12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care.[1]

PROCEDURES:

A. PCPs are responsible for coordinating care management services for assigned Members, when indicated.

B. PCPs are responsible for identifying Members who may potentially require care management services and notifying the IPA Care Management (CM) Department. PCPs may also submit a completed Care Management Referral Form to IEHP to refer the Member for care management. This form is found in the "Providers" portal of the IEHP website (See, "IEHP Care Management Referral Form" found on the IEHP website[2]). IEHP shall coordinate with the Member's IPA, as needed. Members, who may benefit from care management include, but are not limited to:

   1. Members with complex medical or behavioral health conditions requiring multiple Providers or multiple interventions and care coordination needs;
   2. Any child with a potential California Children's Services (CCS) eligible condition or Members with suspected or confirmed developmental disabilities that may qualify for enrollment into Inland Regional Center/Early Start Program;
   3. Potential major organ transplant candidates;
   4. Members frequently accessing Emergency Room services;
   5. Members who live alone, are frail, have inadequate family support systems, need continuity of care services, and could benefit from Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and/or Multipurpose Senior Services Program (MSSP) services; and
   6. Any other Member who could benefit from CM services.

C. PCPs are responsible for referring Members to IEHP for health education classes, care management programs, and disease management programs.

[1] Department of Health Care Services (DHCS)- IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions

[2] https://www.iehp.org/en/providers/provider-resources?target=forms

12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

D. PCPs are responsible for coordinating care for the Member with the IPA CM or IEHP CM, including but not limited to contacting other clinicians or entities, facilitating the transfer of medical records as necessary and initiating specialty referrals.

E. PCPs are responsible for ensuring Members receive preventive care in accordance with IEHP's approved guidelines.

F. PCPs are responsible for referring Members to the appropriate Long-Term Services and Supports (LTSS) services when it is determined that the Member is a potential candidate for any of these LTSS services:

1. CBAS – See Policy 12H, "Community-Based Adult Services" for more information.
2. Long-Term Care (LTC) – See Policies 14F1, "Long-Term Care – Custodial Level," and 14F2, "Long-Term Care – Skilled Level" for more information.
3. IHSS – See Policy 12F, "In-Home Supportive Services" for more information.
4. MSSP – See Policy 12N, "Multipurpose Senior Services Program" for more information.

G. PCPs shall not charge a fee for the completion of certification forms, which is required for referral to the IHSS program.

H. PCPs are responsible for logging onto the secure IEHP Provider portal to review the Member's Health Risk Assessment (HRA) results and Individualized Care Plan (ICP) and incorporate the results into the Member's medical record.

I. PCPs are expected to participate in the development of the Member's ICP and in Interdisciplinary Care Team (ICT) case conferences, as needed.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

A. Care Management Requirements
2. Continuity of Care

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs allow Members, who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as an IEHP Member or transitioning from another managed care plan with contracts expiring or terminating on or after January 1, 2023, to request Continuity of Care (COC) for up to 12 months after their enrollment date with IEHP, if a pre-existing relationship exists with an out-of-network Medi-Cal provider, regardless if the Member has a condition listed in the California Health & Safety Code Section 1373.96. IEHP and its IPAs will initiate the process described herein immediately upon request unless otherwise specified.[1]

   1. COC extends to primary, specialty, durable medical equipment (DME), medical supplies, mental health, and select ancillary care providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health therapy, and speech therapy providers. These eligible Members may require COC for services they have been receiving through Medi-Cal FFS or another health plan.[2]

B. IEHP and its IPAs provide COC with an out-of-network provider when all of the following requirements are met:[3]

   1. IEHP or its IPAs are able to determine that the Member has a pre-existing relationship with the provider;
   2. The provider is willing to accept IEHP's contract rates, or the Member's IPA contract rates based on the service offered or applicable Medi-Cal FFS rate, whichever is higher;
   3. IEHP or its IPA determines that the provider meets applicable professional standards and has no disqualifying quality of care issues that would otherwise exclude the provider from its network; and
   4. The provider is a California State Plan approved provider.

C. If a Member changes MCPs by choice following their initial enrollment in an MCP or if a Member loses and then later regains MCP eligibility during the 12-month COC period, the 12-month COC period may start over one (1) time. If the Member changes MCPs a second

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-032 Supersedes APL 18-008, "Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Care Health Plan On or After January 1, 2023
[2] Ibid.
[3] Ibid.

time or more, the COC period does not start over, which means that the Member does not have the right to a new 12 months of COC. If the Member returns to Medi-Cal FFS and later re-enrolls in an MCP, the COC period does not start over.[4] If the Member changes IPA during their enrollment with IEHP, the COC period does not start over.

D. The Member is assigned to IEHP or an IPA that has the Member's preferred PCP in its network. For example, if a Member has an existing relationship with a PCP and a specialist in IPA #1, as well as a specialist in IPA #2, IEHP assigns the Member to IPA #1, who is contracted with the Member's preferred PCP. IPA #1 is responsible for allowing the Member to continue treatment with both specialists, pursuant to COC requirements.

PURPOSE:

A. To achieve an improved quality of care, support coordination and continuity of care, increase Member satisfaction with care, and enhance system efficiencies.

DEFINITIONS:

A. **Assessment:** A process by which a Member is seen by an in-network Provider, who then conducts a review of the Member's current condition and completes a new treatment plan which includes an evaluation of the services specified by the pre-transition active treatment authorization.

PROCEDURES:

Continuity of Care

A. Requesting for COC

1. Members, their authorized representative, or their Provider, may make a direct request to IEHP or the Member's IPA for COC.
2. IEHP and its IPAs accept requests for COC over the telephone and do not require the requestor to complete or submit a paper or computer form if the requester prefers to request telephonically.[5]
3. IEHP provides acknowledgment of the COC request advising the Member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution. Acknowledgement of COC request will be provided within the following timeframes, using the Member's known preference of communication or by one of these methods in the following order – telephone call, text message, and then notice by mail:[6]

[4] DHCS APL 22-032
[5] Ibid.
[6] Ibid.

a. Within seven (7) calendar days of receipt of non-urgent requests; and

b. Within the shortest applicable timeframe that is appropriate for the Member's condition, but no later than three (3) calendar days of receipt of urgent requests.

2. If requested by a newly enrolled or transitioning Member, their authorized representative, or provider, IEHP allows the Member to keep previously authorized and scheduled specialist appointments with out-of-network specialists when COC has been established and the appointment(s) occur within the 12- month COC period.[7]

   a. If pre-existing relationship with the out-of-network provider has not been established, IEHP and its Delegates are encouraged to make a good faith effort to either, arrange for an alternative in-network Provider on or before the scheduled appointment date, or keep the appointment with the out-of-network provider. However, since the appointment with the out-of-network provider occurs after the Member's transition to IEHP, it does not establish the requisite pre-existing provider relationship for the Member to submit a Continuity of Care request.[8]

B. Medical Exemption Requests (MER)

1. A MER is a request for temporary exemption from enrollment into IEHP only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to an in-network Provider without deleterious medical effects.[9,10]

2. IEHP and its IPAs consider MERs that have been denied as automatic COC requests to allow Members to complete their courses of treatment with Medi-Cal FFS providers.[11,12]

3. Regardless of the Member's IPA assignment, IEHP performs an initial outreach to these Members by mail and by phone to inform them of their COC rights.

4. IEHP outreaches to these Members per regulatory requirements and reaches out to the Member's IPA to complete the COC request within regulatory timeframes.

C. Retroactive Approval of COC Requests[13]

[7] DHCS APL 22-032
[8] Ibid.
[9] Ibid.
[10] DHCS APL 17-007 Supersedes APL 15-001, "Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting"
[11] DHCS APL 22-032
[12] DHCS APL 17-007
[13] DHCS APL 22-032

1. IEHP and its IPAs retroactively approve and reimburse out-of-network providers for services that were already provided if the claim meets all COC requirements described in this policy as well as the following:
    a. Services were provided after the Member's enrollment into IEHP; and
    b. Dates of service are within 30 calendar days of the first service for which the provider requests retroactive COC reimbursement.
2. Retroactive COC reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

D. Validating Pre-Existing Provider Relationship[14]

1. A pre-existing relationship means the Member has been seen by the out-of-network Primary Care Provider (PCP), specialist, or select ancillary provider including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), and speech therapy provider for a non-emergency visit, at least once during the 12 months prior to the Member's initial enrollment with IEHP.
2. IEHP and its IPAs determine if the Member has an existing relationship with the out-of-network provider through the following:
    a. Review of data provided by DHCS or a terminating plan, such as Medi-Cal FFS utilization or claims data; and/or
    b. Information or documentation provided by the Member, their authorized representative, or their provider (self-attestation from the Member is not sufficient proof).
3. Upon validation of the Member's pre-existing relationship with the out-of-network provider, IEHP or the Member's IPA will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other forms of relationship to establish COC for the Member.
    a. If the provider is in-network, the Member is allowed to continue seeing the Provider.
4. IEHP requests from the out-of-network provider all relevant treatment information, for the purposes of determining medical necessity, as well as current treatment plan, if it is allowable under federal and state privacy laws and regulations.

E. Completing COC Request

[14] DHCS APL 22-032

1. IEHP and it's IPAs begins to process a COC request within five (5) working days following receipt of the request. The COC process begins when IEHP starts the process to determine if the Member has a pre-existing relationship with the Provider.[15]
2. IEHP and its IPAs complete COC requests within the following timelines:[16]
   a. 30 calendar days from the date of receipt of COC request;
   b. 15 calendar days from the date of receipt of the COC request if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   c. As soon as possible, but no longer than three (3) calendar days from receipt of an urgent request (i.e., there is identified risk of harm to the Member).

   To ensure that decisions are rendered as expeditiously as required by the Member's condition, IEHP has developed and applies a standard for assessing the Member's medical condition and determining the urgency of their request.
3. A COC request is considered completed when:
   a. IEHP or the Member's IPA notifies the Member that the request has been approved or denied;
   b. IEHP or the Member's IPA and the out-of-network provider are unable to agree to a rate;
   c. IEHP or the Member's IPA has documented quality of care issues with the out-of-network provider; or
   d. IEHP or the Member's IPA makes a good faith effort to contact the provider, and the provider is non-responsive for 30 calendar days.
4. IEHP or the Member's IPA notifies the Member of the decision, using the Member's preferred method of communication or by telephone, and by mail within seven (7) calendar days of the decision.[17]
   a. IEHP and it's IPAs include the following in approval notices:
      1) A statement of the Plan's decision;
      2) Duration of the COC arrangement;
      3) The process that will occur to transition the Member's care back into the network at the end of the COC period; and

[15] DHCS APL 22-032
[16] Ibid.
[17] Ibid.

4) The Member's right to choose a different provider from IEHP's or the IPA's network.

b. IEHP and it's IPAs include the following in denial notices:

1) A statement of the Plan's decision;

2) A clear and concise explanation of the reason for denial; and

3) The Member's right to file a grievance or appeal.

IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Authorization Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

5. If the provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement or other forms of relationship with IEHP or the Member's IPA, the Member is allowed to access the provider for the length of the COC period unless the provider is only willing to work with IEHP or the IPA for a shorter timeframe; in which case, IEHP or the IPA will allow the Member to have access to that provider for the shorter period of time.[18]

6. IEHP and it's IPAs will work with the out-of-network provider and communicate its requirements on letters of agreements, including referral and authorization process, to ensure that Members are not referred to another out-of-network provider without authorization from the Plan. IEHP and it's IPAs will review requests for referrals and approve if the request is deemed medically necessary and if there is not an appropriate Provider available in-network.[19]

7. IEHP an it's IPAs will work with providers to establish a plan of care for the Member.

8. If IEHP or the IPA and the out-of-network provider are unable to reach an agreement, or if the provider has documented quality of care issues, IEHP or the IPA will assign the Member an in-network alternative. If the Member does not make a selection, one will be assigned to them.

F. Transitioning the Member's Care to an In-Network Provider[20]

1. IEHP and its IPAs may choose to allow the Member continued access to the out-of-network provider past the 12 month COC period; however, neither IEHP nor its IPAs are required to do so.

2. Members may change their provider to an in-network Provider at any time, regardless of whether a COC relationship has been established.

[18] DHCS APL 22-032
[19] Ibid.
[20] Ibid.

3. IEHP and its IPAs notify the Member, using their preferred method of communications, at least 30 calendar days before the end of the COC period to assist in transitioning their care to an in-network Provider at the end of the COC period. This process includes engaging with the Member and the out-of-network provider before the end of the COC period to ensure continuity of services and patient safety through the transition to the in-network Provider.
    a. IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Terminate Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

G. Covered California to Medi-Cal Transition[21]

1. Prior treatment authorizations must be honored without a request by the Member or the out-of-network provider.
2. For Members that undergo a mandatory transition from Covered California to Medi-Cal managed care, IEHP or the IPA will contact these Members by telephone, letter, or other preferred method of communication within 15 calendar days after enrollment to:
    a. Ask if there are upcoming health care appointment or treatment scheduled and assist them in initiating a COC request if the Member chooses to do so;
    b. Make a good faith effort to learn from and obtain information from the Member so that it is able to honor active prior treatment authorizations with a network Provider and/or establish COC.
3. For Members that undergo a mandatory transition, IEHP or the IPA will honor any active prior treatment authorizations for covered services for 90 days from the date of enrollment, without a request by the Member, authorized representative, or provider. IEHP or the IPA will arrange for these services with an in-network Provider if possible, and an out-of-network Provider if a suitable in-network Provider is not able to be identified. After 90 days, the active authorization will remain in effect for the duration of the treatment authorization or until completion of a new assessment by IEHP, whichever is shorter.

H. Fee-For-Service (FFS) Medi-Cal or Expiring Plan Transition[22]

1. Following a Member's mandatory transition from Medi-Cal FFS to IEHP, or from another plan with its contract expiring or terminating on or after January 1, 2023:

[21] DHCS APL 22-032
[22] Ibid.

a. Active prior treatment authorizations for services remain in effect for 90 days and will be honored without a request by the Member, their authorized representative, or Provider.

b. IEHP will arrange for services authorized under the active prior treatment authorization with a in-network Provider. If a suitable in-network Provider cannot be arranged within time and distance standards, care from an out-of-network Provider will be arranged.

c. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by IEHP, whichever is shorter.

d. If IEHP does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, IEHP may reassess the Member's prior treatment authorization at any time.

2. When reassessing enhanced care management (ECM) authorizations after 90 days, IEHP will reassess against ECM discontinuation criteria, not the ECM Population of Focus Eligibility criteria.

I. Non-Specialty Mental Health Services

1. In both Riverside and San Bernardino Counties, Medi-Cal specialty mental health services (SMHS) are organized through the County Behavioral/Mental Health Departments. Riverside and San Bernardino County Behavioral/Mental Health Agencies are responsible for providing medically necessary behavioral health services to children and SMHS to adults (ages 21 and older) who meet county Tier III SMHS criteria. Please see Policy 12K1, "Behavioral Health Services" for more information.

2. IEHP provides COC with an out-of-network SMHS provider, when the Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the County Behavioral/Mental Health Departments and instead becomes eligible to receive non-SMHS from IEHP. In this situation, COC protections only apply to psychiatrists and/or mental health provider types permitted by Medi-Cal to provide outpatient non-SMHS.[23]

3. If the Member later requires SMHS from the County Behavioral/Mental Health Department to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to IEHP for non-SMHS, the 12-month COC period may start over one (1) time only.[24]

[23] DHCS APL 22-032
[24] Ibid.

J. Behavioral Health Treatment (BHT) for Members[25]

1. For BHT services, an existing relationship means a Member has seen the out-of-network BHT provider at least one (1) time during the 12 months prior to either the transition of services from a Regional Center to IEHP or the date of the Member's initial enrollment in IEHP.[26]
2. Retroactive requests for BHT COC reimbursement are limited to services provided after a Member's transition date into IEHP or the date of the Member's enrollment with IEHP if the enrollment date occurred after the transition.
3. IEHP must consider every Member transitioning from a Regional Center as an automatic COC request.

K. Durable Medical Equipment (DME) and medical supplies[27]

1. IEHP and it's IPAs allow transitioning Members to keep their existing DME rentals and medical supplies from their existing Provider, under the previous prior authorization for a minimum of 90 days following enrollment with IEHP and until IEHP or the IPA is able to reassess.
2. Continuity of DME and medical supplies is honored without need for request by the Member, their authorized representative, or Provider.
3. If DME or medical supplies have been arranged for a transitioning Member, but have not yet been delivered, IEHP and it's IPAs allow for delivery and for the Member to keep the DME or medical supplies for a minimum of 90 days following enrollment and until IEHP or the IPA is able to reassess.
4. If IEHP or the IPA does not complete a new assessment, authorizations for DME and medical supplies remain in effect for 90 days, after which IEHP and it's IPAs may reassess the Member's authorization at any time and require the Member to switch to a network DME Provider.

L. Transportation[28]

1. IEHP allows Members to keep the modality of transportation under previous prior authorizations with a network Transportation Provider, until IEHP is able to reassess the Member's continued transportation needs.

M. Other COC Provisions

[25] DHCS APL 22-032
[26] Ibid.
[27] Ibid.
[28] Ibid.

1. IEHP informs Members upon their enrollment through the Member Handbook (Evidence of Coverage) of their COC protections, including how Members, their authorized representatives, and Providers can initiate a COC request. This information is also accessible via the IEHP website. The Member Handbook and all Member-informing materials are translated into IEHP's threshold languages and are available in alternative formats, upon request.[29]
2. Newly enrolled Members currently residing in long-term care at a Skilled Nursing Facility (SNF) will be granted COC for 12 months and will not be required to relocate prior to their enrollment as long as the facility meets the following criteria:[30]
   a. Facility is licensed by the California Department of Public Health (CDPH);
   b. Facility is enrolled as a Provider in Medi-Cal;
   c. Meets acceptable quality standards; and
   d. Facility and IEHP agree to rates that meet state statutory requirements.

   Members currently in a LTC do not have to make a request to IEHP to invoke the above provision.
3. IEHP uses treatment authorization request (TAR) and/or prior authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. IEHP pays claims for prior and existing authorizations when data is incomplete.
4. Members have the right to file their grievance at any time following any incident or action that is the subject of the Member's dissatisfaction during the COC process. Please refer to Policy 16A1, "Grievance and Appeals Resolution Process – Member Rights and Options" for more information.
5. Members have the right to seek review of IEHP's final decisions as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP's Member Call Center at (800) 440-4347.
6. IEHP reports on existing metrics related to COC provisions as outlined in state and federal guidance materials.[31]
7. All Members have the right to continue receiving Medi-Cal services covered under the MCP's contract. IEHP or the Member's IPA will arrange for continuity of care for covered services without delay to the Member with an in-network Provider, or if there is no in-network Provider available within applicable timeframes and access standards,

[29] Ibid.
[30] DHCS APL 23-004 Supersedes APL 22-018 "Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
[31] Ibid.

with a suitable out-of-network provider. If a Member would like their out-of-network provider to provide a service, they can submit a request for COC in accordance with this policy.

Obtaining Care from Terminating or Out-of-Network Providers

A. Upon their request, current or newly enrolled Members with specified conditions may continue to obtain health care services from a Provider ending their contract with their IPA. This is not applicable to Providers with disciplinary actions or sanctions or a non-contracted provider for a specific timeframe as noted below.[32]

1. Acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. Serious chronic condition is a medical condition due to a disease, illness, medical problem, or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the Member and the terminating or nonparticipating provider. Completion of covered services shall not exceed 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered Member.[33]

3. Throughout the Member's pregnancy, which includes three (3) trimesters of the Member's pregnancy and the first 12 months into the post-partum period.[34, 35, 36]

4. For Members who present written documentation of being diagnosed with a maternal mental health condition from their treating provider, completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later. [37]

5. Care of a newborn child between birth and age 36 months. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

[32] CA Health & Saf. Code § 1373.96
[33] DHCS APL 22-032
[34] H.R. 1319, the American Rescue Plan Act of the 117th Congress 2021–2022 (ARPA) (Pub. Law 117-2), Section 9812 "Modification to Certain Coverage Under Medicaid for Pregnant and Postpartum Women"
[35] NCQA, 2023 HP Standards and Guidelines, NET 4, Element B, Factor 2
[36] CA HSC§ 1373.96
[37] Assembly Bill (AB) 577, Eggman. Health care coverage: maternal mental health

6. Performance of a surgery or other procedure that is authorized by IEHP or the IPA as part of a documented course of treatment and has been recommended and documented by the Provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.
7. Completion of covered services of a Member with a documented terminal illness. Completion of these covered services are provided for the duration of the terminal illness, even if it exceeds 12 moths from the contract termination date or 12 months from the Member's enrollment.[38]

B. If IEHP or the IPA is unable to come to an agreement with a terminated or out-of-network Provider, or if the Member, their authorized representative, or their Provider fails to submit a request for completion of covered services, IEHP is not required to continue to cover the Provider's services. In these instances, IEHP will assist the Member with obtaining care from a suitable in-network alternative.[39]

C. IEHP or the IPA's Medical Director is responsible for determining whether the Member may continue to obtain care from their terminating or out-of-network provider.
1. In determining whether or not a Member remains under the care of their current practitioner or maintains a previously scheduled treatment/procedure, the most important factor considered is the impact that a change of Practitioner or change in treatment/procedure has on the clinical status of the Member.
2. Care may continue beyond the specified timeframe if necessary, for a safe transfer to another practitioner.
3. If the decision is made to have the Member continue receiving care through their current practitioner, or maintain their previously scheduled treatment or procedure, the Member's IPA and/or Hospital is financially responsible per the IEHP Capitated Agreement.

D. Members currently under the care of a terminating provider are notified by IEHP or the Member's IPA to avoid disruption in care. Please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers" for information on Plan and IPA responsibilities.

E. If a Member is under the care of a Provider, whose IPA terminates their contract with IEHP, the health plan will make all efforts to assist the Provider with contracting with IEHP or another IPA within the health plan's network.

F. Unless otherwise agreed upon by the terminating Provider and IEHP or by the terminating provider and an IPA, the services rendered under this Policy will be reimbursed at rates and

[38] DHCS APL 22-032
[39] Ibid.

methods of payment similar to those used by IEHP or the IPA for currently contracted Providers providing similar services who are not capitated and who are practicing in the same geographic area as the terminating Provider.

G. For information on block transfers in the event of the termination of a provider contract, please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	January 1, 2016	
Revision Effective Date:	January 1, 2023	

12. COORDINATION OF CARE

A. Care Management Requirements
3. Health Risk Assessment

APPLIES TO:

A. This policy applies to Seniors and Persons with Disabilities (SPDs), who meet the definition of "high risk[1]".

POLICY:

A. IEHP makes every effort to contact all newly enrolled high risk SPD Members, to conduct the Health Risk Assessment (HRA) survey within regulatory timeframes from the effective date of identification.

PURPOSE:

A. To ensure the timely assessment of newly enrolled high risk SPD Members and review, identification of their medical, functional, cognitive, and/or psychosocial health care needs that may require coordination of essential care and services.

PROCEDURES:

Initial Member Stratification

A. IEHP performs initial risk stratification for all newly enrolled SPD Members to stratify them to either a high or low risk. The resources utilized to stratify newly enrolled SPD Members are as follows:
    1. Historical Medi-Cal fee-for-service utilization data from the Department of Health Care Services (DHCS), which may include but not be limited to:
        a. Emergency Room Data;
        b. Inpatient/Outpatient Data:
        c. Ancillary Services Data (for the most recent 12 months); and
        d. Pharmacy Data

B. SPD Members who also meet the following are considered "high risk":
    1. Members authorized to receive:
        a. In-Home Supportive Services (IHSS) greater than, or equal to, 195 hours per month.
        b. Community-Based Adult Services (CBAS), and/or
        c. Multipurpose Senior Services Program (MSSP) Services

[1] Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide

2. Members who:
    a. Have been on oxygen within the past 90 days;
    b. Are residing in an acute hospital setting;
    c. Has been hospitalized within the last 90 days or has had three (3) or more voluntary and/or involuntary hospitalizations within the past year;
    d. Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnoses of chronic diseases);
    e. Has a behavioral health diagnosis or developmental disability in addition to one (1) or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
    f. Have End-Stage Renal Disease, Acquired Immunodeficiency Syndrome (AIDS), and/or a recent organ transplant;
    g. Has cancer and is currently being treated;
    h. Is pregnant;
    i. Has been prescribed antipsychotic medication within the past 90 days;
    j. Has been prescribed 15 or more medications in the past 90 days;
    k. Has a self-report of a deteriorating condition; and/or
    l. Has other conditions as determined by IEHP, based on local resources.

C. All new Members who have no historical data will be stratified as high risk.

Health Risk Assessment Survey Tool

A. IEHP uses a standardized survey tool that is based on DHCS requirements to assess medical, cognitive, functional needs and psychosocial status of the Members. This survey tool:
    1. Includes Long-Term Services and Supports (LTSS) referral questions, which are intended to assist in identifying Members who may qualify for and benefit from LTSS services; and
    2. Incorporates stakeholder and consumer's input from sources such as the Persons' with Disabilities Workgroup (PDW).

B. The HRA survey is an assessment tool which identifies primary, acute, long-term services and supports, behavioral health and functional needs. For all Members, the HRA process will identify, at a minimum:
    1. Referrals to appropriate Long-Term Services and Supports (LTSS) and home- and community-based programs;

2. Caregivers, Members, and authorized representatives' participation;
3. Facilitation of timely access to primary care, specialty care, durable medical equipment (DME), medications, and other health services needed by the Member, including referrals to resolve physical or cognitive barriers to access;
4. Facilitation of communication among the Member's providers, including Behavioral Health Providers as appropriate;
5. Identification of the need for providing other activities or services needed to assist Members in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and
6. Support for Members who need more complex case management.

HRA Survey Completion

A. IEHP uses a risk stratification mechanism, or algorithm, to analyze Member-specific health care utilization data for newly enrolled SPD Members.

B. Following the initial risk stratification, IEHP makes every effort to contact Members identified as high risk to initiate the HRA within 30 days of identification and complete the assessment within 60 days of that identification.

C. IEHP respects Members' right to decline/refuse to participate in the completion of the HRA.

D. IEHP assists with the completion of the HRA if the Member or their authorized representative require assistance.

IEHP and IPA Responsibilities

A. IEHP performs the HRA on SPD Members who meet the definition of "high risk", which includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.

1. IPAs are expected to retrieve and review all SPD HRAs from the secure IEHP Provider portal and/or the Secure File Transfer Protocol (SFTP) daily.
2. The SPD HRA data that is made available to the IPA will identify the post-HRA risk level as High or Low. An HRA risk level of High indicates that the Member should be immediately reviewed by the IPA for care management needs.
3. The IPA must have a process to enroll Members into a care management program appropriate for their risk level.

4. The IPA can refer Members to IEHP for additional program enrollment. The IPA can submit a CM Referral Form to IEHP via email at CMreferralteam@iehp.org (See, "IEHP Care Management Referral Form" found on the IEHP website[2]).
5. The IPA's own risk assessment of the Member should include, at a minimum, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, enrollment into an LTSS program such as IHSS, CBAS or MSSP, and care management assessment data.

B. The IPA is required to contact the Member initially to review the HRA or to complete an assessment, the IPA must make, a total of three (3) contact attempts to locate the Member.

1. Contact attempts must be made within 30 calendar days of IEHP providing the HRA data to the IPA.
2. Attempts may be telephonic, by mail, by email, etc.
3. All contact attempts of the same type on the same day are considered one (1) attempt.
4. All contact attempts must be documented. (See, "Monthly Care Management Log" found on the IEHP website[3]).

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2023	
Revision Effective Date:	January 1, 2024	

[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] Ibid.

12. COORDINATION OF CARE

B. California Children's Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members under the age of 21 with potential California Children's Services (CCS) eligible conditions.

POLICY:

A. IEHP ensures that Members under the age of 21 with potential CCS-eligible conditions are identified and referred to the local CCS program.[1]

B. CCS is a county-administered program that covers the most serious medical conditions of a physical nature that can be cured, improved, or stabilized. The program provides diagnostic services, medical treatment, and case management to children with conditions eligible for treatment under the CCS program. Eligible conditions may include, but are not limited to:

1. Birth defects (such as congenital heart disease);
2. Chronic illnesses (such as cystic fibrosis);
3. Malignancies; and
4. Certain serious injuries and physical disabilities.

PROCEDURES:

Identification CCS Cases

A. Primary Care Providers (PCPs) and Specialty Care Providers are responsible for performing appropriate baseline health assessments and diagnostic evaluations sufficient to establish the identification of Members with potential CCS eligible conditions and directly referring to CCS-paneled Providers and CCS-approved Hospitals within IEHP network, as well as the CCS program.[2]

B. Members with potential CCS-eligible conditions may be identified at any medical encounter, through UM authorization activity or care management interactions by IPA or hospital-based staff.

Referral to CCS

A. CCS offers various program components. Please refer to the following website for more information about the programs CCS offers: https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx.

B. Upon identification of a CCS-eligible condition, Providers and IPAs are responsible for referring the Member to the appropriate County CCS Program.

[1] Department of Health Care Services (DHCS)- IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.15, California Children's Services (CCS)
[2] Ibid.

1. PCPs may refer children under the age of 21 to the local CCS program by email, or fax.[3]

C. Once PCPs, Specialty Care Providers or the Member's IPA are aware of the potential CCS diagnosis they are responsible for the completion of referral forms (See, "CCS-GHPP Client Service Auth Request – New Case" and "CCS-GHPP Client Service Auth Request – Established Case" found on the IEHP website[4]). The CCS referral form includes information including type of requested service, diagnosis, history and management plan, number of days requested, and specific NICU information when necessary. Applicable medical records and a CCS Service Authorization Request form should be submitted to one (1) of the following entities:

Riverside County Residents	San Bernardino County Residents
Riverside County CCS Program	San Bernardino County CCS Program
10769 Hole Ave., Ste. 220	150 E. Holt Blvd, 3rd Floor
Riverside, CA 92505	Ontario, CA 91761
Phone: (951) 358-5401	Phone: (909) 458-1637
Fax: (951) 358-5198	Fax: (909) 986-2970
Referral Must Be Faxed To:	**Referral Must Be E-Mailed To:**
(951) 358-5198	CCSReferrals@DPH.SBCounty.gov

D. PCPs and/or referring Specialists are also responsible for notifying the IPA of Members referred to CCS. IPA Care Managers are responsible for facilitating referrals and tracking outcomes

E. CCS sends a CCS program application and agreement to the Member, parent, or legal guardian. The PCP may assist with the completion of the forms.

F. CCS determines program eligibility by evaluating medical necessity and appropriateness of the requested service. All services require prior authorization by CCS. Criteria for eligibility include documentation of a CCS-eligible condition.

G. Once eligibility is established and the request for service is approved, CCS issues an authorization for treatment to a CCS-approved facility or paneled Provider.[5] (Please refer to the following link for up-to-date list of approved facilities and paneled Providers: http://www.dhcs.ca.gov/services/ccs/pages/CCSProviders.aspx.)

IEHP and IPA Responsibilities

A. IPAs will have an established process which demonstrates the coordination of care between PCPs and Specialty Care Providers.

[3] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.15, CCS
[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.315, CCS

B. The IPA Care Manager follows cases referred to CCS and assists with the coordination of care.

C. Medically necessary health care must continue to be provided throughout the referral process, and regardless of whether or the child is accepted into the CCS program.[6] The PCP and the Member's IPA are responsible for all medically necessary health care related to a potential CCS eligible condition until CCS establishes eligibility and issues a Service Authorization Request (SAR).[7] The IPA will be reimbursed should CCS determine upon later review that the Member qualified for the program. The CCS program is only responsible for treatment and payment for CCS services that treat CCS eligible conditions.

D. The IPA Care Manager must assist the PCP in coordinating available services and providing follow-up for Members requiring referral to CCS through the following methods:

1. Provision of telephonic monitoring of Members potentially eligible for the CCS program;
2. Maintenance of communication and coordination with County CCS Case Managers;
3. Coordination with the PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program or when CCS denies authorization for any services;[8] and
4. Establishing lines of communication between Practitioners.
5. Without limitation, the IPA case manager must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS program that Member desires to utilize.[9,10]

E. IEHP and IPAs provide care coordination services that support Member's health status and functional needs to facilitate a smooth transition when Members will no longer be eligible for CCS due to their age or change of the CCS eligible condition. Within 12 months of a CCS member aging out of the program, a care coordination plan is to be developed to assist the Member in transitioning out of the CCS program. This may include, but not limited to the following:

1. Identify the Member's CCS-Eligible Condition;
2. Plan for the needs of the Member to transition from the CCS program;
3. A communication plan with the Member in advance of the transition;
4. Identification and coordination of Primary Care and specialty care providers appropriate to the member's CCS qualifying condition(s); and

---

[6] DHCS, IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.15 CCS
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Department of Healthcare Services (DHCS) All Plan Letter (APL) 20-012, Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21.

5. Continued assessment of the Member through the first 12 months of the transition.

F. PCPs and IPAs continue to be responsible for other medically necessary care,[11] including certain Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services as discussed in Policy 12D, "Early and Period Screening, Diagnostic and Treatment (EPSDT)." CCS may authorize EPSDT services related to the CCS condition for Medi-Cal Members.

G. PCPs and IPAs can view a list of their CCS Members, their authorizations and diagnosis information by logging in to the secure IEHP Provider portal. IPAs are also provided this information through the Secure File Transfer Protocol (SFTP).

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[11] DHCS, IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.15 CCS

12. COORDINATION OF CARE

C. Early Start Services and Referrals

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) and Specialists are responsible for assessing children's developmental status and identifying children who may be eligible for receiving Early Start services during Well Child exams, or at other medical encounters as appropriate.[1,2] This includes children with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay.

B. PCPs and IPAs are responsible for providing primary care and/or arranging all medically necessary diagnostic, specialty, and/or therapeutic services to evaluate, correct and/or ameliorate a suspected or confirmed condition.[3]

DEFINITION:

A. Early Start Program – California's early intervention program for infants and toddlers with disabilities and their families.

PROCEDURES:

Early Start Program

A. Members from birth to 36 months of age may be eligible for early intervention services if, through documented evaluation and assessment, they meet one (1) of the criteria listed below:[4,5]

   1. Has a developmental delay of at least 25% in one (1) or more areas of cognitive, receptive communication, expressive communication, social or emotional, adaptive, or physical and motor development including vision and hearing;
   2. Has an established risk condition of known etiology, with a high probability of resulting in delayed development; and
   3. Is considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel.

[1] Department of Health Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.8 Other Population Health Requirements for Children
[2] Title 17 California Code of Regulations (CCR), § 52040
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.8 Other Population Health Requirements for Children
[4] California Government Code (Gov. Code), § 95014(a)
[5] 17 CCR § 52022

B. Based on the child's assessed need(s) and in collaboration with the family, the Early Start Program develops the child's Individualized Family Service Plan (IFSP).[6] Services may include:[7]

1. Assistive technology devices and assistive technology services;
2. Audiology;
3. Family training, counseling and home visits;
4. Health services;
5. Medical services for diagnostic/evaluation purposes only;
6. Nursing services;
7. Nutrition services;
8. Occupational therapy;
9. Physical therapy;
10. Psychological services;
11. Service coordination (Case Management);
12. Social work services;
13. Special instruction;
14. Speech and language services;
15. Transportation and related costs; or
16. Vision services.

For more information about services offered through Early Start Program, refer to the following website: https://www.dds.ca.gov/services/Early-Start/.

C. Newly referred families whose infants or toddlers are "at risk" for developmental delay or disability will receive the following services through the Early Start Family Resource Network (ESFRN) (additional details are available on their website at http://www.esfrn.org):

1. Information;
2. Resources;
3. Referrals; and
4. Targeted outreach.

[6] 17 CCR § 52104
[7] Title 20 United States Code (U.S.C) § 1432

Identification and Referral of Members

A. All Members from birth to 36 months of age, suspected of having a developmental concern, including those at risk for developmental delay, are referred to the Early Start program to determine eligibility for services.[8] Early Start will facilitate each family's access to local Family Resource Center's Prevention Resource and Referral Services with parental consent.

B. The Provider must perform the following to facilitate the referral to the Early Start Program, including first discussing their concerns with the family:

1. Regular well baby examinations according to the Child Health and Disability Program (CHDP) schedule (with specific findings noted);
2. Diagnostic and laboratory and radiological test results;
3. Routine developmental assessment using standardized developmental tools;
4. Evaluation of hearing and vision;
5. Explain developmental concerns to family;
6. Identify established risk conditions of known etiology, with a high probability of resulting in delayed development;
7. Obtain parental consent to send child's medical records to the Early Start Program;
8. Other medical referrals as appropriate;
9. Make referral as soon as possible to the Early Start Program;
10. Inform family of the Early Start referral and the importance of following up on child's development; and
11. Inform the IPA Care Management Team that the Member was referred to the Early Start Program.

C. Anyone can make a referral, including parents, medical care Providers, friends, family members, foster parents, and/or daycare providers. The referral must be made by phone or by completing the online referral form: https://inlandrc.seamlessdocs.com/f/esreferral

Riverside County	**San Bernardino County**
Phone: (909) 890-4763	(909) 890-4711

D. The Early Start Program determines a child's eligibility and assessment of service needs.[9]

Primary Care and Specialty Referrals

A. PCPs are responsible for referring Members with suspected or confirmed developmental delay for all medically necessary specialty diagnostic and/or treatment services including but not

[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Section 4.3.8 Other Population Health Requirements for Children

[9] "Parents' Rights: An Early Start Guide for Families", https://www.dds.ca.gov/wp-content/uploads/2019/02/EarlyStart_ProceduralSafeEng_20190205.pdf

limited to the following. See Policy 14D, "Pre-Service Referral Authorization Process," for more information.

1. Specialty diagnostic services to evaluate the Member's condition (e.g., computed tomography (CT) or magnetic resonance imaging (MRI) scans, etc.);
2. Specialists for diagnosis or treatment (e.g., Neurologists);
3. Referrals to Psychologists or Psychiatrists as needed;
4. Referral to other types of Providers as needed (e.g., Physical Therapy (PT), Occupational Therapy (OT)); and
5. All other specialty health care services as needed.

IEHP and IPA Responsibilities

A. IEHP reviews IFSPs received from the Early Start program and collaborates with the Member's IPA to provide case management and care coordination to ensure provision of all medically necessary covered services with their PCP's participation.

B. The Member's IPA is responsible for coordinating all medically necessary specialty care including:

1. In-network diagnostic, therapeutic or specialty services;
2. Out-of-network services as needed; and
3. Referral and coordination of services rendered under Fee-For-Service Medi-Cal as needed, through California Children's Services (CCS), Behavioral Health, PCP, Specialists, or other Providers.

C. When a member is receiving services from the Early Start Program, IEHP is responsible for working with the Member's IPA to ensure that medical and health assessment information is provided to the Early Start Program, as needed. The Member's IPA's responsibility for arranging all necessary transfer of medical information includes but is not limited to:

1. Facilitating PCP or specialist telephonic communication with the Early Start Program or Local Education Agency (LEA) staff as needed;
2. Transferring medical records, diagnostic test results or other hard copy medical information as needed; and
3. Arranging case conferences with PCP, Specialist and Early Start Program or LEA staff as needed.

For more information about services offered by the Regional Center, refer to the following website: https://www.dds.ca.gov/RC/.

D. Member rosters indicating Early Start eligibility are updated monthly on the secure IEHP Provider portal. IEHP ensures the coordination of care and services and joint case management among the Member's IPA, PCPs and Early Start.

E. IEHP sends the IPA a monthly list of Members who will be aging out of the Early Start Program within the next three (3) months. IEHP ensures that the IPA evaluates and assesses the Member to determine if additional care coordination is needed as they transition out of the Early Start Program. This information is shared with the IPA via the IEHP's Secure File Transfer Protocol (SFTP).

F. IEHP Behavioral Health & Care Management (BH & CM) Department is responsible for the following functions:

1. Facilitating working relationships between IPAs and the Regional Center as needed;
2. Assisting IPA CM with referrals to the Early Start Program, care coordination or care management as needed;
3. Resolving any disputes between the Regional Center, PCP/Specialists and/or IPA;
4. Attend Regional Center meetings, as necessary;
5. Arranging appropriate training for PCP and IPA staff regarding the Early Start Program; and
6. Other assistance as required.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1,1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

D. Early and Periodic Screening, Diagnostic and Treatment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members under the age of 21.

POLICY:

A. IEHP and its IPAs provide and cover all medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Members under 21 years of age, when services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions, unless otherwise carved out of the Plan's contract with the Department of Health Care Services (DHCS).[1,2]

1. A service does not need to cure a condition in order to be covered under EPSDT.
2. Services that maintain or improve the Member's current health condition, or those that can prevent adverse health outcomes, are also covered under EPSDT because they 'ameliorate' a condition.[3]

PURPOSE:

A. To assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.[4]

DEFINITION:

A. EPSDT Services – a benefit of the State's Medi-Cal program that provides comprehensive, preventive, diagnostic, and treatment services to eligible children under the age of 21.[5] This is otherwise known as "Medi-Cal for Kids & Teens."

B. Care Coordination – Coordination of services for a Member between settings of care that includes appropriate discharge planning for short-term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; services the Member receives from any other MCP; services the Member receives in Fee-for-Service (FFS); services the Member receives from out-of-network Providers; and services the Member receives from community and social support Providers.[6]

C. Case Management – Services furnished to assist Members who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social,

[1] Department of Health Care Services (DHCS) – IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than 21 Years of Age
[2] DHCS All Plan Letter (APL) 23-005 Supersedes APL 19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Medi-Cal Members Under the Age of 21"
[3] Ibid.
[4] Centers for Medicare and Medicaid Services (CMS), A Guide for States: Coverage in Medicaid Benefit for Children and Adolescents, June 2014
[5] Title 42 United States Code (USC) §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)
[6] DHCS APL 23-005

educational, and other services.[7,8,9,10]

D. Medical Necessity for EPSDT Services – For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity," when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions.[11,12]

E. Maintenance services – Services that sustain or support rather than those that cure or improve health problems.[13]

F. Targeted Case Management (TCM) – Services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.[14]

G. Home Health Agency – A public or private organization licensed by the State which provides skilled nursing services to persons in their place of residence.[15]

H. Individual Nurse Provider (INP) – Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Members.

I. Private Duty Nursing (PDN) – Nursing services provided in a Member's home by a registered nurse or a licensed practical nurse, under the direction of a Member's physician, to a Member who requires more individual and continuous care than is available from a visiting nurse.[16]

PROCEDURES:

EPSDT Services

A. All Members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. IEHP, its IPAs and Providers must provide its Members with appropriate referrals for diagnosis and treatment without delay. IEHP and its IPAs must ensure that Members have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but not later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.[17] See Policy 14D, "Pre-Service Referral Authorization Process" for further details regarding the referral process.

[7] Title 42 Code of Federal Regulations (CFR) §§ 440.169 and 441.18
[8] 42 CFR 440.169(d) and (e)
[9] Title 22 California Code of Regulations (CCR) § 51184
[10] I.N. et al., v. Kent, et al. (Northern District of California 2018)
[11] California Welfare and Institutions Code (Welf. & Inst. Code) § 14095.5
[12] 42 USC § 1396d(r)
[13] DHCS APL 23-005
[14] DHCS–IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions
[15] California Health and Safety Code (Health & Saf. Code), § 1727(a) and (b)
[16] 42 CFR § 440.80
[17] DHCS APL 23-005

B. Primary Care Providers (PCPs) must use current American Academy of Pediatrics (AAP) and Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to health and developmental screening services, physical examination, dental services, vision services, and hearing services. PCPs must provide all age-specific assessments and services required by DHCS and the AAP/Bright Futures periodicity schedule. This, however, does not alleviate IEHP or its IPAs from their responsibility to provide any medically necessary EPSDT services that exceed those recommended by AAP/Bright Futures.[18,19] See Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

C. IEHP and its IPAs are responsible for providing all medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs (LGHPs).

1. Where any of these entities has overlapping responsibility for providing services to a Member under the age of 21, the IPA must:[20]

    a. Assess what level of medically necessary EPSDT services the Member requires;

    b. Determine what level of service (if any) is being provided by other entities, and

    c. Coordinate the provision of services with the other entities to ensure that the IPA and other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.

2. Authorization and financial responsibilities for EPSDT services are delineated in the Division of Financial Responsibility (DOFR). Neither IEHP nor its IPAs impose flat or hard limits on EPSDT services based on a monetary cap or budgetary constraints..

3. Medical necessity decisions are based on the definition set forth in this policy and individualized, considering the particular needs of the child. When medically necessary, neither IEHP or its IPAs impose limits on EPSDT services and cover services whether or not these have been approved under a State Plan Amendment (SPA).[21]

4. IEHP prior authorization criteria must either be the same, or must not be more restrictive, than the criteria for approval set forth in the regulations established from the Medi-Cal Fee-For-Service.

5. Determinations must be made in a timely manner, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners.[22] See Policy 25E1, "Utilization Management - Delegation and Monitoring" for more information.

6. IEHP and its IPAs ensure IEHP Members with pre-existing provider relationships who

[18] DHCS– IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4 Services for Members less than 21 Years of Age
[19] DHCS APL 23-005
[20] Ibid.
[21] Ibid.
[22] 42 CFR §§ 438.210, 422.568, 422.570, and 422.572

make a Continuity of Care (COC) request are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible Members may require COC for services they have been receiving through Medi-Cal Fee-For-Service (FFS) or another health plan.[23] See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

7. Services must be provided in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws.[24]

D. Some medical or behavioral health care service for a Member under age 21 may not be covered as IEHP benefits but may be available as EPSDT services, as medically necessary.

E. IEHP ensures that Subcontractors and Network Providers comply with all applicable state and federal regulatory requirements, including requirements for EPSDT.[25]

Member Outreach and Network Provider Training

A. IEHP provides Members or their families or primary caregivers information about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. Information is shared as follows:[26]

1. Beginning 2023, IEHP will mail with their post-enrollment kit DHCS-developed "Medi-Cal for Kids & Teens" brochures and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter to new Members under the age of 21, or their families or primary caregivers within seven (7) calendar days of their enrollment with IEHP.

2. On January 1st of each calendar year, beginning in 2024, IEHP will mail or share electronically these DHCS-supplied materials to existing Members under the age of 21 or their families/primary caregivers.

3. Information provided meets all language and accessibility standards, including translation, font, and format requirements set forth in federal and state law, the Plan's contract with DHCS, and applicable DHCS All Plan Letters.

4. All member-facing materials are updated as needed with "Medi-Cal for Kids & Teens."

5. IEHP publishes DHCS-supplied materials and "Medi-Cal for Kids and Teens: Your Medi-Cal Rights" letter on the website.

B. Beginning in 2024, IEHP will ensure all Network Providers complete EPSDT-specific training on at least a biannual basis.

C. On an annual basis by February 15 of each calendar year, IEHP will submit to DHCS a

[23] DHCS APL 22-032 Supersedes APL 18-008, "Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members Who Transition Into A New Medi-Cal Managed Care Health Plan on or After January 1, 2023"
[24] California Government Code § 11135
[25] DHCS APL 23-005
[26] Ibid.

comprehensive plan to ensure all Network Providers received proper education and training regarding EPSDT. The annual comprehensive plan will include an attestation that Provider Network is in compliance with EPSDT training requirements and includes a list of Network Providers who have completed training within the past 12 months. The annual comprehensive plan will also include the following:[27]

1. How many Network Providers serve Members under the age of 21;
2. How many Network Providers are not in compliance, and
3. IEHP's steps taken to ensure Network Providers are fully compliant.

D. IEHP will use the Provider training program developed by DHCS to promote a more uniform and shared understanding of the benefit throughout the State. If IEHP chooses to augment the training with additional information, IEHP will submit their training materials with edits highlighted to DHCS for review and approval prior to its use.

Private Duty Nursing

A. IEHP is responsible for authorizing and covering medically necessary private duty nursing services for Members under the age of 21. If an IPA receives a request for these services, the IPA shall forward this request to IEHP Utilization Management via fax at (909) 890-5751.

B. Private duty nursing services are covered when they meet the medical necessity criteria. Below are examples of when these services may be deemed appropriate:

1. The Member for whom nursing care is requested meets any of the criteria of admission to licensed and certified health facility inpatient care settings, and his/her medical condition has stabilized such that care can safely be rendered in the home;
2. The Member is newly discharged from an acute or sub-acute inpatient setting and is dependent upon a life-sustaining medical technology, and his/her medical condition has stabilized such that care can safely be rendered in the home;
3. There is a primary caregiver in the home that is proficient in the tasks necessary to care for the Member; and
4. An assessment of the home environment has been conducted by a qualified home health agency or other appropriate person. The assessment must verify that an attending physician accepts 24 hour responsibility for providing and coordinating medical care; the home environment supports the health and safety of the Member; that space is adequate to accommodate needed equipment, supplies, and personnel; the family caregivers have been appropriately trained; and all necessary supports and an emergency back-up plan are in place.

C. IEHP uses one or more home health agencies (HHAs) and/or individual nurse providers (INPs) to meet the Member's approved private duty nursing needs.[28] IEHP identifies

[27] DHCS APL 23-005
[28] DHCS APL 20-012, "Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21"

potentially eligible HHAs and/or INPs and assists them with navigating the process of enrolling as Medi-Cal Providers.[29]

D. When IEHP has approved an EPSDT eligible Member to receive private duty nursing services, the Plan has primary responsibility to provide case management for approved private duty nursing services.[30,31]

E. Regardless of which Medi-Cal program entity has primary responsibility for providing case management for the approved private duty nursing services, an EPSDT eligible Member approved to receive private duty nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the Member is enrolled in (which may be a Managed Care Plan or CCS) to request case management for private duty nursing services.[32] If contacted by the Member, IEHP will provide case management services to the Member and work collaboratively with the Medi-Cal program entity primarily responsible for case management.[33]

F. Case management services includes arranging for all approved private duty nursing services desired by the Member, even when IEHP is not financially responsible for paying for the approved private duty nursing services.[34]

G. IEHP's obligations to EPSDT eligible Members approved to receive private duty nursing services who request case management services for their approved private duty nursing services include, but are not limited to:[35]

   1. Providing the Member with information about the number of private duty nursing hours the Member is approved to receive;
   2. Contacting enrolled HHAs and Medi-Cal enrolled INPs to seek approved private duty nursing services on the Member's behalf;
   3. Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Provider; and
   4. Working with HHAs and Medi-Cal enrolled INPs to jointly provide private duty nursing services to the Member as needed.

Behavioral Health Treatment Services

A. IEHP is responsible for providing and managing medically necessary Behavioral Health Treatment (BHT) services for all Members that meet all the following coverage criteria:[36]

[29] DHCS APL 20-012
[30] I.N. et al., v. Kent, et al. (N.D. Cal 2018)
[31] DHCS APL 20-012
[32] Ibid.
[33] I.N. et al., v. Kent, et al. (N.D. Cal 2018)
[34] Ibid.
[35] DHCS APL 20-012
[36] DHCS APL 23-010 Supersedes APL 19-014, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"

1. Member is under 21 years of age;
2. Member was recommended by a licensed physician and surgeon or a licensed psychologist that evidence based BHT services are medically necessary;
3. Member is medically stable; and
4. Member does not need 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

See Policy 12K3, "Behavioral Health – Behavioral Health Treatment" for more information on the authorization and management of BHT services.

B. If a contracted Provider within an LEA bills IEHP for medically necessary BHT or BH services, IEHP will reimburse the Provider at the contracted rate.

Carved-Out Services

A. IEHP and its IPAs provide and cover all medically necessary EPSDT services except those services that are specifically carved out of IEHP's contract and not included in IEHP's capitated rate, which includes but is not limited to California Children's Services (CCS), pharmacy services, dental services, specialty mental health services, and substance use disorder services.[37]

1. CCS - Once the IPA has adequate diagnostic evidence that a Member has a CCS-eligible condition, the IPA must refer the Member to the local county CCS office for determination of eligibility. Until the Member's CCS eligibility is confirmed by the local CCS program, and the medically services are being provided under the CCS program, the IPA remains responsible for the provision of all medically necessary EPSDT services. Once member is deemed eligible for CCS, CCS becomes responsible for case management and care coordination. See Policy 12B, "California's Children's Services" for more information.
2. Dental Services – IEHP ensures that dental screenings and oral health assessments for all Members are included as part of the initial health appointment. Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits," for more information on dental screening for Members under 21 years of age. IEHP covers and ensures the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists but may require prior authorization for medical services required in support of dental procedures.[38] See Policy 12J, "Dental Services" for more information.

Care Management and Care Coordination

A. IEHP and its IPAs are responsible for assessing a Member's need for EPSDT care management services.

B. IEHP and its IPAs provide case management and care coordination, as defined in this policy,

[37] DHCS APL 23-005
[38] DHCS APL 15-012, "Dental Services – Intravenous Sedation and General Anesthesia Coverage"

for medically necessary EPSDT services, including but not limited to:

1. Helping ensure that the Member obtains needed services through the following:
    a. Coordinating medically necessary EPSDT services delivered both within and outside the network;
    b. Coordinating carved-out and linked service and referral to appropriate community resources and other agencies, regardless of whether IEHP is responsible for paying for the service;[39]
    c. Providing assistance with scheduling appointments;[40]
    d. Coordinating the Member's care between all Providers (PCPs, Specialists, other EPSDT Providers); and
    e. Facilitating the transfer of medical information as necessary between Providers.

C. IEHP provides necessary transportation, including non-emergency medical transportation (NEMT) and non-medical transportation (NMT) to and from medical appointments for the medically necessary EPSDT services, including those services that are carved-out of the Plan's contract with DHCS.[41] See Policy 9C, "Non-Emergency Medical and Non-Medical Transportation Services" for more information.

D. IEHP ensures coverage of Targeted Case Management (TCM) services,[42] which may be provided by a TCM entity such as the Inland Regional Center or local governmental health program.[43] TCM services provide comprehensive case management services to eligible Members under the age of 21 to gain access to needed medical, social, educational, and other services. Case management services ensure that the changing needs of Members are addressed and that appropriate TCM services components are provided to meet the Member's needs. Eligible Members must be:[44]
    1. At high risk for medical compromise due to one (1) of the following conditions:
        a. Failure to take advantage of necessary health care services;
        b. Noncompliance with their prescribed medical regimen;
        c. Unable to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization;
        d. Unable to understand medical directions because of comprehension barriers;
        e. A lack of community support system to assist in appropriate follow-up care at home;

[39] DHCS APL 23-005
[40] Ibid.
[41] Ibid.
[42] Ibid.
[43] DHCS California State Plan Amendments (SPA) 21-0022, "Children Under the Age of 21"
[44] Ibid.

f. Substance abuse; or

g. A victim of abuse, neglect or violence.

2. In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

E. Upon identification of an eligible Member, IPAs are responsible for referring Members directly to a TCM entity, such as the Regional Center (RC) or local governmental health program.

F. IPAs must coordinate with IEHP to determine if the Member is eligible or is already receiving TCM through a participating local governmental health program or the RC.

G. If the Member is receiving TCM through one of these entities, IEHP or its IPAs will coordinate care with the case manager from the agency and determination of medical necessity of diagnostic and treatment services.[45]

H. If the Member is not eligible for TCM services, IEHP or its IPAs will ensure the Member has access to services that are comparable to TCM services.[46]

I. EPSDT care management services may be provided by IEHP and its IPAs, RC, Child Protective Services, the Department of Mental Health, and/or other community-based entities as needed. See below for a list of contacts:

Inland Regional Center

San Bernardino Office:
1365 S. Waterman
San Bernardino, CA 92408
(909) 890-3000

Mailing address:
PO Box 19037
San Bernardino, CA 92423

Riverside Office:
1500 Iowa Avenue, Suite 100
Riverside, CA 92507
(909) 890-3000

https://www.inlandrc.org/

Children's Protective Services

Riverside County – Department of Public Social Services
(800) 442-4918 (Hotline)

San Bernardino County – Children and Family Services
(909) 384-9233
(800) 827-8724

[45] DHCS APL 23-005
[46] Ibid.

Mental Health Program – Children's Coordination
Riverside County Mental Health (http://www.rcdmh.org)
Managed Care Office
4060A County Circle Dr
Riverside, CA 92503
Ph: (951) 358-7797

San Bernardino County Behavioral Health (http://www.sbcounty.gov/dbh)
850 E. Foothill Blvd.
Rialto, CA 92375
Ph: (909) 421-9200
Fax: (909) 421-9219

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

E. Genetically Handicapped Persons Program

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. The Genetically Handicapped Persons Program (GHPP) is a health care program which provides medical care and other related services for persons with genetically handicapping conditions.[1] GHPP will cover services only if they are not covered by IEHP. The program applies to adults with specific GHPP eligible conditions.

B. GHPP helps each client achieve the highest level of health and functioning through:[2]

1. Early identification and enrollment into the GHPP for persons with eligible conditions.
2. Prevention and treatment services from highly skilled Special Care Center teams.
3. Ongoing care in the home community provided by qualified physicians and other health team members.

PROCEDURES:

GHPP Services

A. GHPP services Members with specific genetic diseases. Conditions may include but are not limited to the following:[3]

1. Cystic fibrosis;[4]
2. Diseases of the Blood, i.e., Hemophilia, Von Willebrand's Disease, Sickle Cell Disease;[5]
3. Diseases of the Brain and Nerves, i.e., Huntington's disease, Hereditary Spastic Paraplegia;[6]
4. Diseases of Metabolism, i.e., Phenylketonuria (PKU), Wilson's Disease, Galactosemia;[7] and
5. Von Hippel-Lindau Disease.

For the most current overview of GHPP medical eligibility information, refer to the following website at: http://www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx

[1] Title 17 California Code of Regulations (CCR) § 2930
[2] Ibid.
[3] California Health and Safety Code (Health & Saf. Code) § 125130
[4] 17 CCR § 2932
[5] Ibid.
[6] Ibid.
[7] Ibid.

B. GHPP offers the following program components:[8]

1. Medical and dental services provided in inpatient and outpatient settings including surgical and reconstructive services, home health, medications, vitamins, food supplements, blood products and oxygen;
2. Physical, occupational and speech therapy;
3. Prosthetic and orthopedic appliances and other durable medical equipment; and
4. Psychosocial services and respite care.

C. GHPP provides services at approved Special Care Centers (SCC). The GHPP Special Care Centers are a system that:[9]

1. Provides coordinated care to clients with specific genetic conditions;
2. Multi-disciplinary and multi-specialty teams which consists of doctors, nurses, social workers, and other health team members;
3. Provides family centered planning; and
4. Facilitates timely and appropriate care.

D. The GHPP SCCs are located throughout California and usually connected with tertiary level medical centers. Each SCC must comply with the GHPP program standards to become an approved provider.

Identification and Referral of GHPP Cases

A. Primary Care Providers (PCPs), Specialists and IPAs are responsible for the identification of Members with potentially eligible conditions and subsequent referral of those adults to the GHPP.

B. Once approved, GHPP provides authorization and payment for medical and non-medical services to adult Members with conditions eligible for treatment under the GHPP guidelines.

C. Application and all supporting documentation may be submitted to GHPP in one of the three (3) following ways (See, "GHPP Application to Determine Eligibility" found in the IEHP website[10]):

Email: GHPPEligibility@dhcs.ca.gov;
Fax: 916-440-5762; or
Mail: Genetically Handicapped Persons Program
Integrated Systems of Care Division
MS 4502
P.O. Box 997413

[8] https://www.dhcs.ca.gov/services/ghpp/Pages/Benefits.aspx.
[9] Ibid.
[10] https://www.iehp.org/en/providers/provider-resources?target=forms

Sacramento, CA 95899-7413

D. IEHP Members may apply for GHPP benefits. Once the Member is enrolled in the program, they will receive the same services they are receiving from IEHP in addition to the services available through the GHPP, such as Special Care Center services.

IPA and Provider Responsibilities

A. GHPP is only responsible for treatment and payment for GHPP eligible conditions that are not a covered by IEHP or the Member's IPA. PCPs, IPAs and IEHP continue to provide for all other medically necessary care without interruption while pending GHPP determination. Financial and authorization responsibilities are delineated in the Division of Financial Responsibility (DOFR).

B. The IPA must follow all GHPP referred cases throughout the treatment process and assist with coordination and continuity of care, including but not limited to facilitating referrals and tracking outcomes.

C. IEHP is available to assist the IPA Care Manager with care coordination activities through the following methods:

1. Identification of appropriate community referral sources available to Members; or
2. Facilitating GHPP referrals if assistance is needed.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

F. In-Home Supportive Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members eligible for In-Home Supportive Services (IHSS).

POLICY:

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. IHSS is an LTSS that is provided over an extended period, predominantly in the Member's home and community.

B. In-Home Supportive Services (IHSS) is provided in accordance with the eligibility determination performed by the County IHSS office. IHSS is a county-administered program with a foundation in consumer self-direction of care.[1]

C. IEHP and its IPAs maintain the consumer-directed model for IHSS Members, which allows Members to self-direct their care by being able to hire, fire, and manage their caregivers.[2]

PROCEDURES:

IHSS Eligibility Criteria

A. IEHP and its IPAs coordinate care and ensure referral to IHSS of Members who meet the eligibility criteria of being aged, blind or disabled persons who are unable to perform activities of daily living (ADLs) and cannot remain safely in their own homes without help.[3] In addition, Members requesting IHSS must meet these following eligibility criteria:[4]

1. Live at home or a home of Member's own choosing; and
2. At risk of institutionalization in long-term care facility.

B. An IHSS Member may be eligible to a maximum of 283 hours per month.[5,6]

Identification and Referral of IHSS Cases

A. IEHP and its IPAs proactively identify Members with potential case management or IHSS program needs. Referral sources may include, but are not limited to the following:

1. IEHP and its IPAs;
2. Interdisciplinary Care Team (ICT);

[1] California Welfare and Institutions Code (Welf. & Inst. Code), § 12300
[2] CA Welf. & Inst. Code § 14186
[3] CA Welf & Inst. Code, § 12300
[4] https://www.cdss.ca.gov/in-home-supportive-services
[5] CA Welf. & Inst. Code, § 12300
[6] CA Welf. & Inst. Code, § 14132.95

3. Health assessments (e.g., Health Risk Assessment);
4. Care plan intervention;
5. Internal IEHP departments (e.g., Behavioral Health & Care Management (BH & CM), Member Services, Utilization Management, Provider Experience, Pharmacy);
6. External Providers (e.g., Community-Based Adult Services (CBAS), Community-Based Organizations, Multipurpose Senior Services Program (MSSP), Independent Living Centers, Primary Care Providers (PCP), Hospitals, and Skilled Nursing Facilities);
7. Member and/or authorized representative; or
8. Member's caregiver.

B. IHSS accepts referrals from any entity including, but not limited to IEHP, IPAs, Hospital Care Managers, Providers, Members and/or their caregiver. Members who may benefit from IHSS are referred to the appropriate IHSS Central Intake Office.

1. Riverside County IHSS Hotline:
   a. Telephone number: (888) 960-4477
   b. Apply online at https://riversideihss.org/
2. San Bernardino County IHSS Hotline:
   a. Telephone number: (877) 800-4544
   b. Facsimile referral form: (909) 948-6560

C. It is the responsibility of the Member's PCP to complete the required IHSS Health Certification form. The PCP cannot charge or bill the Member for this service. See Policy 18L, "Providers Charging Members." The Member's IPA assists Members in obtaining IHSS Health Care Certification Form SOC 873, if not submitted by Member in a timely manner.

D. The appropriate County IHSS office is responsible for all assessments and reassessments associated with authorization of IHSS hours.[7] Based on the assessment findings, the County Social Worker determines IHSS hours and services. The County Social Worker will send the Notice of Action (NOA) to the Member following their service eligibility determination.[8] The NOA will describe Member's right to a State Fair Hearing process should the Member disagree with the number of determined hours or the denial of the IHSS request.

E. If IEHP or its IPAs learn a Member who is currently receiving IHSS has a condition that has changed, IEHP or the IPA must advise the Member to contact the County IHSS Office to conduct an eligibility redetermination for IHSS.

[7] CA Welf. & Inst. Code, § 14186
[8] CA Welf. & Inst. Code § 12300.2

12. COORDINATION OF CARE

F. In-Home Supportive Services

Care Management and Care Coordination

A. IEHP maintains a memorandum of understanding (MOU) with Riverside and San Bernardino County IHSS agencies that delineates roles and responsibilities of the Plan and IHSS in providing IHSS to Members.[9]

B. IEHP and its IPAs are responsible for authorizing medically necessary covered services and coordinating care for Members provided by IEHP's Network Providers, providing information necessary to assist Members or their authorized representatives in referring themselves to County for IHSS, and coordinating services and other related Medi-Cal LTSS provided by IEHP and other providers of carve-out programs, services, and benefits. [10,11]

C. The Member's IPA CM staff coordinate care and make referrals to IHSS county programs when needs are identified, such as Members who are at risk for out-of-home placement.[12] The Member's IPA:[13]

   1. Ensures Members do not receive duplicative services through Enhanced Care Management (ECM), Community Supports, and other services;
   2. Tracks all Members receiving IHSS and continues coordinating services with IHSS until IHSS determines that IHSS is no longer needed for the Member;
   3. Outreaches and coordinates with IHSS for any Members identified by the Department of Health Care Services (DHCS) as receiving IHSS;
   4. Upon identifying Members receiving, referred to, or approved for IHSS, conducts a reassessment of Members' risk tier;
   5. Continues to provide basic population health management (care coordination) of all medically necessary services while Members receive IHSS; and
   6. Adheres to a Member's determination about the appropriate involvement of their medical Providers and caregivers, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which includes obtaining expressed consent from the Member or authorized representative to include the IHSS Provider in Member's care coordination planning.

D. IEHP shares with the IPA through the secure IEHP Provider web portal, IHSS information, including IHSS hour allocations.

[9] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 4.3.22, IHSS
[10] Memorandum of Understanding (MOU) between IEHP and Riverside County In-Home Supportive Services Public Authority (PA)
[11] MOU between IEHP and San Bernardino County In-Home Supportive Services Public Authority (PA)
[12] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.22, IHSS
[13] Ibid.

E. IHSS County Social Worker, PCP or IHSS Provider may request an interdisciplinary case conference (ICC) at any time to discuss the Member's needs by calling the IEHP Provide Relations Team at (909) 890-2054.

1. IEHP and its IPAs conduct interdisciplinary case conferences (ICC) to coordinate the delivery of services and benefits as needed for each Member.
2. IEHP and its IPAs determine which Members need an ICC based on medical need, although every Member shall have access to an ICC, if requested.
3. Members can also request an ICC at any time by calling IEHP Member Services at (800) 440-4347.

F. Members are advised to call IHSS Public Authority to obtain emergency back-up services if their IHSS Provider does not arrive to provide assistance with authorized activities of daily living services:

1. Riverside County IHSS Public Authority: (800) 915-1777
2. San Bernardino County IHSS Public Authority: (866) 985-6322

Complaints, Grievances, and Appeals

A. IEHP Members have a right to register grievances and appeals with the State of California about the determination of authorized IHSS service hours by following the State Fair Hearing process.[14] Members are provided the following information:

1. The California Department of Social Services (CDSS) accepts formal complaint submissions in writing or by telephone.
   a. California Department of Social Services
      Public Inquiry and Response
      P.O. Box 944243, MS 9-17-37
      Sacramento, CA 94244-2430
   b. Phone 1-800-952-5253 (TDD 1-800-952-8349)
2. Members may also be directed to speak with a representative of their county Department of Public Social Services (for Riverside County residents) or the Department of Aging and Adult Services (for San Bernardino County residents) for assistance with the State Fair Hearing process.
3. IEHP does not adjudicate appeals from county decisions about IHSS services.
4. It is the responsibility of IEHP to report IHSS grievance resolutions to the state of California.

[14] CA Welf. & Inst. Code, §10950

5. IEHP complies with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS.

IEHP Staff Training and Orientation Responsibilities

A. IEHP conducts annual trainings to educate health plan staff on IHSS as part of a LTSS option including:
   1. IHSS program overview;
   2. Referral Process;
   3. Eligibility and Assessment Criteria; and
   4. Program Services Available to Members.

B. IEHP trains IEHP personnel at least annually regarding the health plan's covered services and policies and procedures to access services and coordinate care.

C. IEHP trains personnel of IHSS organizations regarding IEHP's covered services and policies and procedures to access services and coordinate care.[15,16]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 2014	
Revision Effective Date:	January 1, 2024	

[15] MOU between IEHP and Riverside County In-Home Supportive Services Public Authority (PA)
[16] MOU between IEHP and San Bernardino County In-Home Supportive Services Public Authority (PA)

12. COORDINATION OF CARE

G. Organ Transplant

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and their living donors.

POLICY:

A. Effective January 1, 2022, IEHP covers all medically necessary adult and pediatric major organ transplants (MOTs) for eligible beneficiaries. IEHP will authorize, refer, and coordinate, the delivery of the MOT benefit and all medically necessary services associated with MOTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, cadaver organ transplants, hospitalization, surgery, discharge planning, readmissions from complications for up to one (1) year post-transplant, post-operative services, dialysis, medications not otherwise covered by the MCP contract, transportation, and care coordination, including care and transportation for living donors. These services will be provided as outlined in the Medi-Cal Provider Manual, at facilities that have been designated as Medi-Cal Centers of Excellence (COEs) for the following transplants:[1]

1. Bone Marrow;
2. Heart;
3. Heart/Lung combined;
4. Combined Liver and Kidney
5. Liver /Intestinal;
6. Kidney;
7. Liver;
8. Intestinal;
9. Small Bowel;
10. Combined Liver and Small Bowel;
11. Lung;
12. Simultaneous Kidney and Pancreas;
13. Pancreas; and
14. Stem Cell.

B. IEHP covers medically necessary kidney, corneal, and autologous islet cell transplants from facilities that have been approved by Centers for Medicare and Medicaid Services (CMS) for

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015 "Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative"

these types of transplants.[2]

PROCEDURES:

Provider Responsibilities

A. The Primary Care Provider (PCP) or Specialist is responsible for the initial diagnostic work-up prior to a referral to a Medi-Cal approved Transplant COE, California Children's Services (CCS) approved Special Care Center (SCC), or a CMS approved Organ Procurement and Transplantation Network (OTPN) member. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow IEHP's prior authorization referral procedures.

IEHP and IPA Responsibilities

A. IEHP is responsible for the authorization and care of all medically necessary MOTs per the Division of Financial Responsibility (DOFR).

1. IEHP, in collaboration with the IPAs, is responsible for coordinating pre-work up, transplant surgery, and one (1) year of post-transplant care for all MOTs. This includes related care including but not limited to, dialysis, evaluation of potential donors, organ procurement, readmissions due to complications for one (1) year post-transplant, living donor care, and transportation services[3]. For more information about the transportation process, see Policy MC_09C "Non-Emergency Medical and Non-Medical Transportation Services."
    a. For beneficiaries under the age of 21 that are eligible for CCS, lodging and transportation services may be covered by the CCS Maintenance and Transportation (M&T) Benefit.[4]
2. IEHP is responsible for assisting the PCP or Specialist with all necessary diagnostic, therapeutic, or other specialty referrals for the Member being evaluated as a candidate for a possible organ transplant.
3. IEHP in collaboration with the IPAs, is responsible for assessing and approving, as appropriate, transplant services for Members who had an approved treatment authorization request (TAR) prior to January 1, 2022 but were not subsequently disenrolled from IEHP.[5]
4. IEHP Members may temporarily remain in FFS Medi-Cal for any of the following circumstances:[6]
    a. If they were temporarily disenrolled from IEHP in anticipation of receiving a MOT

[2]Ibid.
[3] DHCS APL 21-015
[4] Ibid.
[5] Ibid.
[6] Ibid.

and their approved TAR has expired (or is about to expire); or

b. If they have been enrolled with IEHP for 90 days or less, and submit a medical exemption request (MER) that is approved by DHCS.

5. IEHP refers Members who meet medical necessity criteria for a specific major organ transplant to the appropriate transplant facility:[7]

   a. Members 21 years old and older are referred to a Medi-Cal Approved Transplant COE for an evaluation within 72 hours of the PCP or Specialist identifying the Member as a potential candidate for the MOT.

   b. Members under 21 years old are referred to the appropriate County CCS program for CCS eligibility determination within 72 hours of the PCP or Specialist identifying the Member as potential candidate for the MOT. IEHP will refer the Member to a CCS-approved SCC from this online resource while awaiting outcome of the CCS referral: https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx.

   c. For all age groups, kidney, corneal, and autologous islet cell transplants, are not required to be performed at either a COE. These procedures may instead be performed at a CMS-approved OPTN member facility.

6. If the Member is deemed a suitable candidate by the appropriate facility, the facility will place the Member on the transplant waiting list.

7. Once a Member has been determined to be an appropriate surgical candidate for the organ transplant, the facility will submit a request for authorization of transplant surgery.[8]

   a. IEHP uses nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to major organ transplants. Please see Policy 14A, "Utilization Management - Delegation and Monitoring" for a description of decision process. Please see the DHCS Medi-Cal Provider Manual for detailed requirements of specific organ transplant procedures.

   b. Decisions for these referrals are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (See"UM Timeliness Standards – Medi-Cal" found on the IEHP website[9]).

B. Under circumstances in which the transplant program cannot perform the MOT surgery and an organ is available, IEHP may arrange for the surgery to be performed at an out-of-network hospital. IEHP is responsible for ensuring the transplant program at this out-of-network hospital meets DHCS' COE requirements.[10]

[7] DHCS APL 21-015
[8] Ibid.
[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[10] DHCS APL 21-015.

C. The IPA will refer to IEHP any potential transplant candidates for care management services by faxing the Transplant Team Referral Form to (909) 477-8542 (See, "Transplant Team Referral Form" found in the IEHP website[11]).

D. Please see Policy MC_11A, "Pharmacy Benefits and Services," for information on prescription drug coverage for major organ transplants.

E. IEHP, in collaboration with the IPA, coordinates all aspects of the referral, including providing to the COE all medical information (diagnostic tests, specialty physician notes, etc.) relevant to the particular major organ transplant; and assuring that the Member makes all appointments.

F. IEHP, in collaboration with the IPA, ensure coordination of care between all providers, organ donor entities, and transplant programs, for both the donor and the recipient, to ensure the MOT is completed as expeditiously as possible.[12]

G. To maintain an adequate network for this program, IEHP obtains from DHCS a list of Medi-Cal Approved Transplant COEs, which operate in a hospital setting, are certified and licensed through the Centers for Medicare and Medicaid Services (CMS) and meet Medi-Cal state and federal regulations.[13]

H. IEHP is responsible for the oversight and monitoring of its MOT network. If IEHP becomes aware that a contracted transplant program is no longer active, has lost its Medi-Cal approved COE status, is no longer enrolled to participate in the Medi-Cal program, or is no longer on DHCS' COE or SCC list, IEHP will notify impacted Members no later than 30 days prior to the planned inactivation date. IEHP will coordinate the redirection of care and services.[14]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[11] https://www.iehp.org/en/providers/provider-resources?target=forms
[12] DHCS APL 21-015
[13] Ibid.
[14] Ibid.

12. COORDINATION OF CARE

H. Community-Based Adult Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. Community-Based Adult Services (CBAS) are covered benefits under IEHP.[1] IEHP is responsible for authorization and payment of CBAS services.

B. The CBAS program provides services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care. The intent of CBAS is to restore or maintain optimal capacity for self-care, delay or prevent inappropriate undesirable institutionalization, and engage the Member and/or caregiver, Primary Care Provider (PCP), and the community in working toward maintaining Member's independence.

PURPOSE:

A. To identify and coordinate care for Members requiring services at contracted CBAS centers.

B. To ensure Member access to CBAS equivalent services in all areas where a CBAS center is not available.

PROCEDURES:

CBAS Services

A. CBAS centers offer a package of health, therapeutic and social services in a community-based day care program.

1. Core services include: [2]
    a. Professional nursing services;
    b. Social services;
    c. Personal care services;
    d. Therapeutic activities; and
    e. Meal services (one (1) meal offered per day).
2. Additional services, if specified in the Member's Individualized Plan of Care (IPC), include:[3]
    a. Physical therapy;

[1] Department of Health Care Services (DHCS)- IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.4 Community Based Adult Services (CBAS)
[2] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[3] Ibid.

b. Occupational therapy;

c. Speech therapy;

d. Behavioral health services;

e. Registered dietician services;

f. Social services; and

g. Transportation to/from CBAS center to Member's place of residence.

3. CBAS centers must also make available to Members emergency remote services (ERS), when all ERS criteria, as described in this policy, are met.[4]

B. Each CBAS center shall have a multidisciplinary team of health professionals who conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific health and social needs.

C. Members have the right to select a CBAS center of their choosing, as per appropriate California Department of Health Care Services (DHCS) guidelines.[5]

D. IEHP will contract with sufficient available CBAS centers in its service area to address in a timely way the needs of its Members, who meet the CBAS eligibility criteria. IEHP will reimburse CBAS centers the daily rate for eligible Members who attend four (4) hours or more in any given day at the CBAS center.[6]

E. IEHP coordinates the Member care with CBAS centers to ensure:[7]

1. CBAS IPCs are consistent with Members' overall care plans and goals developed by Members and their care teams.

2. Exchange of Members' discharge plan information, reports of incidents that threaten their welfare, health and safety, and significant changes in their condition are conducted in a timely manner and facilitate care coordination;

3. Clear communication pathways to appropriate Plan personnel having responsibility for Member eligibility determination, authorization, care planning, including identification of the lead care coordinator for Members who have a care team, and utilization management;

4. Written notification of plan policy and procedure changes, and a process to provide education and training for CBAS centers regarding any substantive changes that may be implemented, prior to the policy and procedures changes taking effect.

F. IEHP ensures that CBAS services delivered via telehealth meet requires set forth by the Health

[4] DHCS All Plan Letter (APL) 22-020 Supersedes APL 20-007, "Community-Based Adult Services Emergency Remote Services"
[5] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[6] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation
[7] Ibid.

Insurance Portability and Accountability Act of 1996 (HIPAA).[8]

G. The Member's assigned PCP remains responsible for providing primary care and all necessary referrals for specialty services, diagnostic testing and other services.[9]

Identification of CBAS Cases

A. Members who would benefit from CBAS services may be identified by multiple sources and will include those with the following conditions:

1. Serious and/or complex medical conditions requiring rehabilitative services;
2. Physical or psychiatric disability that limits the performance of activities of daily living but do not require 24 hour institutional care;
3. Present level of functioning would either be maintained or improved if receiving preventative services; and/or
4. High potential for further impairment and probable need for institutional care if additional services are not received.

B. IEHP's determination of eligibility for CBAS may be requested by Members, caregivers, PCPs, Specialists, nursing facilities, hospitals, Community-Based Organizations (CBO), CBAS Providers, or other Providers assisting with Member's care.

C. Members who would benefit from CBAS may be identified through any of the following:

1. Routine or other office visits to the PCP or Specialist, including by other office, clinic, hospital, or nursing facility staff;
2. Evaluation of requested specialty referrals, including requests for rehabilitation services or Members with significant illness requiring multiple specialty referrals;
3. The discharge planning process, concurrent case review or referral;
4. Grievances or other Member contacts;
5. Calls to IEHP or CBAS centers by Member or on behalf of a Member that needs assistance; and
6. For Seniors and Persons with Disabilities (SPD) Members, through Health Risk Assessments (HRA).

D. IEHP and its IPAs will arrange medically necessary covered services for Members with similar conditions as CBAS recipients if there is insufficient CBAS Provider capacity and coordinate their access to community resources to assist them to remain in the community.[10]

[8] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation
[9] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[10] Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services

Eligibility Criteria for CBAS

A. IEHP will make CBAS eligibility determination in accordance with regulatory requirements.[11]

B. In order to be considered for the CBAS Program, the Member must be 18 years of age or older and meets one (1) or more of these conditions:[12]

1. Has been determined by DHCS to meet the Nursing Facility-A (NF-A) Level of Care or above;
2. Has Organic/Acquired or Traumatic Brain Injury and/or Chronic Mental Health condition;
3. Alzheimer's Disease or other Dementia Stage 5, 6, or 7;
4. Mild Cognitive Impairment, including moderate Alzheimer's (Stage 4);
5. Significant chronic medical illness; and/or
6. Developmental disability; and
7. In addition to which, the Member shall need assistance or supervision with either:
    a. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
    b. One (1) need from the above and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

CBAS Referral Process

A. If the IPA or PCP receives a request for CBAS services or identifies a potential CBAS candidate, the IPA or PCP shall forward the request immediately to the IEHP Utilization Management (UM) Department through the secure IEHP Provider web portal or by fax at (909) 890-5751 for processing.

B. The PCP is responsible for the submission of a current history and physical and proof of negative Tuberculosis (TB) test results to the CBAS center.[13]

C. The IPA's Care Manager assists the PCP with completion of the referral, telephonic monitoring of potentially eligible Members, monitoring the status of Members, facilitating any needed transfer of medical records, and coordinating any necessary specialty services for Members.

D. IEHP is available for assistance with eligibility questions, coordination of care and other questions regarding CBAS center services.

[11] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.4 Community Based Adult Services (CBAS)
[12] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[13] Ibid.

CBAS Authorization Process

A. CBAS authorization requests must include the signature of the Member's PCP or Care Manager.

B. Authorization is valid for six (6) months. IEHP requires CBAS centers to submit a Member's IPC with the authorization extension request at least every six (6) months.

C. Routine New Cases

1. Upon receipt of the request for CBAS, the IEHP UM Department will forward the authorization request to IEHP CBAS Team to ensure completion of the DHCS-Approved CBAS Eligibility Determination Tool (CEDT) face-to-face assessment by a registered nurse with level of care determination experience. IEHP must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to face review.

    a. For Members in a hospital or skilled nursing facility, whose discharge plan includes CBAS, or Members facing imminent and serious threat to their health, a face-to-face assessment may not need to be performed; therefore, expedited.[14]

    b. For all other Members, the face-to-face evaluation will be done within 30 calendar days of the authorization request.

2. CBAS centers will perform a multidisciplinary team assessment and then submit prior authorization requests with the Member's IPC and recommended Level of Service (LOS) to IEHP UM Department.

3. Following review of Member's IPC and recommended LOS with CBAS RN, IEHP UM Medical Director determines CBAS LOS approval within five (5) business days.

D. Expedited New Cases

1. Upon receipt of the expedited authorization request from UM, the IEHP CBAS RN will conduct the face-to-face assessment by using CEDT.

2. Approval or denial of CBAS eligibility will be sent to the CBAS center within 72 hours of the receipt of the request.[15,16]

3. CBAS centers will perform multi-disciplinary team assessment and then submit prior authorization requests with Member's IPC and recommended LOS to IEHP UM Department.

4. Following review of Member's IPC and recommended LOS with CBAS RN the IEHP UM Medical Director determines CBAS LOS approval in accordance with regulatory requirements.[17]

[14] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[15] California Health and Safety Code (Health & Saf. Code), § 1367.01
[16] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation
[17] CA Health & Saf. Code, § 1367.01

E. Existing Cases

1. IEHP will reassess the Member, with family involvement (when appropriate), and redetermine eligibility at least every six (6) months from the initial assessment or up to every 12 months when determined by the Plan to be clinical appropriate. CBAS centers will send prior authorization request including IPC with LOS recommendation to IEHP UM Department.[18]
2. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, the reassessment may be performed using only the Member's IPC, including any supporting documentation supplied by the CBAS center.

F. Members that are referred for CBAS by their PCP or IPA, as part of a care plan, must be care managed by the IPA to assure coordination of care until the Member is approved for CBAS services.

G. Once the Member has been approved for CBAS services, the IEHP CBAS staff will coordinate services with the respective IPA, as needed.

H. Members are to be notified in writing of their CBAS assessment determination within two (2) business days of the decision.[19]

I. Denial in services or reduction in the requested number of days for services requires a face-to-face review.[20]

J. Members not accepted into the CBAS Program will continue to receive medical care through their PCP and their IPA and should be referred for other appropriate services as needed.

CBAS Discharge

A. CBAS centers must update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and IEHP, when services are terminated. The discharge plan of care must include:

1. Member Name;
2. Member ID;
3. If applicable, the date the Notice of Action denying authorization for CBAS was issued;
4. If applicable, the date the CBAS benefit will be terminated;
5. Specific information about the Member's current medical condition, treatments, and medications;
6. Potential referrals for medically necessary services and other services or community

[18] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.4 Community Based Adult Services (CBAS)
[19] Ibid.
[20] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 11/28/14

resources that the Member may need upon discharge;

7. Contact information for the Member's case manager; and
8. A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

CBAS Unbundled Services

A. If there are no CBAS centers or if there is a lack in capacity at CBAS centers in the Member's local area and the Member qualifies for CBAS services, IEHP will preauthorize "equivalent" unbundled services.[21] These unbundled CBAS services are the health plan's financial responsibility. These services include:[22]
   1. Professional Nursing Services;
   2. Nutrition;
   3. Physical Therapy;
   4. Occupational Therapy;
   5. Speech and Language Pathology Services; and
   6. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) only between the Member's home and the CBAS unbundled service Provider; and
   7. Non-Specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services.[23]

B. In addition to the requirements for unbundled CBAS, IEHP will coordinate care for unbundled CBAS services, based on the assessed needs of the Member that is eligible for CBAS, that are not covered services. These include:[24]
   1. Personal Care Services;
   2. Social Services;
   3. Physical and Occupational Maintenance Therapy;
   4. Meals;
   5. Mental Health Services; and
   6. SUD Services.

CBAS Emergency Remote Services

A. Effective October 1, 2022, IEHP will cover emergency remove services (ERS) as a mode of

[21] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 11/28/14
[22] Ibid.
[23] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, 5.4.1, Covered Services
[24] Ibid.

service delivery if the Member meets all ERS criteria and all required ERS policy and procedures are followed. The CBAS center, in consultation with IEHP, may determine the need for ERS in these unique circumstances:[25]

1. Public emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, Norovirus, etc.
2. Personal emergencies, such as serious illness or injury or crises, or care transitions, such as to or from a nursing facility, hospital, and home.

B. The CBAS center must support the rapid response to the Member's needs, when they are restricted or prevented from receiving services at the center.[26]

1. The CBAS center must ensure that emergencies resulting in ERS are assessed initially by the CBAS center's RN and social worker, with care plans modified as needed by the full CBAS multidisciplinary team.[27]
2. When need for ERS is appropriately assessed and determined, the CBAS center must complete and fax the CBAS ERS Initiation Form (CEIF) form to IEHP's Utilization Management department at (909) 890-5751 for review and confirmation.[28]
3. To support rapid response to the Member's needs, the CBAS center must not wait for notification from IEHP.
4. On a monthly basis, IEHP will provide CBAS centers a list of Members identified to be receiving ERS based on review of CEIF submissions.

C. The provision of ERS supports and services is temporary and time-limited, and specifically either:[29]

1. Short-Term – The Member may receive ERS for an emergency occurrence for up to three (3) consecutive months; and
2. Beyond Three (3) Consecutive Months – ERS for an emergency occurrence may not exceed three (3) consecutive months, either within or crossing over an authorized period, without assessment and review of possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the Member's care plan.

D. In both of the above, IEHP and the CBAS center must coordinate to ensure that the duration of ERS is appropriate. IEHP will reach out to Members receiving ERS telephonically to verify that service and supports needs are being met during the duration of ERS.

[25] DHCS APL 22-020
[26] Ibid.
[27] Ibid.
[28] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Emergency_Remote_Services/
[29] DHCS APL 22-020

E. CBAS centers and IEHP may consider the following to determine initial need for and/or duration of ERS. Should there be any concerns regarding the appropriateness of ERS, IEHP and the CBAS center must collaboratively agree on the method of providing ERS.[30]

1. Medical necessity – services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain;
2. Hospitalization – whether the Member has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center;
3. Restrictions set form by the Members primary or personal health care provider due to recent illness or injury;
4. Member's overall health condition;
5. Extent to which other services or supports meet the Member's needs during the emergency; and
6. Personal crises such as sudden loss of caregiver or housing that threaten the Member's health, safety and welfare.

F. Within 30 days of discharge from CBAS, IEHP must review and retain a copy of the Member's discharge plan from the CBAS center. IEHP must review the discharge plan to determine if the Member needs further coordination of care or services. When there are unmet needs due to the discharge from CBAS, IEHP must ensure the Member's needs are met through other covered non-CBAS services and that these needs are updated appropriately in the Member's care plan.[31]

G. IEHP will provide oversight of its contracted CBAS Providers' compliance with ERS requirements per DHCS APL 22-020 and All Center Letters issued by the California Department of Aging through data and reporting, and monitoring of CBAS-related grievances.

Grievance and Appeal Process

A. A Member has the right to request an appeal within 60 calendar days of the date on the Notice of Action.[32,33,34,35] Please see 16B, "Member Appeal Resolution Process" for more information.

B. A Member has the right to file a grievance at any time following any incident or action that is subject to Member's dissatisfaction. Please see Policy 16A, "Member Grievance Resolution

[30] DHCS APL 22-020
[31] Ibid.
[32] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 11/28/14
[33] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 2, Grievance Process
[34] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006 and 04-006, "Grievance and Appeal Requirements, Notice and 'Your Rights' Templates
[35] Title 42 Code of Federal Regulation (CFR) § 438.402(c)(2)(i)

Process" for more information.[36,37,38]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	July 1, 2013	
Revision Effective Date:	January 1, 2024	

[36] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 11/28/14
[37] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[38] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments"

12. COORDINATION OF CARE

I. Complex Case Management

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, in collaboration with the Member's Primary Care Provider (PCP), provides complex case management (CCM) services, which include:[1]

1. Basic case management services;
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;
3. Intense coordination of resources to ensure Member regains optimal health or improved functionality in the right setting;
4. With the Member and their PCP's input, development of care plans specific to individual needs, and updating these care plans as needed or at least annually; and
5. Members may opt-in or opt-out of the CCM program.

B. PCPs provide basic care management services[2] and are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care.[3]

PURPOSE:

A. To ensure the coordination of care and services for higher- and medium risk[4] Members with complex conditions and help them access needed resources.[5]

DEFINITION:

A. Complex Case Management – The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.[6]

PROCEDURES:

[1] Department of Health Care Services (DHCS) IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.7, Care Management Programs
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3, Population Health Management and Coordination of Care
[3] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions
[4] DHCS CalAIM: Population Health Management (PHM) Policy Guide
[5] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, PHM 5
[6] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions

12. COORDINATION OF CARE

I. Complex Case Management

A. IEHP does not delegate CCM responsibilities to its IPAs. IPAs may instead, refer to IEHP's Behavioral Health and Care Management (BH & CM) Department Members that may benefit from CCM services, including information that supports the complex need. The CM Referral Form can be found on the IEHP website at www.iehp.org or on the secure IEHP Provider portal. (See, "IEHP Care Management Referral Form" found on the IEHP website).[7]

Member Identification

A. Identification of Members for CCM include data and referral sources, which identify health risk factors, complex social needs, and behavioral health concerns.

B. Members needing CCM services typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely decline or use acute services more frequently. Members needing CCM level of assistance often require numerous or extensive resource coordination to improve their health or circumstances. The following CCM Program Trigger List was developed as a general guide for identifying Members that may benefit from CCM and should be used in combination with considering the following questions:

1. Does the Member have two (2) or more chronic medical conditions not being managed, along with social determinant concerns such as food insecurity, financial concerns, housing, or other factors that may affect the Member's decisions/health status?
2. Is the Member's condition expected to progress in complexity and/or result in hospitalizations/ER visit (s) without resources and specialists?
3. Does the Member have one or more complex behavioral health conditions not being managed effectively and would need multiple resources/specialists?

Triggers for CCM include but are not limited to:

Diagnosis Triggers

1. Advanced Liver Disease
2. Metastatic Cancer
3. Pediatric Cancer
4. Decompensating Neurological Conditions
5. New Cerebral Vascular Accident
6. Trauma (current)
7. Chronic uncontrolled (physical condition and/or behavioral health symptoms) that impact Member's activities of daily living (ADL)
8. Chronic homelessness impairing the ability to function in the community

[7] https://www.iehp.org/en/providers/provider-resources?target=forms

AND/OR

Utilization Triggers

1. Six (6) or more ER visits in the past 6 months
2. Four (4) or more inpatient stays for physical or behavioral health (self-reported) in the past 12 months
3. On six (6) or more medications to treat chronic conditions and/or polypharmacy for the same medical/behavioral health conditions
4. Projected cost of care within a 12-month period anticipated to be > $100,000 (including high-cost medications and/or DME)

AND/OR

Psychosocial/Frailty Triggers

1. Weight loss of more than eight (8) pounds per month or 48 pounds in six months
2. Severe vision impairment needing total dependence to complete ADLs
3. Presence of Decubitus Ulcer (2 or more at Stage III; 1 at Stage IV)

Member Referrals

A. IEHP will review referrals to its CCM program. On a monthly basis, IEHP will provide IPAs through the Secure File Transfer Protocol (SFTP), a CCM report that identifies the following:
   1. Members assigned to the IPA that are in active CCM with IEHP as of report run date;
   2. Members assigned to the IPA that were closed from CCM with IEHP in the previous month with the reason for CCM closure included; and
   3. Members assigned to the IPA that were referred to IEHP for CCM but were not opened to CCM as of report run date, because the Member did not meet criteria.

B. IPAs are responsible for reviewing cases and evaluating Members who did not meet CCM criteria. IPAs must outreach to these Members and assess for care coordination and case management needs.

Monitoring and Oversight

A. When a Member is receiving Transitional Care Management (TCM) or a Member's care involves multiple Subcontractors, Downstream Subcontractors, and/or IEHP Providers, IEHP ensures Members are not receiving duplicative services.

B. While IEHP does not delegate CCM to its IPAs, IEHP will review cases that potentially qualify and assess for appropriate referral. See Policy 25C1, "Care Management– Delegation and Monitoring" for more information on monitoring and oversight activities.

12. COORDINATION OF CARE

I. Complex Case Management

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2021	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

J. Dental Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) are required to perform dental screenings and oral health assessments for all Members as part of the initial health appointment (IHA) and periodic health examinations.[1] Please see Policies 10A, "Initial Health Appointment," 10B, "Adult Preventive Services" and 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

B. Dental services may be provided to Medi-Cal Members on a fee-for-service (FFS) basis through Denti-Cal.[2] IEHP provides covered medical services related to dental services that are not provided by dentists or dental anesthetists, including prescription drugs, laboratory services, physical examinations required for admission for a dental procedure.[3,4]

PROCEDURES:

A. IEHP provides medically necessary federally required dental services including fluoride varnish for adults that may be performed by a medical professional.[5] Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for information on dental services for pediatric Members.

B. IEHP is responsible for the facility component and services related to dental procedures that require intravenous sedation and general anesthesia that are provided by a physician anesthesiologist or certified registered nurse anesthetist for Medi-Cal Members who need dental services performed by a licensed dentist that are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury or defect. A dental procedure may be provided under general anesthesia in a setting deemed appropriate.[6]

C. Adult Denti-Cal services are available to Members age 21 and above. Dental services are covered under Medi-Cal FFS for Members under age 21 and for pregnant women per Denti-Cal specific allowable procedure codes.[7]

D. PCPs refer Medi-Cal Members needing dental services to Denti-Cal Practitioners by giving

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.18, Dental
[2] DHCS All Plan Letter (APL) 15-012 (Revised) Supersedes Policy Letter (PL) 13-002, "Dental Services – Intravenous Sedation and General Anesthesia Coverage"
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.18, Dental
[4] DHCS APL 15-012
[5] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.18, Dental
[6] Ibid.
[7] Ibid.

the Member the Denti-Cal Practitioner referral phone number, (800) 322-6384.[8] PCPs can also refer Medi-Cal Members needing dental services to IEHP Member Services at (800) 440-IEHP (4347) for assistance in accessing the Denti-Cal Practitioner referral line.

E. PCPs and IPAs continue to provide all necessary health care services to Members even if referred to a dental Practitioner for services.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Date:	January 1, 2024	

[8] California Department of Health Care Services, Medi-Cal Dental Member Contact Information, https://www.dental.dhcs.ca.gov/Contact_Us/Medi-Cal_Dental_Member_Contact_Information/

12. COORDINATION OF CARE

K. Behavioral Health

1. Behavioral Health Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) and other health care Providers are required to provide behavioral health and/or substance use services within their scope of practice.[1,2,3,4]

B. IEHP and its County Mental Health Plan (MHP) partners administer standardized, statewide Adult and Youth Screening and Transition of Care Tools for Members under 21 (youth) and for Members age 21 and over (adults). These tools guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and ensure that Members requiring transition between delivery systems receive timely coordinated care.[5]

C. In both Riverside and San Bernardino Counties, Medi-Cal Specialty Mental Health (SMHS) are organized through the County MHPs namely, Riverside University Health Services – Behavioral Health (RUHS-BH) and San Bernardino County Department of Behavioral Health (SBDBH).[6]

DEFINITIONS:

A. Specialty Mental Health Services (SMHS) – Refer to services provided by the County MHPs for Medi-Cal Members who meet access criteria for SMHS.[7]

B. Non-Specialty Mental Health Services (NSMHS) - Refer to services provided by IEHP BH Providers to IEHP Members as described in this policy.

PROCEDURES:

Covered Benefits

A. IEHP is responsible for non-specialty mental health services (NSMHS) to Members, who are:[8]

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7 Services for All Members
[2] DHCS All Plan Letter (APL) 22-006 Supersedes APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services"
[3] Memorandum of Understanding (MOU) between the IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 01/01/18
[4] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Behavioral Health Services, 12/14/20
[5] DHCS APL 22-028, "Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services"
[6] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"
[7] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"
[8] DHCS APL 22-005, "No Wrong Door for Mental Health Services Policy"

1. 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined in the current Diagnostic and Statistical Manual of Mental Disorders;
2. Under the age of 21, to the extent they are eligible for services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;
3. Under the age of 21, with specified risks or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy;[9] and
4. Of any age with potential mental health disorders not yet diagnosed.

B. County MHPs are responsible for providing medically necessary behavioral health services to children and SMHS to adults (ages 21 and older) who meet access criteria for SMHS.[10,11,12]

C. IEHP is not responsible for payment of the following behavioral health services, which are carved out to the County MHPs:

1. Acute inpatient psychiatric hospital services;
2. Substance use services; and/or
3. SMHS outpatient behavioral health services such as:
    a. Mental health assessments, plan development, therapy, rehabilitation, and collateral services;
    b. Medication support;
    c. Day treatment services and day rehabilitation;
    d. Crisis and adult residential treatment;
    e. Crisis intervention and crisis stabilization;
    f. Targeted case management;
    g. Intensive care coordination;
    h. Intensive home-based services; and
    i. Therapeutic foster care and behavioral services.

D. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder

[9] DHCS APL 22-006
[10] MOU between IEHP and RUHS-BH, 01/01/18
[11] MOU between IEHP and SBDBH, 02/12/18, 2/14/20
[12] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"

services than are imposed on medical/surgical services.[13]

E. IEHP provides access to the following NSMHS, as medically necessary, when provided by network PCPs, Specialists, or other licensed mental health professionals within their scope of practice.[14] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

1. Individual mental health evaluation and treatment (no authorization is required for initial evaluation for therapy and psychiatry);
2. Group and family psychotherapy;
3. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
4. Outpatient services for the purpose of monitoring medication therapy;
5. Outpatient laboratory tests, supplies, supplements and prescription medications, including physician-administered drugs (excluding anti-psychotic medications which are covered by Medi-Cal Fee-For-Service) administered by a health care professional in a clinic, physician's office or outpatient setting through the medical benefit, to assess and treat mental health conditions;
6. Psychiatric and therapy follow up or ongoing visits;
7. Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings;
8. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT);[15]
9. Up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth;[16] and
10. Autism assessments and Behavioral Health Treatment including Applied Behavioral Analysis (ABA), Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Therapy (ST) (See Policies 12D, "Early and Periodic Screening, Diagnosis and Treatment" and 12K3, "Behavioral Health Treatment").[17]

[13] Title 42 Code of Federal Regulations (CFR) §§ 438.900, 438.910(d)
[14] DHCS APL 22-005
[15] DHCS APL 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief interventions and Referral to Treatment"
[16] DHCS APL 22-006
[17] DHCS APL 23-010 Supersedes APL 19-014, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"

F. IEHP does not deny or disallow reimbursement for clinically appropriate and covered NSMHS even when:[18]

1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
2. Services are not included in an individual treatment plan;
3. The Member has a co-occurring mental health condition and substance use disorder (SUD); or
4. NSMHS and SMHS are provided concurrently if those services are coordinated and not duplicated.

G. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) are covered by counties participating in DMC-ODS, whether or not the Member has a co-occurring mental health condition.[19]

Identification/Diagnosis

A. PCPs and other health care Providers are responsible for identifying Members with behavioral health conditions that require referral to behavioral health specialists for treatment and triage according to the level of urgency.[20] Identification of these Members can occur during routine visits.

B. PCPs and BH Providers are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.[21,22,23]

C. PCPs and other Providers may advise Members who are exhibiting severe symptoms which impair their Activities of Daily Living **and** who are **not** currently in treatment with a BH Provider to contact their respective County BH Call Centers:

1. **Riverside County Residents:**
   CARES Line
   (800) 499-3008

2. **San Bernardino County Residents:**
   San Bernardino County Access Unit
   (888) 743-1478

3. **IEHP Behavioral Health & Care Management Department:**

[18] DHCS APL 22-005
[19] Ibid.
[20] DHCS APL 22-006
[21] Ibid.
[22] MOU between IEHP and RUHS-BH, 03/12/18
[23] MOU between IEHP and SBDBH, 12/14/20

Monday-Friday 8:00am-5:00pm
Provider Line: (909) 890-2054
Member Line: (800) 440-4347
Fax Number: (909) 890-5763

Screening for Mental Health Services

A. IEHP administers standardized DHCS-issued Adult and Youth Screening Tools when a Member or a person on behalf a Member under age 21, who is not currently receiving mental health services. These screening tools:[24]

1. Identify indicators of Member needs in order to make a determination for referral to either an in-network Provider for a clinical assessment and medically necessary NSMHS or the County MHP for a clinical assessment and medically necessary SMHS;
2. Are not required or intended for use with Members who are currently receiving mental health services;
3. Are not required to be used when Members contact mental health Providers directly to seek mental health services;
4. May be administered by clinicians or non-clinicians in a variety of ways, including in person, by telephone, or video conference;
5. Must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is able to respond;
6. Do not replace the following:
    a. IEHP's policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;
    b. IEHP's protocols that address clinically appropriate, timely, and equitable access to care;
    c. IEHP's clinical assessments, level of care determinations and service recommendations; and
    d. IEHP's requirements to provide EPSDT services.

B. The Adult Screening Tool, which is used for Members age 21 and older, includes screening questions that are intended to elicit information about the following:

1. Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services;
2. Clinical Experiences: Information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications;

[24] DHCS APL 22-028

3. Life Circumstances: Information about challenges the Member may be experiencing, issues related to school, work, relationships, housing, or other circumstances;
4. Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.

This also includes questions related to substance use disorder (SUD). If a Member responds affirmatively to these SUD questions, they are offered a referral to the County MHP for SUD assessment. The Member may decline this referral without impact to their mental health delivery system referral.[25] See Policy 12K2, "Substance Use Treatment Services" for more information.

C. The Youth Screening Tool, which is used for Members under the age of 21, includes screening questions that are intended to elicit information about the following: [26]

1. Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services;
2. System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system;
3. Life Circumstances: Information about challenges the member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances; and
4. Risk: Information about suicidality, self-harm, harm to others, and hospitalizations.

This also includes questions related to SMHS access and referral to other services.

D. These screening tools, their contents, including the specific wording and order of fields must remain intact and unchanged.[27]

E. IEHP uses the scoring methodology provided in these screening tools are used to determine an overall score for each screen Member and whether they must be referred to an in-network Provider or the County MHP for clinical assessment and medically necessary services. [28]

F. IEHP coordinates Member referrals with County MHPs by sharing the completed screening tool and following up to ensure a timely clinical assessment has been made available to the Member. Members must be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.[29]

[25] DHCS APL 22-028
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] DHCS APL 22-028

G. IEHP allows its contracted mental health Providers who are contacted by Members seeking mental health services to begin the clinical assessment process and provide services during the assessment period without using the screening tools.[30]

Treatment

A. Certain behavioral health conditions beyond the PCP's scope of practice require treatment by a BH Provider. In these cases, the PCP can directly refer the Member to a BH Provider for an initial assessment without prior authorization.[31,32]

B. Members referred to the County MHPs for behavioral health services remain enrolled in IEHP. IEHP, its IPAs and Providers remain responsible for all necessary physical health care.[33,34]

C. IEHP and County MHPs provide medically necessary behavioral health interventions:[35,36]

1. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to preventive significant illness or significant disability, or to alleviate severe pain.

2. For individuals under 21 years of age, services, including NSMHS, are "medically necessary" or a "medical necessity," when the services are necessary to correct or ameliorate defects and physical and mental illnesses or conditions that are discovered by screening services, regardless of whether services are covered by Medi-Cal.[37,38,39] Behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition, which is consistent with federal guidance from the Centers for Medicare and Medicaid Services (CMS).[40] Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and covered under the EPSDT mandate.[41]

3. Treatment may include the provision of appropriate psychotropic medications as well as acute crisis intervention.[42,43]

---

[30] Ibid.
[31] DHCS APL 22-006
[32] 28 CCR § 1300.74.72(f)
[33] MOU between IEHP and RUHS-BH, 03/12/18
[34] MOU between IEHP and SBDBH, 12/14/20
[35] California Welfare & Institutions (Welf. & Inst.) Code § 14059.5
[36] CA Welf. & Inst. Code § 14184.402
[37] DHCS APL 23-005 Supersedes APL 19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21"
[38] DHCS – IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder
[39] Title 42 United States Code (USC) § 1396(d)
[40] DHCS APL 22-006
[41] DHCS APL 22-006
[42] MOU between IEHP and RUHS-BH, 03/12/18
[43] MOU between IEHP and SBDBH, 12/14/20

4. IEHP provides medically necessary Behavioral Health Treatment (BHT) services for all Members that meet criteria, even without a diagnosis of autism spectrum disorder (ASD).[44,45] See Policy 12K3, "Behavioral Health – Behavioral Health Treatment" for more information.

Referral Process

A. IEHP processes all requests for BH or Substance Use Disorder (SUD) services in compliance with State and Federal regulatory requirements, including requirements for parity in mental health and substance use disorder benefits.[46,47] See Policy 12K2, "Behavioral Health – Substance Use Treatment Services" for more information about substance use services and referrals.

B. IEHP does not require prior authorization for initial mental health assessment. IEHP covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements.[48] IEHP's Behavioral Health and Care Management (BH & CM) Department can assist in the referral process for all Members. Members may be directed to IEHP BH & CM Department through several sources, which include, but are not limited to:

   1. Member or their representative;
   2. PCPs and other Providers;
   3. County agencies;
   4. IPAs; and
   5. IEHP Departments.

C. IEHP will process requests for BH services. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers.[49] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

   1. Expedited/Urgent Referrals

      a. In the event a Member needs urgent access to NSMHS and is NOT experiencing a behavioral health crisis or psychiatric emergency, the Provider can call, fax, or send an electronic referral through the secure IEHP Provider portal.

[44] DHCS APL 23-005
[45] DHCS APL 23-010
[46] 42 CFR § 438.910(d)
[47] CA Health and Safety Code (Health & Saf. Code) § 1367.01
[48] DHCS APL 22-006
[49] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

b. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). See Policies 14C, "Emergency Services" and 9A, "Access Standards" for more information.

c. Assistance with locating a hospital emergency department is available after hours through the Nurse Advice Line at (888) 244-4347.

2. Standard or Non-Emergent Referrals

a. PCPs and Specialists, with the assistance from the Member's IPA care management staff as needed, are responsible for referring Members to the IEHP BH & CM Department.

b. When a Member contacts the County Mental Health system and the County determines that the Member is not eligible for SMHS Services, the County will refer the Member to IEHP.

c. For routine referrals that do not require urgent access to services, the County will submit a BH web form referral to IEHP.

D. IEHP will provide continuity of care in accordance with applicable regulatory requirements.[50] See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

Transition of Care Tool for Medi-Cal Mental Health Services

A. If a Member is currently in treatment with an IEHP BH Provider or County MHP and is identified as possibly needing to be transitioned to the other delivery system, the treating Provider will complete the Transition of Care tool through the secure IEHP Provider portal.

B. The Transition of Care Tool is intended to ensure that Members, including adults age 21 and older and youth under age 21, who are receiving mental health services from one delivery system receive timely and coordinated care when either: (1) their existing services are being transitioned to the other delivery system; or (2) Services are being added to their existing mental health treatment from the other delivery system.[51] This tool:

1. Documents the Member's information and provide information from the entity making the referral to the receiving delivery system to begin the Member's care transition;

2. Leverages existing clinical information to document a Member's mental health needs and facilitate a referral for a transition of care to, or addition of services from the Plan or County MHP, as needed;

[50] DHCS APL 22-032 (Revised) Supersedes APL 18-008, "Continuity of Care for Medi-Cal Members who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023"
[51] DHCS APL 22-028

3. Documents the IEHP's contact information and care team, Member demographics and contact information, Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications, and requested services;
4. Designed to be used for both adults and youth alike and may be administered in a variety of ways, including in person, by telephone or by video conference;
5. Do not replace the following:
    a. IEHP's policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;
    b. IEHP's protocols that address clinically appropriate, timely, and equitable access to care;
    c. IEHP's clinical assessments, level of care determinations and service recommendations; and
    d. IEHP's requirements to provide EPSDT services.

C. The Transition of Care tool, its contents, including the specific wording and order of fields must remain intact and unchanged.[52]

D. The determination to transition services to and/or add services from the County MHP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with Plan protocols. Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.[53]

E. A Member with established therapeutic relationship with an IEHP BH Provider may continue receiving NSMHS from the IEHP BH Provider (billed to IEHP), even if the Member simultaneously receives SMHS from a County MHP Provider (billed to the County MHP), as long as the services are coordinated between the delivery systems and are non-duplicative.[54]

Eating Disorders

A. IEHP and the County MHPs share a joint responsibility to provide medically necessary services to Medi-Cal Members with eating disorders. IEHP is responsible for the physical health components of eating disorder treatment and NSMHS, and County MHPs are responsible for the SMHS components of eating disorder treatment:[55]
    1. County MHPs provide, or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

[52] DHCS APL 22-028
[53] Ibid.
[54] DHCS APL 22-005
[55] DHCS APL-22-003, "Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders"

2. IEHP provides inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization. IEHP also provides or arranges for NSMHS for Members requiring these services
3. IEHP covers and pays for emergency room professional services, including professional physical, mental, and substance use treatment services, including screening. See Policy 14C, "Emergency Services" for more information.

B. IEHP coordinates all medically necessary care for Members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a Member.[56]

C. IEHP maintains a Memoranda of Understanding (MOU) with both County MHPs that outline the following:[57,58,59]

1. Mutually agreed upon division of financial responsibilities;
2. Provider reimbursement requirements;
3. Care coordination and concurrent review activities; and
4. Description of timely and complete exchange of information between parties.

D. IEHP does not delay care management and care coordination, as well as coverage of medically necessary services pending the resolution of a dispute.[60]

IEHP Responsibilities

A. For Members concurrently receiving NSMHS and SMHS, IEHP coordinates their care with County MHP to ensure Member choice.[61]

B. IEHP refers the Member to the County MHP and coordinates their care services with County MHPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the Member has been connected with a Provider in the new system, the new Provider accepts the care of the Member, and medically necessary services have been made available to the Member. All appropriate consents must be obtained in accordance with accepted standards of clinical practice.[62]

C. PCPs and BH Providers are responsible for maintaining communication with treating Providers, assigned IPAs and/or IEHP BH & CM Department to coordinate the Member's care.

[56] DHCS APL-22-003
[57] Ibid.
[58] MOU between IEHP and RUHS-BH, 01/01/18
[59] MOU between IEHP and SBDBH, 12/14/20
[60] DHCS APL 22-003
[61] DHCS APL 22-005
[62] DHCS APL 22-028

D. IEHP BH & CM Department is available for consultation regarding complex cases or to assist with coordinating care with BH Providers, including County BH Providers.

Medications

A. IEHP is responsible for payment of most psychotropic medications when prescribed by an IEHP Provider. Most of the anti-psychotic (neuroleptics) medications and the medications that mitigate the side effects of anti-psychotic medications are excluded as a benefit administered by IEHP and are not paid for by IEHP but are instead covered by Medi-Cal Fee-For-Service (FFS).

B. IEHP Providers are responsible for writing prescriptions for medications that are medically necessary and providing any additional information required by IEHP or Medi-Cal FFS to obtain a particular medication (e.g., Prescription Drug Prior Authorization (RxPA) information).

C. Out-of-network physicians prescribing medications for Members must provide any additional information requested by IEHP or Medi-Cal FFS.

Releasing Member Information

A. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care, when IEHP is the payer of services. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records."

B. Providers may use their own Release of Information (ROI) form or use IEHP's Authorization for Use or Disclosure of Patient Health Information Form (see, "Authorization for Use or Disclosure of Protected Health Information – English" and "Authorization for Use or Disclosure of Protected Health Information – Spanish" found on the IEHP website).[63]

Reporting and BH Web Forms

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests, transition care and review reports.

B. PCPs must inform IEHP of Members identified to have significant or complex behavioral health conditions using the BH web forms on the secure IEHP Provider portal.

C. BH Providers must submit the "Coordination of Care Treatment Plan" through the secure IEHP Provider portal as follows:

1. Prior to the expiration date of the authorization, request continued services, when medically necessary;
2. When a Member requires transition to SMHS;
3. When a Member needs additional SMHS;

[63] https://www.iehp.org/en/providers/provider-resources?target=forms

4. When a Member no longer needs medically necessary services, the Member discharges from treatment, and/or when treatment is terminated for any reason; and
5. Provide results of a second opinion three (3) business days after the second opinion was performed. See Policy 14B, "Second Opinions" for more information.

E. All IPAs, PCPs and BH Providers can access BH web forms on the secure IEHP Provider portal. Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

K. Behavioral Health
2. Substance Use Treatment Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, its IPAs, and Providers identify Members requiring substance use disorder treatment services and arrange for their referral to the County Behavioral Health Department for substance use treatment, or other community resources.[1]

PROCEDURES:

Identification/Diagnosis

A. Provision or arrangement of medically necessary care for acute medical conditions related to substance use, such as delirium tremens or gastrointestinal hemorrhage, is the responsibility of the Primary Care Provider (PCP) or the Specialist.

B. PCPs must complete the initial health assessment (IHA) for all new Members within 120 calendar days of their enrollment.[2] An IHA includes a review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc.[3] as well as the Staying Healthy Assessment (SHA) through which the PCP can identify alcohol misuse.[4, 5] Subsequent contact with the Member provides PCPs the opportunity to evaluate the Member's health and screen regarding substance use problems. See Policies 10A, "Initial Health Assessment," 10B, "Adult Preventive Services," 10C1, "Pediatric Preventive Services – well Child Visit," and 15F, "Individual Health Education Behavioral Assessment/Staying Healthy Assessment," for more information on alcohol and drug screening, assessment, brief interventions and referral to treatment.[6]

C. Members with substance use problems may also be identified through:

1. Utilization Management (UM) activities;
2. Care Management (CM) activities;
3. Provider referrals; and
4. Pharmacy utilization management activities.

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.14, Alcohol and SUD Treatment Services
[2] DHCS Policy Letter (PL) 08-003, "Initial Comprehensive Health Assessment"
[3] Ibid.
[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.5 Mental Health and Substance Use Disorder Benefits
[5] DHCS PL 08-003
[6] DHCS All Plan Letter (APL) 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)"

Treatment

A. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[7]

B. PCPs are responsible for all necessary physical and mental health care for Members with substance use problems within their scope of practice.[8]

C. Depending on the specific substance use problem and the health status of the Member, services may include:

1. Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT);
2. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);
3. Mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; or
4. Referral to specialty Providers for evaluation as necessary.

D. The PCP must discuss recommendations for treatment with the Member, develop a treatment plan, and/or as appropriate, refer them to the appropriate County Substance Abuse Service Agency.

Referral Process

A. PCPs, IPAs, and BH Providers are responsible for referring Members with substance use problems to an appropriate treatment program covered through the county substance abuse treatment program.[9]

B. PCPs, Specialists, and BH Providers, who identify a potential need for services are responsible for referring IEHP Medi-Cal Members to the appropriate County Substance Abuse Service Agency:

1. **Riverside County Residents:**
   Substance Use Community Access, Referral, Evaluation, and Support
   (800) 499-3008
2. **San Bernardino County Residents:**
   Substance Abuse Referral Service
   (800) 968-2636

C. IEHP Behavioral Health & Care Management (BH & CM) Department can assist with

[7] Title 42 Code of Federal Regulations (CFR) § 438.900 *et seq*.
[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7, Service for All Members
[9] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.5, Mental Health and Substance Use Disorder Services

facilitating referrals to the appropriate County Substance Abuse Service Agency's referral unit, as necessary. [10,11]

1. IEHP BH & CM Department contact information:

   Monday-Friday 8:00am-5:00pm
   Provider Line: (909) 890-2054
   Member Line: (800) 440-4347
   Fax Number: (909) 890-5763

2. Expedited/Urgent Referrals

   a. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). See Policies 14C, "Emergency Services" and 9A, "Access Standards" for more information.

   b. Assistance with locating a hospital emergency department is available after hours through the Nurse Advice Line at (888) 244-4347.

   c. Any Medi-Cal Member presenting to a Provider or facility with an acute substance use problem requiring an immediate detoxification evaluation may be referred to the appropriate County Substance Abuse Referral Unit.

   d. Any Member presenting with acute withdrawal symptoms requiring medical detoxification should be referred to a contracted hospital emergency department.

3. Standard Non-Emergent Referrals

   a. PCPs and/or Specialists are responsible for referring Members with non-emergent substance abuse conditions to the appropriate local County Substance Abuse Agency's Referral Unit.

   b. IEHP refers Members to community resources as necessary.

   c. Members who respond affirmatively to the alcohol pre-screen question on the SHA or are identified by their PCP to potentially misuse alcohol are referred to the County Behavioral Health Department.[12]

D. Members referred for substance use treatment to a County Substance Abuse Service Agency remain enrolled in IEHP and the assigned PCP, Provider, and IPA remain responsible for all necessary physical health care. E. IEHP BH & CM Department coordinates with the County Substance Abuse Service Agency to refer Members to available treatment outside of the Plan's service area, when substance use treatment services are not available within its service

[10] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 03/12/18
[11] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Mental Health Services, 12/14/20
[12] DHCS APL 21-014

area.

1. IEHP will share protected health information ("PHI") with the MHP for SMHS and Substance Use Disorder Treatment for the purposes of medical and behavioral health care coordination pursuant to Cal. Code Regs. tit. 9, Section 1810.370(a)(3), and to the fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA") and 42 Code Federal Regulations Part 2, and other State and federal privacy laws. When necessary, consent to release information will be requested from the Member.

Covered Benefits

A. Inpatient services are available for medical detoxification, when medically necessary (i.e. when Member has a qualifying medical condition for hospital admission), for the treatment of substance abuse at a participating hospital.[13] Authorization for this service is coordinated through IEHP's Utilization Management Department.

B. Outpatient services including evaluation, crisis intervention, and treatment, when medically necessary, are provided through the corresponding County Substance Abuse Agency based on the Member's county of residence. The County Substance Abuse Agency is responsible for approving substance use services, not IEHP.[14]

C. Multidisciplinary Medication Assisted Treatment is available for the treatment of Opioid Use Disorder (OUD) through contracted network Providers. Members may self-refer to services by calling IEHP Member Services. Providers may refer Members through IEHP Provider Services.

D. Members may self-refer to Community Based Organizations (CBOs) for care and assistance on a self-pay basis.

Case Management

A. IEHP BH & CM Department can assist the PCP with the referral process, follow up with Members referred for substance use treatment, and facilitate the Member's transition back into the primary care setting. IEHP BH & CM Department continues to case manage Members before, during, and after referral and/or treatment.

B. PCPs, IPAs and BH Providers are responsible for maintaining communication with substance use providers to coordinate the Member's care.

Releasing Member Information

A. PCPs and BH Providers must maintain procedures to ensure appropriate records processing

[13] Title 9 California Code of Regulations § 1820.205(a)
[14] DHCS APL 22-006 Supersedes 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services"

to prevent breach of confidentiality.[15] Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for information pertaining to the release of medical records.

B. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care when IEHP is the payer of services. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records."

C. Whenever a Release of Information is completed, all Providers shall adhere to confidentiality requirements.[16]

Reporting and Web Forms

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests and review reports.

B. IPAs, PCPs and BH Providers can refer Members to IEHP or the appropriate County Substance Abuse Agency using IEHP's BH web forms on the secure IEHP Provider portal when the Member is in agreement with the referral.

C. IPAs, PCPs and BH Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[15] DHCS- IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.1, Member Rights and Responsibilities
[16] 42 CFR § 431.306

12. COORDINATION OF CARE

K. Behavioral Health

3. Behavioral Health Treatment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP provides and covers all medically necessary Behavioral Health Treatment (BHT) services covered under Medi-Cal for eligible[1] Members under 21 years of age. This applies to any health condition, including children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services are medically necessary.[2]

B. IEHP is responsible for ensuring that all of a Member's needs for medically necessary BHT services are met across environments, including on-site at school or during virtual school sessions.

PURPOSE:

A. To ensure benefits and services are provided in a standardized manner to Members in accordance with State health care regulations.

DEFINITIONS:

A. Behavioral Health Treatment (BHT) – These services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.[3]

B. Applied Behavioral Analysis (ABA) – The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.[4]

PROCEDURES:

BHT Coverage

A. IEHP covers all necessary EPSDT services, including BHT services, regardless of whether

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005 Requirements for coverage of early and periodic screening, diagnostic, and treatment services for Medi-Cal members under the age of 21.
[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-010 Supersedes APL 19-014, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"
[3] DHCS APL 23-010
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions

California's Medicaid State Plan covers such services for adults, when the BHT services have an ameliorative, maintenance purpose.

C. BHT is a benefit for those under age 21 under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.[5,6] See Policy 12D, "Early and Periodic Screening, Diagnostic and Treatment" for more information regarding EPSDT benefit. The Member must have a current authorization before BHT services can be provided. A Member must:[7]

1. Be under 21 years of age;
2. Have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary and covered under Medi-Cal;
3. Be medically stable; and
4. Be without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

D. BHT is provided, observed, and directed under an approved BHT plan developed by BHT Provider(s) who meet the requirements in California's Medicaid State Plan, which includes ABA and other evidence-based methodologies.[8]

E. BHT is provided by a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional who meets the_requirements in California's Medicaid State Plan.

F. IEHP provides medically necessary covered under Medi-Cal supplementary BHT services and addresses gaps in services caused when a Local Education Agency (LEA) discontinues the provision of BHT services.[9] If medically necessary BHT services are otherwise still needed, but the need is not documented in an Individualized Education Plan (IEP) or Individualized Health and Support Plan (IHSP)/ Individualized Family Service Plan (IFSP), then IEHP may coordinate any needed BHT services in a school-linked setting.

G. IEHP ensures members have access to and support medication adherence for the carved-out prescription.

H. IEHP complies with mental health parity requirements when providing BHT services, which requires that the Plan disclose utilization management criteria.

I. IEHP uses nationally recognized clinical criteria and/or IEHP UM Subcommittee Approved Authorization Guidelines, when making decisions related to medical care, including BHT services. IEHP ensures an appropriate independent review of Member's medical needs for

[5] DHCS APL 23-010
[6] DHCS APL 23-005
[7] DHCS APL 23-010
[8] Ibid.
[9] Ibid.

BHT services in accordance with EPSDT requirements and medically accepted standards of care. See Policy 25E1, "Utilization Management Delegation and Monitoring" for more information.

J. IEHP will offer Members continuity of care from an out-of-network provider of BHT services for up to twelve (12) months if required conditions are met.[10] See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

BHT Treatment Plan

A. The BHT treatment plan must identify the medically necessary services covered by Medi-Cal to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions.

B. The approved BHT treatment plan must also meet the following criteria:[11]

1. Include a description of Member information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence based BHT services;
2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation;
4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
5. Include the Member's current level of need (baseline, expected behaviors the Guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan of generalization and report goal as met, not met, modified (include explanation);
6. Utilize evidence based BHT services with demonstrated clinical efficacy tailored to the Member;
7. Clearly identify the service type, number of hours of direct service(s), observation and direction, Guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider responsible for delivering the

[10] DHCS APL 18-008 Supersedes APL 15-019, "Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care"
[11] DHCS APL 23-010

services;

8. Include care coordination involving the Guardian, school, state disability programs and other programs and institutions, as applicable;
9. Consider the Member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision;
10. Deliver BHT services in a home or community-based setting, including clinics; and
11. Include an exit plan/criteria; however, only a determination that services are no longer Medically Necessary under the EPSDT standard can be used to reduce or eliminate services.

C. The BHT provider must review, revise, and/or modify no less than once every six months the BHT treatment plan. If services are no longer Medically Necessary under the EPSDT medical necessity must be modified or discontinued.[12]
D. IEHP permits the Member's Guardian(s) to be involved in the development, revision, and modification of the BHT treatment plan to promote Guardian participation in treatment.[13]

BHT Provider Responsibilities

A. BHT Providers must adhere to the following access standard for BHT:
   1. Appointment for initial assessment must be offered within ten (10) business days of authorization being approved.[14] See Policy 9A, "Access Standards" for more information.
B. BHT Provider must promptly notify IEHP, in writing, if at any time BHT Provider determines that BHT Provider no longer satisfies the requirements of applicable laws and/or regulations.

BHT Services

A. All BHT services provided by the BHT Provider under this policy require prior authorization. See Policy 12K1, "Behavioral Health – Behavioral Health Services" for more information.
B. BHT intervention services provided in schools, in the home, or other community setting must be clinically indicated, medically necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.
C. BHT Providers can submit an amendment for additional treatment hours. This may be needed when school is out of session or there is an increase in maladaptive behaviors, etc. The BHT Provider must include the clinical justification for the increase in hours. The plan will review

[12] DHCS APL 23-010
[13] Ibid.
[14] Title 28, California Code of Regulations (CCR) § 1300.67.2.2

and approve as medically necessary. Submit the request via the Coordination of Care Treatment Plan form found on the Provider Portal.

D. The Plan will not reduce the number of medically necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities.

E. Authorizations for BHT will not extend past the Member's 21st birthday. For Members who are within sixty (60) days of their 21st birthday, the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).

F. The BHT Provider may work collaboratively with other health care professionals involved in the care of a Member (e.g., PCP, Community Entities, Local Education Agencies, Regional Centers, Occupational Therapy, Speech Language Pathologist, Mental Health Provider).[15]

G. Exit criteria may be met when the Member has met the goals and objectives identified in the assessment plan or the treatment goals and objectives are no longer appropriate, and BHT is no longer medically necessary. Other exit criteria may include, but are not limited to the following:

1. Parents have a poor or conflicting relationship or alliance with the BHT Provider, the Member qualifies for a higher or lower level of care, and/or lack of improvement on goals, or failure to meet intervention goals. This may also be the case when other services are deemed more appropriate such as Speech Therapy or Occupational Therapy.
2. Members can also meet exit criteria when their goals are met.

Coordination of Care

A. IEHP is required to establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services including but not limited to Regional Centers,[16] LEAs, and County Mental Health Plans.[17,18]

1. When another entity has overlapping responsibility to provide BHT services to the Member, IEHP is required to:
    a. Assess the medical needs of the Member for BHT services across community settings

[15] DHCS APL 23-010
[16] Memorandum of Understanding (MOU) between IEHP and Inland Regional Center, Services for Developmentally Disabled Members, First Amendment, 01/01/21
[17] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Behavioral Health Services, 12/14/20
[18] MOU between IEHP and Riverside University Health System- Behavioral Health (RUHS-BH), Mental Health Services"

according to the EPSDT standard;

b. Determine what BHT services (if any) are actively being provided by other entities;

c. Coordinate the provision of all services including Durable Medical Equipment (DME) and medication with the other entities to ensure that the Plan and the other entities are not providing duplicative services; and

d. Ensure that all of the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.

2. Medically Necessary BHT must not be considered duplicative when the Plan has overlapping responsibility with another entity for the provision of BHT services unless the service provided by the other entity is the same type of service (e.g., ABA), addresses the same deficits, and is directed to equivalent goals.

B. The Plan must not rely on LEA programs to be the primary Provider of medically necessary BHT services on-site at school or during remote school sessions and assume that BHT services included in a Member's Individualized Education Plan (IEP)/ Individualized Health and Support Plan (IHSP)/ Individualized Family Service Plan (IFSP) are actively being provided by the LEA.

C. If a Member's IEP team concludes that the Plan-approved BHT services are necessary to the Member's education, the IEP team must determine that the Plan-approved BHT services must be included in the Member's IEP. Services in a Member's IEP must not be reduced or discontinued without formal amendment of the IEP.

D. If the Plan-contracted Provider determines that BHT services included in a Member's IEP are no longer medically necessary, the Plan is required not to authorize the use of Medi-Cal funding to provide such services.

E. IEHP may attempt to obtain written agreement from the LEA to timely take over the provision of any Plan-approved BHT services included in the IEP upon a determination that the services are no longer medically necessary.

F. IEHP may coordinate with the LEA to contract directly with a school-based BHT services practitioner enrolled in Medi-Cal to provide any medically necessary BHT services included in a Member's IEP.

12. COORDINATION OF CARE

K. Behavioral Health

3. Behavioral Health Treatment

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

L. Vision Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Vision services, including a comprehensive eye exam, lenses and frames for Medi-Cal Members are provided directly by IEHP per the Medi-Cal Vision benefit.

B. Optometry services for Medi-Cal Members include Diabetic Retinal Examination (DRE), Therapeutic Pharmaceutical Agents (TPA), diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system. Vision Providers are required to obtain prior authorizations for all routine vision benefits.

PROCEDURES:

Initial Health Assessment – Vision Screening

A. The initial health assessment for children and adults must be performed by the Primary Care Provider (PCP) within 60 days of enrollment for Medi-Cal Members under the age of 18 months and within one hundred 120 days of enrollment for Members 18 months and older. A component of the initial health assessment requires vision screening of the eyes to determine the presence of eye disease or potential refractive errors. The PCP must advise the Member of findings and encourage the Member to seek vision services when appropriate. Refer to Policy 10A, "Initial Health Assessment" for more information.

Follow-up Vision Screening

A. The PCP must continue to observe Members for vision conditions and advise Members to seek vision services as applicable. Follow-up screenings for adults should take place during periodic routine physical exams as outlined in Policy 10B, "Adult Preventive Services." For children, periodic vision screenings should be performed in accordance with IEHP Well Child Visit requirements as outlined in Policy 10C1, "Pediatric Preventive Services – Well Child Visits."

Access to Vision Providers

A. PCPs are responsible for directing Members to an IEHP Vision Provider if non-medical vision conditions are noted during the visits or if the Member has Diabetes and is being referred for a Diabetic Retinal Exam (DRE).

B. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.

Vision Providers for Medi-Cal Members

A. A Vision Provider list is included in the IEHP Provider Directory or can be obtained online at www.iehp.org. To receive assistance with referral, a Vision Provider may call IEHP

Provider Call Center (PCC) at (909) 890-2054. Members may also call IEHP Member Services at (800) 440-4347 to obtain assistance.

Vision Benefits for Medi-Cal Members

A. Members are limited to one bilateral comprehensive eye examination with refraction, including dilation when medically indicated, in a 24 month period unless more frequent examinations are determined to be medically necessary.

1. All routine vision benefits require prior authorizations.
2. Providers are strongly encouraged to obtain self-service referrals through **IEHP's Vision Referral Request** online on the Provider Portal at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.
3. Before ordering services, Providers must verify eligibility through IEHP's Online Eligibility Verification System at www.iehp.org. When ordering medically necessary absorptive lenses, medical justification must be provided and prior authorization must be obtained. IEHP designated contract optical lab order forms are available online at www.iehp.org.
4. Eyeglass frames are covered for all Medi-Cal Members. Eyeglass frames provided to Members must be of good quality with the manufacturer's or American distributor's name or identification clearly stamped on the frame. Only frames that Providers supply to the general public may be given to Members. Discontinued or closeout frames are not covered and cannot be dispensed. The Provider must maintain an adequate supply of covered frames to allow sufficient choice by the Member (i.e., male/female and ten (10) choices for children).
5. In the event that services are not covered under the IEHP Plan or are denied by IEHP as not being medically necessary, for example non-covered cosmetic contact lenses or non-Medi-Cal benefit frames, **the Provider must not charge the Member unless the Provider has obtained a written waiver from the Member**. The waiver must be obtained in advance of rendering services and must specify those non-covered services or services IEHP has denied as not being medically necessary and must clearly state that the Member is responsible for payment of those services. Members must sign a Non-Covered Service/Materials Waiver Form for expenses exceeding the covered material benefit. Non Covered Services Waiver Forms are accessible at: https://www.iehp.org/en/providers/provider-resources?target=forms#Vision.

B. Lenses are fabricated at the Prison Industry Authority (PIA) according to the DHCS contract for Medi-Cal Members. The lens specifications and frame are forwarded to the PIA for fabrication and returned to the Vision Provider for dispensing to the Member.[1]

1. Prior to ordering PIA services, Providers must verify eligibility and obtain the Member's county and aid code through IEHP's Online Eligibility Verification System at

[1] Department of health Care Services (DHCS) Medi-Cal Provider Manual. "Vision Care - Lenses"

www.iehp.org. Providers must include the Member's 14-digit Medi-Cal ID number from the Benefit Identification Card (BIC) on the PIA order form.

a. Riverside and San Bernardino County Providers must use California State Prison - Solano when ordering all lens prescriptions:

1) California State Prison - Solano

Prison Industry Authority

Optical Laboratory

2100 Peabody Road

Vacaville, CA 95687

Customer Service: (800) 700-9861; (707) 451-0182 ext 6644

Fax: (707) 454-3214

b. Los Angeles County Providers must use Valley State Prison for Women when ordering all lens prescriptions:

1) Valley State Prison for Women

Prison Industry Authority

Optical Laboratory

23370 Road 22

Chowchilla, CA 93610-4329

Customer Service: (800) 377-8953; (559) 665-5531 ext 7436

Fax: (559) 665-5147

c. **Providers are to obtain order through the PIA Optical Web Site.**

1) Set up your username and password at https://optical.pia.ca.gov/pool/

2) For question call. (800) 541-5555

d. PIA Optical Laboratory Order Books/Forms may be obtained by calling the toll-free phone numbers for the appropriate optical laboratory listed above.

e. Only materials covered by Medi-Cal can be ordered from PIA.

2. If PIA is unable to complete the order, Providers must contact IEHP to obtain approval to use the following IEHP designated contract optical lab when ordering lens materials. IEHP Providers must use the IEHP Lab Order Form (See, "IEHP Lab Order Form" found on the IEHP website[2]) when ordering materials from the IEHP designated contract lab.

[2] https://www.iehp.org/en/providers/provider-resources?target=forms

Express Lens Lab

17150 Newhope St., Suite 305

Fountain Valley, CA 92708-4251

(714) 545-1024 Phone

(714) 556-2026 Fax

Unique Optical

43990 Golf Center Pkwy Ste B2

Indio, CA 92203

(760) 391-9100Phone

(760) 391-9101 Fax

C. Pediatric and Adult Members diagnosed with diabetes are entitled to an annual Diabetic Retinal Examination (DRE). Vision Providers are required to coordinate care with Member's PCP by notifying the PCP in writing of the results of the DRE.

1. Prior to rendering services, Providers are required to obtain a referral through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.
2. For the purpose of benefit availability, annual shall mean once per calendar year but no less than nine (9) months since the last DRE.
3. DRE may be performed on the same day as a comprehensive examination if the Member is eligible for the periodic routine eye examination.
4. Vision Providers are required to coordinate care with the Member's PCP by notifying the Member's PCP in writing of the results of the DRE, utilizing the IEHP PCP Vision Report Form (See, "PCP Vision Report Form"[3] found on the IEHP website).

D. Members are limited to vision aids.[4]

1. A physician or optometrist must prescribe vision aids when medically necessary, after appropriate assessment.
2. Low Vision Aids require a Vision Exception Request (VER) to be submitted see Policy 12.L.1, "Vision Services - Vision Exception Request (VER)."

E. The IEHP Therapeutic Pharmaceutical Agents (TPA) Program allows IEHP credentialed and TPA certified Providers to perform specific services to Members without a referral from the Members' PCPs. In addition to performing TPA services an optometrist with TPG or TLG

[3] Ibid.
[4] Title 22 California Code of Regulations (CCR) §51317

certification can diagnose and treat primary open angle glaucoma in patients over the age of 18 years old. IEHP follows Medi-Cal guidelines for referral requirements.

1. Any IEHP Vision Provider may provide TPA services to Pediatric and Adult Members if the following minimum criteria are met:
   a. Provider is an ophthalmologist that participates in IEHPs vision program.
   b. Provider is credentialed by IEHP.
   c. Optometrists must be TPA, TPL, TPG or TLG certified as verified by the California Board of Optometry.
   d. Provider must be contracted by IEHP to provide those services.
   e. Symptoms and conditions covered under the Program are consistent with Section 3041 of the Business and Professions Code and Section 3051.76 of the Title 5 California Code of Regulations.[5,6]
   f. All Members with confirmed chronic conditions must be referred to their PCP unless Vision Provider has TPG and/or TLG certification to treat glaucoma.
2. Additional equipment that is required in order to provide TPA services includes:
   a. Binocular Indirect Ophthalmoscope.
   b. Condensing Lens.
   c. Automated Threshold Field Analyzer.
   d. Goldman Applanation Tonometer.
3. Prior to rendering services, Providers are required to obtain a referral in accordance to Medi-Cal guidelines through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.
4. TPA services may not be performed on the same day as a comprehensive examination or Diabetic Retinal Examination (DRE).
5. TPA Providers are required to notify the Member's PCP that medical services have been provided within two (2) working days of rendering services. Providers must complete the PCP Vision Report form (See, "PCP Vision Report Form" found on the IEHP website[7]).
6. A legible copy of the PCP Vision Report must be sent to the Member's assigned PCP.
   a. The Member's assigned PCP information can be found on the eligibility page of the secure Provider portal.

[5] California Code Business and Professions Code (Bus. & Prof. Code) §3041
[6] Title 5 California Code of Regulation (CCR) §3051.75
[7] https://www.iehp.org/en/providers/provider-resources?target=forms

7. The PCP Vision Report form must be completed in its entirety and includes:
   a. Patient's presenting symptoms.
   b. Diagnosis description.
   c. ICD code(s).
   d. Procedure(s) and/or treatment performed.
   e. If applicable, the name and type (form) of medication prescribed.
   f. Provider's signature.
   g. Date of the next follow-up appointment, if indicated, in "Next Visit" otherwise specify N/A (not applicable).
8. Claims for TPA, TPG and TLG services can be submitted through **IEHP's Claims Entry** form on the IEHP Provider portal at www.iehp.org on a CMS 1500 Health Insurance Claim Form and must include all information necessary to process the claim for payment.
   a. Under the TPA Program, IEHP performs retrospective review on all non-authorized services. Claims are also reviewed for unbundling and inappropriate use of codes. Claims with unbundled services, or where two (2) or more lower level codes are billed on the same date of service without substantiated documentation, result in lower reimbursement.
   b. Members cannot be billed for any covered service, including services that have been denied because of improper billing.
9. Prescription Medications
   a. All prescription medications prescribed to IEHP Members must comply to IEHP's formulary. Providers wishing to prescribe non-formulary medication must first submit a Prescription Drug Prior Authorization (RxPA) Request form for approval.
   b. TPA Providers must use Prescription Drug RxPA Request forms for the following:
      1) Medication or dosage not included in the IEHP formulary.
      2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions.
      3) Branded medications when generic is available.
      4) Prescriptions for formulary medications that do not comply with Dose/Duration/or Quantity guidelines as outlined in the IEHP formulary at www.iehp.org under Pharmaceutical Services page.
      5) The RxPA form is available on the IEHP web portal at https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-rx-pa-universal-form/.

c. A Member currently taking medication that has been deleted from IEHP's formulary may continue to receive the medication, if prescribed.

d. All completed Prescription Drug RxPA Requests will be reviewed within 24 hours for approval or denial.

F. IEHP PCPs continue to provide all necessary health care services to Members even if the Member has been referred to a Vision Provider for services.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 1998	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

L. Vision Services

1. Vision Exception Request

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. All non-routine benefits require prior authorization utilizing the Vision Exception Request (VER) form. Vision Provider must submit a completed VER form to obtain prior authorization.

B. All VERs must contain information that supports the medical necessity of a non-routine benefit.

C. VERs are required for replacement of eye appliances that are lost, stolen, or destroyed in circumstances beyond the Member's control and that exceed the Member's benefit.

PROCEDURE:

A. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.

B. Vision Exception Requests (VER) can be submitted for vision aids, including but not limited to:[1]

1. Second eye examination within 24 months covered when signs or symptoms indicate a need and documentation substantiates the need for a second exam.
2. Medi-Cal Members are entitled to Single Vision Lenses in -lieu of Bifocals – Two (2) pairs of single vision glasses, one (1) for near vision and one (1) for distance vision are covered when one (1) of the following exists:
    a. Sufficient evidence that a Member cannot wear bifocal lenses.
    b. Member is currently using two (2) pairs of glasses.
    c. New presbyopes must have failed with bifocals first.
3. Medi-Cal Members are entitled to replacement of lost, broken or damaged appliances may be covered when accompanied by a written statement signed by the Member that includes:
    a. The circumstances of the loss or destruction;
    b. The steps taken to recover the lost item; and
    c. Certification that the loss, breakage, or damage was beyond the Member's control.

[1] Title 22 California Code of Regulation (CCR) § 51317

4. Medi-Cal Members are entitled to Contact Lenses Only when medically necessary. Request for contact lenses must include sufficient clinical information and an explanation that justifies the request including, but not limited to:
   a. Valid diagnosis.
   b. Type of lens.
   c. Any other medical justification necessary to support the need for contact lenses.
5. Medi-Cal Members are entitled to Low Vision Aids covered when such aids can markedly enhance visual function with sufficient clinical information or explanation that justifies the request.
6. Other Covered Items- VER Required:
   a. Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes and prosthetic scleral shells are covered when medically indicated. A brief justification must be provided when prescribing or dispensing the covered item.

C. When a VER is determined necessary, Vision Providers have two (2) working days from the determination to submit the VER and all supporting documentation.

D. All requests are reviewed and acted on based on the type of request submitted:
   1. Routine (Non-urgent) Pre-Service: Decision within five (5) working days of receipt of all information reasonably necessary to render a decision.
   2. Expedited Authorization (Pre-Service): Decision within 72 hours of receipt of the request.
   3. Post-Service / Retrospective Review: Decision within 30 calendar days from receipt or request.

E. IEHP reviews the VER, verifies eligibility, benefit availability and previous utilization and either approves, modifies, or denies the request. All decisions are communicated to the Provider via a "Non-PHI fax" form.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

L. Vision Services
2. Vision Provider Referrals

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP Vision Providers are required to provide evaluation and management (E&M) services within their scope of practice to Members with known or suspected diseases and conditions of the eye and visual system. [1]

B. Vision Providers caring for Medi-Cal Members that require further diagnosis and treatment beyond the scope of practice of the Vision Provider must refer the Member to the appropriate health care Provider, as follows:

1. Medi-Cal Members with a known or suspected pathology of the eye, or any of its appendages, may be referred directly by the Vision Provider to an Ophthalmologist by submitting a referral request to the Member's assigned IPA or IEHP, as applicable.
2. Medi-Cal Members with a known or suspected medical condition that may be systemic or neurological in nature shall be referred to the Member's Primary Care Provider (PCP) for appropriate coordination of care.
3. Vision Providers may also call the IEHP Provider Call Center (PCC) at (909) 890-2054 for assistance regarding information on the Member's IPA or IEHP contact assignment for referral submission.

PROCEDURES:

Identification/Diagnosis

A. Vision Providers are responsible for identifying Members with any pathological ocular health condition that requires treatment. Identification of these Members can occur during the routine physical examination of the eyes and visual system and through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.

B. Members presenting with complex or mixed symptoms or conditions that make the diagnosis uncertain or that may indicate a systemic etiology must be referred to the Member's PCP for assessment, diagnosis, and/or treatment. If the Vision Provider determines that an ophthalmologist consultation and/or treatment is warranted, the Vision Provider can submit a referral directly to the Member's assigned IPA or IEHP, as applicable.

D. Vision Providers are responsible for treating Members with ocular conditions within their scope of practice. Treatment includes the provision of appropriate optical devices and the use

[1] California Business and Professions Code (Bus. & Prof. Code) § 3041

of topical ophthalmic pharmaceutical agents, as indicated. Typical ocular health conditions within the scope of practice of Vision Providers, depending on their level of certification and legal authority include, but are not limited to:

1. Refractive and motility disorders of the human eyes
2. Ocular infections
3. Ocular inflammations and allergies
4. Ocular trauma and superficial foreign bodies
5. Primary open angle glaucoma
6. Nothing in this section shall be construed to grant privileges to the optometric Vision Provider beyond the scope set forth in the statutes and regulations of the Optometry Code.[2,3]

E. Scope and limitations to IEHP Medi-Cal Vision Benefit: IEHP Medi-Cal Members are entitled to a routine comprehensive eye examination every 24 months and, if medically indicated. Eyeglass frames and lenses are covered for Members every 24 months. When indicated, medical evaluation and management services of certain eye conditions are available to the Member through an IEHP Vision Provider. Treatment of any eye condition shall be limited to acute conditions. The long-term treatment of chronic medical conditions of the eyes shall be managed and coordinated by the Member's PCP.

Referral to PCP

A. Vision Providers shall complete a PCP Vision Report (See, "PCP Vision Report Form" found on the IEHP website[4]) to report examination findings and/or treatment provided during an active ocular condition that require further evaluation or follow up by Member's PCP.

1. To ensure Member's continuity of care, Vision Providers are required to notify the Member's PCP if medical services have been provided within two (2) days of rendering service.

Referral to Ophthalmologist

A. Vision Providers, with the assistance of the IPA Utilization Management (UM) staff, are responsible for referring Medi-Cal Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

B. PCPs are also responsible for referring Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

[2] CA Bus. & Prof. Code § 3041
[3] California Code of Regulations (CCR) § 1569
[4] https://www.iehp.org/en/providers/provider-resources?target=forms

C. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the ophthalmologist specialty Provider through phone calls, transfer of medical records, and other specialty referrals as indicated.

D. Vision Providers shall prepare a written request for referral on the standardized Ophthalmologist Referral Request Form (See, "Ophthalmologist Referral Form" found on the IEHP website[5]) and submit the completed referral to the Member's assigned the IPA within 24 hours of the encounter with the Member. Direct Vision Providers can submit a Referral Request Form via the Secure Provider Portal in lieu of a written request. Vision Providers may indicate desired ophthalmological sub-specialty by selecting: General Ophthalmology, Retinal Specialist or Pediatric Ophthalmology.

E. IPA UM staff are responsible for faxing back a copy of the completed referral form including the specific ophthalmologist selected back to the Vision Provider.

F. Vision Providers may also call the IEHP PCC at (909) 890-2054 and/or Medical Director for advice or consultation regarding Member ocular health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

Medications

A. IEHP covers medically necessary medications for the treatment of ocular disease as listed in the IEHP formulary.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

[5] https://www.iehp.org/en/providers/provider-resources?target=forms

12. COORDINATION OF CARE

M. Developmental Disabilities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs have established procedures for the identification, referral and case management of Members identified with or suspected of having developmental disabilities to ensure their access to medically necessary screening, preventive, diagnostic, and treatment services.[1]

PROCEDURES:

Identification and Referral of Developmental Disability Cases

A. Members at risk for developmental disabilities may be identified through:
    1. Primary Care Provider (PCP) or Specialist referrals; or
    2. An IPA or IEHP Care Manager through:
        a. Screening of incoming California Children's Services (CCS) referrals;
        b. Review of hospital admission and discharge information;
        c. Member calls;
        d. IEHP Inland Regional Center (Regional Center) liaison; and
        e. IEHP Specialty Kids Intervention Team.

B. To qualify for Regional Center services, the Member's developmental disability must originate before their 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.[2]

Provider and IPA Responsibilities

A. PCPs are required to provide all necessary primary care for individuals with developmental disabilities including:
    1. Well-child exams;
    2. Immunizations;
    3. Developmental status screening, illness or injury care;
    4. Diagnostic testing (laboratory, x-rays) as needed;

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, 1/1/24, Exhibit A, Attachment III, Provision 4.3.16, Services for Persons with Developmental Disabilities (DD)
[2] California Welfare and Institutions Code (Welf. & Inst. Code), § 4512

5. Health education as needed; and
6. Other primary care services as needed.

B. PCPs are required to arrange for and/or request from the Member's IPA all medically necessary specialty, diagnostic or therapeutic services, including out-of-network referrals, if a service is not available in-network.[3] If services are out-of-network, the IPA must send the referral to IEHP's UM Department for authorization. See Policy 14D, "Pre-Service Referral Authorization Process," for more information. These services include but are not limited to:

1. Referral to Specialist or sub-specialist Providers (e.g., Neurologists, Physiatrists);
2. Referrals for occupational or physical therapy;
3. Orders for medically necessary Durable Medical Equipment (DME) or home health services; and
4. Referrals for specialized diagnostic testing (e.g., computed tomography (CT) or Magnetic resonance imaging (MRI)).

C. IPA Care Managers are responsible for referring to the Regional Center, Members in need of non-medical, home and community-based services including but not limited to:

1. Training in skills for daily living;
   a. Acquisition of skills and behavior and/or;
   b. Family support; and/or
   c. Day habilitation.
2. For all ages:
   a. Respite care;
   b. Out-of-home placement;
   c. Supportive living; and/or
   d. Residential care or assisted living.

D. PCPs, with assistance from IPA Care Managers, are responsible for assessing the behavioral health status of Members and referring those Medi-Cal Members with behavioral health disorders outside their scope of practice to the County Mental Health Plan.[4] Refer to Policy 12K1, "Behavioral Health - Behavioral Health Services," for more information.

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers

[4] DHCS All Plan Letter (APL) 17-018 Supersedes APL 13-021, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services"

E. PCPs or Obstetrics (OB) Providers who identify Members as being at risk of parenting a child with genetic disorders must provide counseling and referrals, as appropriate. Please see Policy 10D1, "Obstetric Services – Guidelines for Obstetrical Services" for more information.

F. PCPs and Specialists are responsible for referring to the Regional Center Members under the age of 18 who may be potentially eligible for Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver Program.[5] If the Member is placed in the program, the Member will receive waiver services while enrolled with IEHP.

G. IPAs and PCPs are responsible for assisting the family with referrals to the Regional Center's intake coordinator. The family must contact the Regional Center to initiate the intake process. For referral of children age 0 to 36 months, see Policy 12C, "Early Start Services and Referrals." Referrals include the following information:

1. The reason for referral;
2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
4. Individual Educational Plan (IEP), as appropriate.

H. Regional Center staff review the referral and notify the IPA, PCP and the Member, and Member's family or guardian when appropriate, regarding the Member's eligibility and recommendations for services.

IEHP and IPA Responsibilities

A. IEHP maintains a Memorandum of Understanding (MOU) with the Inland Regional Center to coordinate services for the Member with the Regional Center staff to ensure the non-duplication of services and to create the individual developmental services plan required for all Members with developmental disabilities, which includes the identification of the Member's medical needs and the provision of medically necessary services such as medical care, non-specialty mental health services, and behavioral health treatment (BHT).[6]

B. IEHP and its IPAs are responsible for tracking Members with developmental disabilities, including all services they receive.[7]

C. IEHP and its IPA Care Management (CM) teams coordinate services with Regional Center to achieve optimum outcomes for Members with developmental disabilities. IEHP's Specialty Kids Intervention Team and Regional Center liaison assist Members with understanding and

[5] DHCS-IEHP Primary Operations Contract, 1/1/24, Exhibit A, Attachment III, Provision 4.3.16, Services for Persons with Developmental Disabilities (DD)
[6] Ibid.
[7] Ibid.

accessing services, as well as act as point of contact for questions, access and care concerns, and problem resolution.[8,9]

D. IPA CM is responsible for performing the following activities:

1. Assisting the PCP with the referral to the Regional Center including arranging for transfer of medical information, approving medically necessary referrals and contact with the Regional Center;
2. Consulting with the PCP in the development of the individual care plan (ICP) for the Member;[10] and
3. Coordinating necessary follow-up between the PCP, Specialty Providers, IEHP, and the Regional Center to assure an organized care plan and delivery for the Member.

E. IPA CM remains responsible for providing care coordination and care management services for Members regardless of whether they receive services from Regional Center.

F. IEHP is responsible for providing assistance to the IPA CM or the Regional Center in complex or difficult cases or when differences arise regarding necessary services or care plans.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 1998	
Revision Effective Date:	January 1, 2024	

[8] Memorandum of Understanding (MOU) between IEHP and Inland Regional Center, Services for Developmentally Disabled Members, First Amendment, 01/01/21
[9] DHCS-IEHP Primary Operations Contract, 1/1/24, Exhibit A, Attachment III, Provision 4.3.16, Services for Persons with Developmental Disabilities
[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services

12. COORDINATION OF CARE

N. Multipurpose Senior Services Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs ensure access to and provision of Multipurpose Senior Services Program (MSSP) for Members who meet the following eligibility criteria:[1]

1. Medi-Cal Members who, but for the provision of such services, would require the Nursing Facility level of care;
2. Age 65 or older;
3. Able to be served within MSSP's cost limitations; and
4. Appropriate for care management services.

PURPOSE:

A. To promote identification and coordination of care for Members requiring services through the MSSP.

B. To ensure and support care coordination between IEHP and County agencies regarding Members' access to appropriate MSSP resources and focus on providing services in the least restrictive setting.

PROCEDURES:

MSSP Services

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. The MSSP program was approved under the federal Medicaid Home and Community-Based Services (HCBS), 1915(c) Waiver to provide HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement. MSSP services include:[2]

1. Case Management;
2. Personal Care and Chore Services;
3. Respite Care (in-home and out-of-home);
4. Environmental Accessibility Adaptations;

[1] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Multipurpose Senior Services Program (MSSP)"
[2] Ibid.

5. Housing Assistance/Minor Home Repair, etc.;
6. Non-Medical Transportation;
7. Personal Emergency Response System /Communication Device;
8. Adult Day Care;
9. Protective Supervision;
10. Meal Services – Congregate/Home Delivered;
11. Social Reassurance/Therapeutic Counseling;
12. Money Management; and
13. Communication Services (such as translation/interpretation).

Identification of MSSP Cases

A. The Member's IPA performs care management activities and is responsible for assisting the PCP with identification and referral of Members to MSSP.

B. IEHP and its IPAs engage in outreach and case finding efforts to identify Members with potential MSSP program needs.

Referral of MSSP Cases

A. Referral and/or data sources may include but are not limited to the following:
   1. IEHP and/or IPA;
   2. Member and/or caregiver;
   3. PCP and/or Specialist;
   4. Member of Interdisciplinary Care Team (ICT);
   5. Medi-Cal and/or Health Plan utilization data;
   6. Health Risk Assessments;
   7. In-Home Supportive Services Provider; or
   8. Community agency representative.

B. Referrals for MSSP can be received through the following mechanisms:
   1. Member and/or caregiver may self-refer by calling MSSP, IEHP or their IPA.
   2. Providers, IPAs, care managers, and community representatives can submit the Care Management (CM) Referral form requesting IEHP assistance to refer the Member to MSSP. The CM Referral form can be found on the IEHP website[3], or on the secure IEHP Provider web portal.

C. IEHP's Behavioral Health and Care Management (BH & CM) Team submits the referral to

[3] https://www.iehp.org/en/providers/provider-resources?target=forms

the appropriate MSSP county agency on behalf of the IPA and communicates the referral outcome to IPA staff.

D. The MSSP county agency is responsible for all assessments and reassessments associated with authorizations of MSSP services.

IEHP, IPA and Provider Responsibilities

A. IPA Care Manager assists the PCP with completing their MSSP referral through IEHP and follow up.

B. County MSSP agencies establish and maintain a wait list of individuals referred to MSSP. After the Member is placed on the MSSP wait list, the appropriate county MSSP agency provides IEHP with a list of Members on the wait list. IEHP's BH & CM Team shares the Member's status with the Member's IPA.

C. The IPA continues to provide care management services to Members placed on a county MSSP waiting list, including but not limited to coordinating available services and providing follow-up for Members.

D. Members not accepted into MSSP continue to receive medical care and care management services through their IPA and PCP.

E. Members authorized for MSSP services continue to receive medical services from IEHP.

F. IEHP or the IPA Care Manager coordinates and works collaboratively with MSSP county case managers on care coordination activities surrounding the MSSP Member including, but not limited to:

1. Coordination of benefits between IEHP and MSSP county case manager to avoid duplication of services;[4] and

2. Coordination of care management activities particularly at the point of discharge from the MSSP.

Interdisciplinary Care Team Case Conference

A. Members shall have access to an ICT case conference upon request or when there is a change in the care plan or significant change in the Member's health status. Members and/or their caregivers may request an ICT case conference at any time by calling their IPA.

B. MSSP County Case Managers and PCPs may call an ICT case conference at any time to discuss the Member's needs by calling Provider Call Center at (909) 890-2054. IEHP and its IPAs ensure the ability to facilitate and support a case conference.

C. The IPA facilitates and supports an ICT to coordinate the delivery of services and benefits as needed for each Member.

D. The IPA Care Manager notifies the MSSP County Case Manager regarding the Member's

[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.21 HCBS Waiver Programs

scheduled ICT meeting and invites them to participate in the case conference.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

O. Open Access (Foster Care) Program

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Foster Care Members that have been designated to participate in the Open Access program by either San Bernardino County Children and Family Services (CFS) or Riverside County Department of Public Social Services (DPSS).

POLICY:

A. IEHP provides needed health care services for youth in foster care who are enrolled in Open Access.[1,2]

PROCEDURES:

A. Only the Riverside County Department of Public Social Services (DPSS) or San Bernardino County Children and Family Services (CFS) can authorize a foster child to participate in IEHP's Open Access program.

B. Foster children who are not specifically authorized to participate in IEHP's Open Access program receive service as general IEHP members.

C. Open Access Members are assigned to IEHP-Direct; therefore, IEHP retains responsibility for utilization management (UM) activities.

D. Open Access Members are automatically assigned to a participating Open Access Primary Care Provider (PCP); however, they may access care from any of the PCPs that participate in the Open Access Network. The Open Access PCP is reimbursed on a Fee-For-Service basis, per visit, for services.

E. If the Open Access Member is new to the PCP office, the PCP can access all known medical history from the secure IEHP Provider portal from the Medical History Profile with the following data (if available to IEHP):

   1. Encounter/claims data;
   2. Pharmacy data; and
   3. Immunization data.

F. IEHP has an Open Access Team responsible for collaborating with county agencies to meet the care coordination and care management needs of Open Access members.

G. Referrals for services or procedures are sent to IEHP's UM department. See Policy 14D, "Pre-Service Referral Authorization Process" for further details regarding the referral process.

H. For anticipated invasive procedures or anticipated treatment with psychotropic medications the physician should:

   1. Educate the Foster Parent at the time of the visit.

[1] Memorandum of Understanding (MOU) between IEHP and Riverside County Department of Public Social Services (DPSS), Open Access, 05/14/18
[2] MOU between IEHP and San Bernardino County Children and Family Services (CFS), Open Access, 02/01/10

I. For referral process information on Dental Services, Vision Services and Health Education please see the following Provider Manual policies:

1. Policy 12J, "Dental Services"
2. Policy 12L, "Vision Services"
3. Policy 15A, "Health Education"

J. Whenever a Provider has knowledge of or observes a child whom the Provider knows or reasonably suspects has been the victim of child abuse or neglect, the Provider must make an initial report by telephone to the appropriate agency immediately or as soon as is practicably possible. See Policy 10N, "Mandatory Child Abuse and Neglect Reporting," for more information on reporting known or suspected cases of child abuse or neglect.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	August 1, 2007	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

P. Home and Community-Based Alternatives Waiver Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs have established processes to identify and refer Members who may benefit from Home and Community-Based Services (HCBS) waiver programs, including but not limited to Home and Community-Based Alternatives (HCBA) waiver program (formerly known as the Nursing Facility/Acute Hospital Waiver) to the appropriate agency.[1]

PROCEDURES:

HCBA Waiver Program

A. The HCBA Waiver Program is for Members who are at risk or require care for 90 consecutive days or greater in an inpatient skilled nursing facility (SNF). The goals of the waiver program are to:[2,3]

   1. Facilitate a safe and timely transition of Medi-Cal eligible Members from a medical facility to their home and community utilizing HCBA Waiver services; and
   2. Offer eligible Members who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing the HCBA Waiver services to develop a home program that will safely meet their medical care needs.

B. The HCBA Waiver Program provides in-home care to Members as an alternative to institutionalization.[4] Services are available to Members with physical disabilities or Members who meet the acute hospital, adult or pediatric sub-acute, nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility, or Level A (intermediate) nursing facility (NF) Level of Care.[5]

C. This program is intended to support Members with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. Services may include, but are not limited to:[6]

   1. Private Duty Nursing, including shared nursing;
   2. Home Health Aide Services;
   3. Case Management and Transitional Case Management;

[1] Department of Health Care Services (DHCS)- IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.21, HCBS Waiver Programs
[2] Section 1915(c) Home and Community-Based Services (HCBS) Waiver, 01/01/20
[3] DHCS Medi-Cal Provider Manual, HCBS.
[4] Ibid.
[5] Section 1915(c) HCBS Waiver, 01/01/20
[6] Ibid.

4. Family and caregiver training;
5. Environmental accessibility adaptations;
6. Personal emergency response systems, including installation and training;
7. Medical equipment operating expenses;
8. Waiver personal care services;
9. Community transition;
10. Habilitation services;
11. Respite care (home and facility); and
12. Developmentally disabled/continuous nursing care (non-ventilator and ventilator dependent services).

D. A Member may be enrolled in only one (1) HCBS Waiver program at a time.[7]

Member Identification and Referral

A. Primary Care Providers (PCPs) or Specialists are responsible for the identification of Members potentially eligible for the HCBA Waiver Program.

B. The Provider identifies Members with potential HCBA Waiver Program needs. Criteria for eligibility include:[8]

1. Must have full scope Medi-Cal;
2. Physically disabled (no age limit);
3. Must meet the acute hospital, adult or pediatric sub-acute, nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility, Level A (intermediate) nursing facility Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization; and
4. Must meet other criteria and requirements listed in the waiver.

C. IEHP and its IPAs are responsible for assisting Providers with the identification and referral of Members to the HCBA Waiver Program.

D. The Provider, with the assistance from IEHP or their IPA, submits applicable medical records and a request for HCBA Waiver services to the Institute on Aging:[9]

1. By fax: (909) 284-8002
2. By efax: eFaxCLS-IE-HCBA@ioaging.org

[7] DHCS Medi-Cal Provider Manual, HCBS
[8] Ibid.
[9] https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

3. On the website: www.ioaging.org

Case Management

A. IEHP and its IPAs track all Members enrolled in HCBS waiver programs and continue to provide care coordination for all medically necessary non-waiver services, as needed.[10]

B. When requested by the treating Provider, the Member's IPA Care Manager assists in coordinating available services and providing follow-up for Members requiring referral to the HCBA Waiver Program through the following methods:

1. Maintenance of continuity of care through coordination with case managers from the Institute on Aging;
2. Coordination with the PCP to ensure that medically necessary health care services are provided until transfer to the HCBA Waiver Program services is completed; and
3. Maintenance of a continuous and unimpeded flow of medical information between Providers.

C. IEHP is available to assist the IPA Care Managers with care management activities through the following methods:

1. Identification of appropriate community referral sources available to Members; and
2. Assistance with eligibility questions, coordination of care assistance and other questions.

D. The Provider continues to provide medical care for the Member until transfer to the HCBA Waiver Program has been completed. Members not accepted into the HCBA Waiver Program continue to receive medical care through their Provider and continue to receive services from the IPA Care Manager.

E. Members are not disenrolled from IEHP when placed on HCBA waiver.[11] The Provider will continue to be involved, especially the PCP who will work directly with the home health agencies and/or other community providers.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[10] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 4.3.21, HCBS Waiver Programs
[11] DHCS Medi-Cal Provider Manual, HCBS

12. COORDINATION OF CARE

Q. Medi-Cal Waiver Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, IPAs, Primary Care Providers (PCPs), and Specialists are responsible for the identification of candidates potentially eligible for the Medi-Cal Waiver Program (formerly known as the AIDS Medi-Cal Waiver Program).

B. IEHP and its IPAs perform care management activities and are responsible for assisting Providers with identification and referral of Members to the Medi-Cal Waiver Program.

PROCEDURES:

Medi-Cal Waiver Program

A. The Medi-Cal Waiver Program provides in-home and community-based services to Members with AIDS or related diseases as an alternative to institutionalized care. Services include:[1]

1. Care management;
2. In-home skilled nursing care;
3. Attendant and homemaker care;
4. Psychosocial counseling;
5. Equipment and minor physical adaptations to the home;
6. Medi-Cal supplements for infants and children in foster care;
7. Non-emergency medical transportation;
8. Nutritional counseling and supplements;
9. Home-delivered meals and administrative expenses.

B. Providers, IPAs and IEHP identify Members with potential Medi-Cal Waiver Program needs. Criteria for eligibility include:[2]

1. Diagnosis of AIDS or symptomatic HIV disease; and
2. Medi-Cal eligibility.

Referral Process

A. The Provider, IPA or IEHP obtains a written consent for referral from eligible Members. The referring party is responsible for completion of the Desert AIDS Project Enrollment Form

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 02-001, "Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program"
[2] Ibid.

(See Attachment, "Desert AIDS Project Enrollment Form" found on the IEHP website[3]) and submission of a request for services to local AIDS Projects at the following location:

Desert AIDS Project

(760) 323-2118 (Palm Springs)

B. The AIDS Project sends information materials including agreement and consent forms to the Member. Once eligibility is established and the request for services is approved, the AIDS Project case managers assist with coordinating available services.

IPA and Provider Responsibilities

A. The Member's IPA Care Manager assists the treating Provider in coordinating available services and providing follow-up for Members requiring referral through the following methods:

1. Assistance with eligibility questions and completion of the referral;
2. Provision of telephonic monitoring of potential high-risk Members;
3. Maintenance of continuity of care through coordination with AIDS Project case managers;
4. Coordination with the PCP to ensure that all medically necessary health services are provided to the Member except for those services covered under the Medi-Cal Waiver Program; [4,5] and
5. Maintenance of a continuous and unimpeded flow of medical information between Providers. The PCP obtains medical records of health services provided.

B. IEHP is available for assistance with identification of appropriate community referral sources available to Members and other questions or difficulties regarding the Medi-Cal Waiver Program, as well as care coordination.

C. Members not accepted into the Medi-Cal Waiver Program continue to receive medical care and case management through the Provider and their IPA Care Managers.

[3] https://www.iehp.org/en/providers/provider-resources?target=forms
[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.21 HCBS Waiver Programs
[5] DHCS APL 02-001

12. COORDINATION OF CARE

Q. Medi-Cal Waiver Program

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	