KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Comprehensive Case Management and Coordination of Care				POLICY #: 19.13-P	
DEPARTMENT: Population Health Management					
Effective Date: 01-2006	Review/Revised Date: 12/16/2022	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Population Health Management

POLICY:
Kern Health Systems (KHS) provides basic comprehensive medical case management to Medi-Cal members ("members"). KHS maintains procedures for monitoring the coordination of care provided to members, including medically necessary services delivered within and outside the KHS provider network.

Comprehensive case management and coordination of care will be provided in accordance with the contractual requirements outlined in KHS' Medi-Cal contract with the DHCS.

DEFINITIONS:

Comprehensive Medical Case Management Services	Services provided by a Primary Care Physician to promote the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules, and the continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

PROCEDURES:

1.0 GENERAL CASE MANAGEMENT AND COORDINATION OF CARE

KHS members receive comprehensive case management and coordination of care services from their assigned Primary Care Physician (PCP), which includes procedures used to monitor the provision of Basic Case Management**.**

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

The PCP is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

Members completed IHA and IHEBA tool are to be contained in the Members' medical record and available during subsequent preventive health visits.

KHS PCP's will make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the PCP's unsuccessful efforts to contact a Member and schedule an IHA shall be considered compliant with the requirement.

Members will be informed during the New Member entry process to complete the IHA and the Staying Healthy Assessment (SHA) within the designated timeframes with their assigned PCP.

KHS will monitor the IHA/SHA completion through monthly report reconciliation with claims data and if not completed, outreach will be performed to promote gap closure.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with KHS, and shall include:

- Initial Health Assessment (IHA) performed within 120 calendar days of enrollment to identify the need for preventive health visits for all Members under 21 years of age at times specified by the most recent AAP periodicity schedule (Bright Futures guidelines) and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. KHS providers will provide, as part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age-specific health education behavioral assessment IHEBA as necessary. Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, KHS providers will ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.
- Individual Health Education Behavioral Assessment (IHEBA) performed within 120 calendar days for all members; and that all existing Members who have not completed an IHEBA, must complete it during the next non-acute, preventative care office visit according to the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment IHEBA. The IHEBA tool must be;
    a) administered and reviewed by the primary care Provider during an office visit,
    b) reviewed at least annually by the primary care provider Primary Care Provider with Members who present for a scheduled visit, and
    c) Re-administered by the primary care provider Primary Care Provider at the appropriate age-intervals.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and;
- Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

IHAs for Adults (Age 21 and older)

- KHS covers and ensures that an IHA for adult Members is performed by the PCP within 120 calendar days of enrollment. The performance of the initial complete history and physical exam for adults includes, but is not limited to:
- blood pressure,
- height and weight,
- total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
- clinical breast examination for women over 40,
- mammogram for women age 50 and over,

- Pap smear (or arrangements made for performance) on all women determined to be sexually active,
- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
- screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
- IHEBA.

Immunizations

KHS PCP's are responsible for assuring that all adults are fully immunized. KHS will cover and ensure the member's PCP adheres to the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, PCP will provide age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

KHS PCP's will document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate unsuccessful efforts to provide the immunization shall be considered compliant in meeting this requirement.

Member-specific immunization information will be periodically reported to an immunization registry established in the KHS Service Area as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment IHA and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws.

Dental Services

Dental services are not covered under KHS DHCS contract. KHS covers and ensures KHS providers conduct dental screenings/oral health assessments for all Members as a part of the initial health assessment IHA.

For Members under 21 years of age, PCP's responsible for ensuring that a dental screening/oral health assessment is performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) or earlier if conditions warrant with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

Members will be referred to appropriate Medi-Cal dental providers for further evaluation and treatment as deemed necessary. KHS PCP's provide Medically Necessary Federally Required Adult

Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered benefits under KHS.

Women, Infant, and Children Program

WIC services are not covered under KHS contract with the DHCS. However, KHS has procedures to identify and refer eligible Members for WIC services. As part of the referral process, KHS providers will furnish the WIC program with a current hemoglobin or hematocrit laboratory value and document the laboratory values and the referral in the Member's medical record.

As part of its initial health assessment IHA of Members, or, as part of the initial evaluation of newly pregnant women, the member's PCP will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c). KHS will execute a MOU with the WIC program as stipulated by the DHCS for services provided to Members through the WIC program.

KHS will administer and perform ongoing monitoring of the provision of Complex Case Management to Members to include procedures to identify members who may benefit from complex case management services.

Complex Case Management Services are provided by the primary care provider, in collaboration with KHS, and shall include, at a minimum:

- Basic Case Management Services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team to include the following mental health services performed within the scope of practice for licensed mental health care providers:
  - Individual/group/family mental health evaluation and treatment (psychotherapy);
  - Psychological testing when clinically indicated to evaluate a mental health condition;
  - Outpatient services for the purpose of monitoring drug therapy;
  - Psychiatric consultation for medication management. Outpatient laboratory supplies and supplements; including those prescribed by mental health providers in the KHS network and PCPs, including physician administered drugs 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. KHS may require that Non Specialty Mental Health Services (NSMHS) for adults are provided through the KHS provider network, subject to a medical necessity determination. KHS will ensure that its network is adequate to provide the full range of covered NSMHS to its members.
  - Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies.
  - Screening and Brief Intervention (SBI) for substance use conditions.

- Intense coordination of resources to accomplish the goal that the member regains optimal health or improved functionality
- With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern e.g. homelessness.
- If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services, KHS shall continue the provision of non-duplicative, Medically Necessary Outpatient Mental Health Services.
- Any time that a Member requires a Medically Necessary Outpatient Mental Health Service that is not available within the provider network, KHS shall ensure access to out-of-network and Telehealth mental health providers as necessary to meet access requirements.
- KHS shall ensure the provision of SBI services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- Members will receive timely mental health services without delay regardless of the delivery system where they seek care and be able to maintain treatment relationships with trusted providers without interruption.
- KHS will provide or arrange for the provision of the following non-specialty mental health services (NSMHS):
- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies and supplements.
- KHS will provide or arrange for the provision of the NSMHS listed above for the following populations:

  Members who are 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 by the current Diagnostic and Statistical Manual of Mental Disorders;5
    - Members who are under the age of services1, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis
    - Members of any age with potential mental health disorders not yet diagnosed.

In addition to the above requirements KHS will provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder. KHS will cover 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. Details regarding

NSMHS psychiatric and psychological services, including psychotherapy coverage, Current Procedural Terminology (CPT) codes that are covered, and information regarding eligible provider types can be found in the Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services.

KHS will furnish all services it defines as appropriate and medically necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening, regardless of whether services are covered in the Medicaid State Plan.

For individuals under 21 years of age, a service will be "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.). The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services.

Members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

County MHPs are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder, in accordance with SMHS access criteria described in Behavioral Health Information Notice (BHIN) No: 21-073.14

KHS will also cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.8 7 This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services includes facility and professional services and facility charges claimed by emergency departments.

KHS will provide covered substance use disorder (SUD) services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, KHS must provide or arrange for the provision of:

- Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and
- Emergency services necessary to stabilize the member.9
- MHPs are required to provide or arrange for the provision of medically necessary SMHS for members in their counties who meet access criteria for SMHS as described in BHIN 21-073.

Care Management and Care Coordination

KHS will continue to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an member receiving SMHS. KHS will coordinate care with the MHP. KHS will take responsibility for the appropriate management of a member's mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the KHS provider network.
Consistent with W&I Code section 14184.402KHS will cover clinically appropriate and covered NSMHS even when:

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 SUD; or,
4) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the KHS provider network. KHS will ensure that a mental health screening of members is conducted by network Primary Care Providers (PCP). Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The member may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the KHS network.

KHS will ensure direct access to an initial mental health assessment by a licensed mental health provider within the KHS provider network. KHS will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health network provider. KHS will notify beneficiaries members of this policy, and member informing materials must clearly state that referral and prior authorization are not required for a beneficiary member to seek an initial mental health assessment from a network mental health provider.

KHS will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 19-002 or subsequent guidance.

If further services are needed that require authorization, KHS will follow guidance developed for mental health parity.

KHS will disclose the utilization management or utilization review policies and procedures that they utilize to DHCS, and any Subcontractors they use to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorization, under the benefits included in the KHS contract.

Authorization determinations will be based on the medical necessity of the requested medically necessary health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and P&Ps may also take into consideration the following:

a. Service type.
b. Appropriate service usage.
c. Cost and effectiveness of service and service alternatives.
d. Contraindications to service and service alternatives.
e. Potential fraud, waste, and abuse.
f. Patient and medical safety.
g. Providers' adherence to quality and access standards.
h. Other clinically relevant factors.

The P&P's will be consistently applied to medical/surgical, mental health and SUD benefits. KHS will notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all network providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Utilization management criteria for medical necessity determinations for mental health and SUD benefits will be available to members, eligible beneficiaries, and network providers upon request. KHS will also provide members the reason for any denial or partial denial for reimbursement of payment of services or any other adverse benefit determination for mental health or SUD. All services will be provided in a culturally and linguistically appropriate manner

Clinically appropriate and covered NSMHS delivered by KHS providers are covered by KHS during the assessment process prior to the determination of a diagnosis or a determination that the member meets criteria for NSMHS. KHS must not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS. Likewise, MHPs will not deny or disallow reimbursement for SMHS services provided during the assessment process if the assessment determines that the member does not meet criteria for SMHS or meets the criteria for NSMHS.

NSMHS Not Included in an Individual Treatment Plan Clinically appropriate and covered NSMHS delivered by KHS providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan. Including voluntary inpatient detoxification as a benefit available to KHS members through the Medi-Cal fee-for-service program,

Clinically appropriate and covered NSMHS delivered by KHS providers are covered by KHS whether or not the member has a co-occurring SUD. KHS will not deny or disallow reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate and covered SUD services delivered by KHS providers (e.g., alcohol and drug

screening, assessment, brief interventions, and referral to treatment; MAT) are covered by KHS whether or not the member has a co-occurring mental health condition.

Likewise, clinically appropriate and covered SMHS are covered by MHPs whether or not the member has a co-occurring SUD. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the member has a co-occurring mental health condition.

Concurrent NSMHS and SMHS Members may concurrently receive NSMHS from a KHS provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. KHS will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Likewise, MHPs will not deny or disallow reimbursement for SMHS provided to a member on the basis of the member also meeting NSMHS criteria and/or receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between KHS and MHPs to ensure member choice. KHS must coordinate with MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

Members with established therapeutic relationships with a KHS provider may continue receiving NSMHS from a KHS provider (billed to KHS), even if the member simultaneously receives SMHS from a MHP provider (billed to the MHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).

Members with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if the member simultaneously receives NSMHS from a KHS provider (billed to the KHS), as long as the services are coordinated between these delivery systems and are non-duplicative. KHS members may simultaneously receive SMHS from a MHP provider (billed to the MHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).

Treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. This precludes any restrictions to a beneficiary's member's access to an initial mental health assessment. Therefore, KHS shall not require prior authorization for an initial mental health assessment. While many PCPs provide initial

mental behavioral health assessments within their scope of practice, but not all do. If a beneficiary's member's PCP cannot perform the mental health assessment because it is outside of their scope of practice, they may refer the beneficiary to the appropriate provider., they must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in the KHS provider network or the county mental health plan's network, is made in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and APL 22-005.

Complex case management services for SPDs must include the concepts of Person-Centered Planning

Complex Case Management Enrollment Criteria may include but are not limited to:

- Are residing in an acute hospital setting
- Have been hospitalized within the last 90 days, or have had 3 or more hospitalizations within the past year
- Have had 3 or more ER 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)
- Have ESRD, AIDS, and/or a recent organ transplant
- Have cancer, currently being treated
- Have been prescribed 15 or more prescriptions in the past 90 days
- Major trauma within the previous 3 months
- Four or more chronic conditions
- Readmission within 30 days with the same /similar diagnosis/condition
- Have been on oxygen within the past 90 days,
- Are Pregnant
- Have been prescribed antipsychotic medication with the past 90 days
- Have a self-report of a deteriorating condition
- Chronic conditions including Asthma, COPD, Diabetes, CHF, CAD, and Cirrhosis/Chronic Liver Disease
- SPD members identified as "high risk" through initial risk stratification, HRA, or one of the data or referral sources listed above
- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnosis or a social circumstance of concern e.g. homelessness.

Criteria for transition out of Complex Case Management may include but are not limited to:

- Loss of eligibility for the program (member no longer enrolled through client).
- Achievement of documented targeted outcomes.
- Chief Medical Officer or designee Decision
- Member opts out of case management program.
- The member is unable to be located.
- Determination by the case manager that he/she is no longer able to provide appropriate case management services (i.e., due to member non-compliance, non-adherence to the plan of care). This last reason for case closure involves discussion and decision making with the Chief Medical Officer or designee.

Person-Centered Planning for SPD Beneficiaries[1]

- Upon the enrollment of an SPD beneficiary, KHS shall provide the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
- Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.
- KHS shall allow the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
- KHS shall monitor that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

For the purpose of this policy, Person-centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered Planning is an integral part of Basic and Complex Case Management and discharge planning. KHS will arrange the following Person-Centered Planning for services to SPD's upon enrollment.

- KHS shall provide, or arrange the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD member's continuing health care needs through careful review of the individualized care plans and Health Risk Assessment (HRA). KHS will foster community resources and facilitate routine and specialty appointments, transportation, or other ancillary services necessary to provide health care needs that are identified. Referrals coordination between KHS Care and Case Management will be maintained to allow for prompt and medically necessary services to be received.
- Person-Centered Planning shall include identifying each SPD member's preferences and choices regarding treatments and services, and abilities. Members can request Continuity of Care with either a PCP or specialist. KHS will coordinate the member's requests with the provider to promote ongoing receipt of necessary services without interruption for up to one year. At that time, transition of care will be reviewed to promote continuity of services with contracted providers within KHS network.
- KHS shall allow or arrange the participation of the SPD member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services. Care management of the entire family unit, not solely the individual, will be conducted at the request of the member. Members will be encouraged to discuss treatment options with their providers and become an active participant in their healthcare. KHS Member Services Representative may be contacted to inquire as to their membership status as well as any pending services that were previously requested. KHS shall arrange that SPD members receive all necessary information regarding treatment and services so that they may make an informed choice. Information is made available detailing specific services, contracted providers as well as covered benefits in various formats, i.e. newsletters, members mailings or bulletins, provider directory and member handbooks to promote the health care of each individual member. Members are informed of approved services via Approval Letter or Notice of Action (NOA) Letters detailing any modifications or denials for services with alternative treatment options.

Discharge Planning and Care Coordination[2]

KHS shall monitor the provision of discharge planning when a SPD Member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall review the documentation submitted to determine if the necessary care, services, and supports in the community are available for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by SPD Member or a SPD Member representative as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, type of placement preferred by the SPD Member/ Member representative and hospital/institution, type of placement agreed to by the SPD Member/Member representative, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD Member/Member representative, and pre-discharge counseling recommended.

D. Summary of the nature and outcome of SPD Member/Member representative involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

It is the PCP's responsibility to track referrals and follow-up care. To assist in this effort, KHS provides the PCP with a quarterly list of open authorizations. The PCP should investigate all open authorizations and follow up with the member, as necessary. PCP follow-up and documentation is monitored by the Quality Improvement Department through facility site review.

Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21

KHS will provide case management services as necessary to ensure the provision of medically necessary services for Medi-Cal eligible members under the age of 21 with approved PDN services. KHS will provide case management services as outlined throughout this policy, including the arrangement of PDN services, regardless of financially responsible for the PDN service.

"Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in supporting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. Pg. 3, para. 1.

Case Management Services will be set forth in the Kern Health Systems' Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including: upon a plan member's request, Case Management

Services to arrange for all approved Private Duty Nursing services utilized by the plan member, even when the Kern Health System is not financially responsible for paying for the approved Private Duty Nursing services. SA Pg. 6, para. 21.a.i. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved by the California Children's Services Program (CCS).

Kern Health Systems shall use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when Kern Health System is not financially responsible for paying for the approved Private Duty Nursing services. SA Pg. 6, para. 21.a.ii.

Kern Health System's obligations to plan enrolled EPSDT eligible Medi-Cal beneficiaries 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:

A. providing the member information about the number of Private Duty Nursing hours that they are approved to receive.
B. contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf;
C. identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider;
D. working with Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

SA Pgs. 6-7, para. 21.a.iii.

When Kern Health System has approved a plan enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, Kern Health System has primary responsibility to provide Case Management for approved Private Duty Nursing services. SA Pg. 11, para. 24.a.

When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary has primary responsibility to provide Case Management for approved Private Duty Nursing services. SA Pg. 11, para. 24.b.

Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be a Managed Care Plan, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management. SA Pg. 12, para. 25.

Definitions:

"EPSDT services" means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)

"Private Duty Nursing" means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

"Home Health Agency" as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.

"Individual Nurse Provider" or "INP" means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

If PDN services are approved by KHS for an eligible member under the age of 21, KHS is primarily responsible for providing case management to arrange for all approved PDN service hours. If another entity, such as CCS, has authorized PDN services and is primarily responsible for providing case management for those PDN services, KHS will still provide case management as necessary, including, at the member's request, arranging for all approved PDN services. KHS will use one or more Medi-Cal enrolled HHA's or individual nurse providers, or any combination thereof to meet the member's approved PDN service needs.

PDN Case Management Responsibilities

When an eligible member under the age of 21 is approved for PDN services and requests that KHS provide case management services for those PDN services, KHS must, but is not limited to:

- Providing the member with information about the number of PDN hours the member is to receive;
- Contacting enrolled HHA's and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible HHA's and individual nurse providers and assisting them with navigating the process of enrolling to become a Medic-Cal provider; and
- Working with enrolled HHA's and enrolled HHA's and enrolled individual nurse providers to jointly provide PDN services to the member.

Members may choose not to use all approved PDN service hours, and KHS will respect the member's choice and document instances when a member chooses not to use approved PDN services. When arranging for the member to receive authorized PDN services, KHS will document

all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

Notice to Members

KHS will issue a notice to every member under the age of 21 for whom it has currently authorized PDN services. The notice will:

- Explain that KHS has primary responsibility for case management of PDN services.
- Give a description of the case management services available to the member in connection with PDN services, as set forth above.
- Explain how to access those services.
- Include a statement that the member may:
    - Utilize KHS existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
    - File a Medi-Cal fair hearing as provided by law; or
    - Email DHCS directly at EPSDT@dhcs.ca.gov
- Include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California at (888) 852-9241.

Monitoring & Oversight

KHS is responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by KHS to all subcontractors and network providers.

Service delivery disputes between KHS and MHPs must be addressed consistent with DHCS guidance regarding the dispute resolution process between KHS and MHPs.

2.0 CASE MANAGEMENT AND COORDINATION OF CARE FOR SPECIFIC SERVICES

Case management and coordination of care for specific services are provided as outlined below:

A. Targeted Case Management Services: See *KHS Policy and Procedure #3.13-P: EPSDT Supplemental Services and Targeted Case Management (TCM)*
B. Disease Management Program Services: See *KHS Policy and Procedure #2.35-P: Disease Management*
C. Out-of-Plan Services: See *KHS Policy and Procedure #3.55-I Coordination of Care for Out-of-Network, Seldom Used, and/or Unusual Specialty Services*
D. Specialty Mental Health Services: See *KHS Policy and Procedure #3.14-P Mental Health Services*
E. Alcohol and Substance Abuse Treatment Services: See *KHS Policy and Procedure #3.10-P Alcohol and Drug Treatment Services*

F. Services for Children with Special Health Care Needs: *See KHS Policy and Procedure #3.56-P Services for Children with Special Health Care Needs*
G. California Children's Services: See *KHS Policy and Procedure #3.16-P California Children's Services*.
H. Services for Persons with Developmental Disabilities: See *KHS Policy and Procedure #3.03-P Kern Regional Center Services (Developmental Disabilities and Early Intervention)*
I. Local Education Agency Services: See *KHS Policy and Procedure #3.57-P Local Education Agency Services*
J. School Linked CHDP Services: No local school districts or school sites in Kern County provide CHDP services. For speech services that are not medically necessary and are not covered by Medi-Cal, KHS provides parents of member children with the phone number of *Search and Serve*, a community referral resource for these non-covered services.
K. Foster Care: Foster care and Adoption Assistance Program (AAP) children receive prompt medical care, and KHS promptly authorizes medically necessary services to such children's providers in the county of placement. KHS billing processes are sensitive to the need to make timely payments to providers who treat children placed out-of-county who are KHS members.
L. HIV/AIDS Home and Community Based Services Waiver Program: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
M. Dental Services: See *KHS Policy and Procedure #3.06-P Dental Services*
N. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB): See *KHS Policy and Procedure #3.46-P Tuberculosis Treatment*
O. Women, Infants, and Children (WIC) Supplemental Nutrition Program: See *KHS Policy and Procedure #3.08-P WIC*
P. Major Organ Transplants: See *KHS Policy and Procedure #3.02-P Major Organ Transplant*
Q. Waiver Programs: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
R. Vision Care: See *KHS Policy and Procedure #3.07-P Vision Care*
S. Nursing Facility and Long Term Care: See *KHS Policy and Procedure #3.42-P Nursing Facility and Long Term Care*
T. Hospice: See *KHS Policy and Procedure #3.43-P Hospice*
U. *APL 22-005 and 22-006*

1 2021 BHINs are searchable at: MHSUDS-BH-Information-Notices.aspx.
2 For more information regarding CalAIM, please visit the CalAIM webpage at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.
3 APL's are searchable at https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. The Medi-Cal provider manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services can be accessed at: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx. See W&I Code section 14184.402. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
4 This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl.
5 Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, KHSs must provide or arrange for NSMHS for recipients with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.
6 See Section 1396d(r)(5) of Title 42 of the U.S.C.*(*requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) and that are necessary to correct or ameliorate a condition, including a behavioral

health condition, discovered by a screening service, whether or not such services are covered under the State Plan), U.S.C. is searchable at: https://uscode.house.gov/.
SHMS Waiver Information can be found at:
http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx.
8 State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
See Section 1396d(r)(5) of Title 42 of the USC (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) and that are necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan) The USC is searchable at:
https://uscode.house.gov/.
CMS' federal EPSDT guidance can be found at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.
13 W&I Code section 14059.5.
14 2021 BHINs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx.
15 The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf.
16 W&I Code Section 14184.402
17 More information regarding KHSs' responsibility for alcohol and substance use disorder screening, referral, and services can be accessed in APL 21-014.
18 This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/
19 Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, KHSs must provide or arrange for NSMHS for recipients with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS.
20 See Section 1396d(r)(5) of Title 42 of the USC (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 USC Section 1396d(a)) and that are necessary to correct or ameliorate a condition, including a behavioral health condition discovered by a screening service, whether or not such services are covered under the State Plan. The USC is searchable at: https://uscode.house.gov/. 21 Medi-Cal Provider Manuals are searchable at: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx. The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf
22 See W&I Code section 14184.402(f).
23 This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/
24 Network Certification Requirement, APL 21-006:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006.pdf
25 The CCR is searchable at:
https://govt.westlaw.com/calregs/index?__lrTS=20210423013246097&transitionType=Default&contextData=%28sc.Default%29
26 Including voluntary inpatient detoxification as a benefit available to KHS members through the Medi-Cal fee-for-service program, as described in APL 18-001.
11 See 42 CFR Subpart K – Parity in Mental Health and Substance Use Disorder Benefits: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-K.
29 Cultural and Linguistic Requirements can be found in Title 22 CCR Section 53876.

REFERENCE:

Revision 2022-11: Per CHSO, renumber policy from UM, 3.61, to PHM Department. Revision **2022-06:** Policy created to comply with DHCS APL 22-005 and 22-006. Policy received approval per 22-005 on 7/25/2022 and approval per 22-006 on 7/29/2022. The policy received DMHC approval on 10/26/2022, Filing No. 20223769.
[1] 2010 DHS Contract Exhibit A, Attachment 11 (1D)
[2] 2010 DHS Contract Exhibit A, Attachment 11(2D)