to	How Frequent	Who generates	Process	Result	Public posting Req'd	Contains elements related to coordination and referrals between MCPs and MHPs	Contains elements related to Due Process
CAHPs	APL 17-014	MCPs	Triennial	EQRO	The EQRO performs consumer satisfaction surveys every three years and produces a report for DHCS	The EQRO includes its results in the External Quality Technical Report	X		
Consumer Perception Surveys	9 CCR § 3530.40	MHPs	Semi-annual	Plans	Plans survey consumers using an instrument developed by DHCS and a private contractor.	The survey results and analysis are validated by the EQRO and its validation is published in the External Quality Statewide Report			