KERN HEALTH SYSTEMS					
POLICY AND PROCEDURES					
SUBJECT: Scope of Services				POLICY #: 21.05-P	
DEPARTMENT: Behavioral Health					
Effective Date: 1/1/2024	Review/Revised Date: 06/26/2024	DMHC		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 Compliance and Fraud Prevention Officer

_____ Date _____
Director of Behavioral Health

_____ Date _____
Senior Director of Provider Network

_____ Date _____

POLICY

Kern Health Systems (KHS) shall cover non-specialty mental health services when they are provided or ordered by a licensed health care professional acting within the scope of her or his license. The behavioral health scope of services policy and procedures will conform to requirements outlined in the following statutory, regulatory, and contractual sources:

A. 2024 Department of Health Care Services (DHCS) Contract, Exhibit A, Attachment III, 22-20201, Section 5.5.2, pages 393-398 of 611
B. DHCS All Plan Letter (APL) 22-005 (March 30, 2022): No Wrong Door for Mental Health Services Policy
C. DHCS All Plan Letter 22-006 (April 8, 2022): Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
D. California Health and Safety Code §1374.72; §1367.01

KHS will provide covered services:

A. Individual/group Mental Health evaluation and treatment (psychotherapy).
B. Psychological testing when clinically indicated to evaluate a Mental Health condition.
C. Outpatient services for the purposes of monitoring drug therapy.
D. Psychiatric consultation for medication management.
E. Outpatient laboratory, supplies, and supplements.
F. Drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services
G. Family therapy (composed of two (2) or more family members) for adult Members with a Mental Health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
    1. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.
H. Dyadic Therapy: "Dyadic care is a form of treatment that serves parents or caregivers and children together, targeting family well-being as a mechanism to support healthy child development and mental health.' (DHCS APL effective January 1, 2023)

KHS shall not impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by KHS, in accordance with the parity in Mental Health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K.

KHS, through a network of licensed Mental Health care Providers, shall provide Behavioral Health Services to Medi Cal Members with Mild to Moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group Mental Health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a Mental Health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

KHS must enter into a Memorandum of Understanding (MOU) with the Mental Health Plan (MHP) Kern Behavioral Health and Recovery Services (Kern BHRS) in the county where KHS operates, which for KHS is Kern County. KHS is responsible for updating, amending, or replacing existing Memorandum of Understandings (MOUs) with Kern BHRS to delineate KHS and Kern BHRS responsibilities when covering mental health services. The existing MOUs between KHS and Kern BHRS are required based on Specialty Mental Health Services (SMHS) regulations and existing KHS contracts.
The MOU will include the following elements:

A. Basic Requirements.
B. Covered Services and Populations.
C. Oversight Responsibilities of the KHS and Kern BHRS.
D. Screening, Assessment, and Referral.
E. Care Coordination.
F. Information Exchange.
G. Reporting and Quality Improvement Requirements.
H. Dispute Resolution.
I. After-Hours Policies and Procedures; and,
J. Member and Provider Education.

The MOU is the primary vehicle for ensuring member access to necessary and appropriate mental health services. The MOU addresses policies and procedures for management of the member's care for both KHS and Kern BHRSs, including but not limited to:

A. Screening, assessment, and referral,
B. Medical necessity determination, care coordination, and exchange of medical information.

The MOU must include a process for resolving disputes between Kern BHRS and KHS that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved. If KHS and Kern BHRS have a dispute that they are unable to resolve regarding the obligations of KHS or Kern BHRS under their respective contracts with DHCS, state laws and/or the KHS - Kern BHRS MOU, the parties are required to submit the dispute to the state for resolution. DHCS encourages both KHS and Kern BHRS to attempt to resolve all disputes collegially, effectively, and at the local level before submitting the dispute to the state for resolution. The local resolution policy should be exhausted within the below prescribed timeframes before filing the dispute with the state.

MOU elements will promote local flexibility and acknowledge the unique relationships and resources that exist at the county level.

PURPOSE

To provide guidelines for the provision and/or coordination of mental health services.

DEFINITIONS

Serious Emotional Disturbance (SED)	A person who is under the age of 18, who have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within Diagnostic and Statistical Manual (DSM)-5, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Severe Mental Illness (SMI):	A mental, behavioral, or emotional disorder resulting in serious

	functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.
Specialty Mental Health Services (SMHS)	Criteria for Adult Beneficiaries to Access the SMHS Delivery System: A. Beneficiaries 21 years of age or older, beneficiaries have significant impairment (distress, disability, or dysfunction in areas of life functioning, or a reasonable probability of significant deterioration in important areas of life functioning). B. The condition is due to either a diagnosed Mental health (MH) disorder or a suspected MH disorder not yet diagnosed. Criteria for Beneficiaries under Age 21 to Access the SMHS Delivery System: A. Beneficiaries under age 21, with condition placing them at high risk for a MH due to trauma, involvement in the child welfare system/juvenile justice system or experiencing homelessness. B. Beneficiaries has significant impairment, a reasonable probability of significant deterioration, a reasonable probability of not progressing developmentally, or a need for SMHS that are not included within the MH benefits that a Managed Care Plan (MCP) is required to provide. C. The condition is due to either a diagnosed MH disorder or a suspected MH disorder not yet diagnosed.
Non-Specialty Mental Health Services (NSMHS)	Criteria for Beneficiaries to Access Non-Specialty Mental Health Services MCPs are required to provide or arrange for the provision of NSMHS for the following populations: A. Beneficiaries 21 years of age and over 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. B. Beneficiaries under age 21, to the extent eligible for services through the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as described above, regardless of level of distress or impairment or the presence of a diagnosis. C. Beneficiaries of any age with potential mental health disorders not yet diagnosed.

PROCEDURE

A. ACCESS

1. Primary Care Physician (PCP) and Behavioral Health Services

a. For Substance and Alcohol Misuse, a KHS Network PCP shall:
   i. Administer the DHCS-approved screening tool for identifying substance and alcohol misuse in accordance with DHCS All Plan Letter (APL) 21-014: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT).
   ii. Provide behavioral counseling intervention on identified issue(s); and,
   iii. Refer members to KHS for linkage to Kern BHRS. KHS will outreach to member and complete the warm hand off to the substance use disorder (SUD) Access Line for initial brief American Society of Addiction Medicine (ASAM) Screening and linkage for additional assessment and counseling when indicated.

b. For Mental Health, a KHS Network PCP shall:
   i. Administer screening tools for identifying members requiring mental health services.
   ii. Based on PCP capacity for the full scope of Behavioral Health (BH) services, PCP may provide Mental Health services within the scope of their practice (refer to covered services); and
   iii. Refer the Member for further Mental Health services through KHS to complete the DHCS approved Screening Tool and linkage to KHS BH Provider Network for NSMHS and /or Kern BHRS Mental Health Provider Network for SMHS.

2. Accessing KHS Behavioral Health Services

a. A Member may access Behavioral Health Services through the KHS Member Services Phone Line.

b. A Member may be referred to the KHS Member Services Phone Line from the following:
   i. Kern BHRS ACCESS Line.
   ii. Self-referral.
   iii. Authorized Representative or caregiver.
   iv. PCP.
   v. Specialty Care Provider.
   vi. Behavioral Health Specialist.
   vii. Long-Term Support Services (LTSS) Provider.
   viii. Community-based agency.
   ix. Care Manager or Discharge Planner; and
   x. Other Providers of a Member's health care team.

c. KHS Member Services Phone Line
   i. Call Center requirements shall include:
      1) Complying with telephone access standards in accordance with KHS Policies:

2) Utilizing linguistic interpreter services as necessary to ensure effective communication.
3) Verifying the caller's Medi-Cal eligibility and Health Network assignment.
   a) If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Kern County Department of Human Services or provide enrollment information and suggest a community resource for treatment of their described symptoms.
4) Determining if the caller is seeking help for a Mental Health concern.
5) Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, including when a caller who potentially presents as a danger to self or others, call center staff shall immediately transfer the caller to the KHS BH Care Management Team without delay to prevent further deterioration of the caller's condition, and complete safety screening.
6) Call center staff must link Emergent calls to the KHS Behavioral Health Care Management Team (Clinician) immediately, but in no case more than two (2) hours after determining the call is emergent.
7) Call center staff must transfer Urgent calls for services to the KHS Behavioral Health Care Management Team (Clinician) immediately, but in no case more than within twenty-four (24) hours after making the determination that the call is urgent.
8) Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to the KHS Behavioral Health Care Management Team (Clinician) and:
9) If the Caller is determined to be a Medi-Cal beneficiary assigned to KHS with a Mental Health need, the call center staff shall transfer call to BH team to complete the telephone clinical screening tool approved by DHCS to verify appropriate level of services and transfer members meeting the threshold criteria for transition/referral to the Kern BHRS Care Coordination Unit. KHS Behavioral Health Care Management Team (Clinicians) will participate in clinical review for members who request services within the KHS BH network who also meet criteria for care within the Kern BHRS network in order to ensure members receive appropriate services in either system consistent with the No Wrong Door APL.

ii. As a result of the brief telephone clinical screening using the DHCS approved Screening Tool:
   1) If it is determined the Member meets Mild to Moderate need for Behavioral Health Services, (scoring 5 or below on the DHCS approved Screening Tool) the BH staff will provide the Member with referrals to appropriate Behavioral Health Services. The BH staff will ensure the Member is linked to Providers that are within the KHS Behavioral Health Network, are currently accepting KHS Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to KHS Timely Access standards.

2) If determined the Member does not meet Mild to Moderate need for Behavioral Health Services and rather does meet for services provided through Kern BHRS based on the threshold score of 6 or higher on the DHCS approved Screening tool, the BH staff will link the member to the Kern BHRS Care Coordination Unit where the Member will initiate appropriate services consistent with APL 22-005 No Wrong Door for Mental Health Services (MHS).
    a) Member can also initiate services by self-referring to KHS contracted provider. When the KHS behavioral health provider determines that the member needs services provided within Kern BHRS network (Specialty Mental Health Services), the provider is to complete the Care Transition Tool approved by DHCS and submit it to KHS for coordination with Kern BHRS Care Coordination Unit (CCU). The Kern BHRS CCU will initiate the appropriate behavioral health services and the KHS Behavioral Health Department will facilitate any additional services indicated.
    b) Members who are in a course of behavioral health treatment within the KHS network will be referred to the Kern BHRS CCU when the behavioral health provider and/or Kern Behavioral Health Care Manger (licensed clinician) determines that Specialty Mental Health Services are needed.
        I. If during treatment provided by a KHS behavioral health provider or during clinical review with an Kern Behavioral Health Care Manager, it is determined that member meets criteria for Specialty Mental Health Services through the Mental Health Plan (Kern BHRS), the BH Provider and/or Kern BH Care Manager will coordinate with member and current provider to complete the DHCS approved Care Transition Tool, provide it to the Kern BHRS CCU to initiate appropriate services within the Kern BHRS network. The KHS BH Care Manager will ensure successful linkage to Kern BHRS for services consistent with the closed loop referral requirements and best practice. If clinically appropriate the member may also continue to receive behavioral health services within the KHS BH network simultaneously with the services provided within the Kern BHRS network as long as such services are not duplicative pursuant to the No Wrong Door policy.
3) If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to Kern BHRS for Drug Medi- Cal services.

iii. KHS shall ensure the following steps are completed during the Member call:
1) Member's eligibility status and Health Network assignment shall be verified each time the Member contacts the KHS Member Services Phone Line.
2) A safety screening and an age-appropriate Screening Tool approved by DHCS will be completed and depending on the outcome/results of the screening, linking the member to the

Kern BHRS CCU for members scoring 6 or above. If applicable, staff will provide appropriate resources/provider referrals,
3) Warm transfer to the KHS BH Care Management Team (clinicians) for further clinical assessment when indicated.

iv. Toll-free telephone number that Providers, Members, or individuals acting on behalf of Members can call to obtain referrals for all KHS Covered Outpatient Mental Health Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:
1) Have authority to approve Covered Services.
2) Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or
3) In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

B. CARE COORDINATION

Kern Health Systems (KHS) is committed to ensuring all KHS members receive coordinated care and timely care across all mental health delivery systems in order to improve their health outcomes. In order to help achieve the goal of providing members with the right care, in the right place, at the right time, KHS will use the DHCS approved Screening and Transition of Care Tools for youth and adults[1],[2],[3] and offer timely access to screening for all members. See KHS Policy Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services.

1. Care Coordination will be provided by KHS for Medi-Cal and Medi-Medi Members with providers, facilities, and agencies to ensure all members receive appropriate and timely access to the services they need. For Medi Cal Members KHS coordinates care in compliance with Cal Aim initiatives including Enhanced Care Management (ECM) and Community Supports (CS)

2. KHS shall coordinate Mental Health care for Members enrolled in the Enhanced Care Management (ECM)and Community Supports (CS) in accordance with KHS polices for ECM and CS.
   a. KHS shall ensure compliance with all applicable State and federal requirements related to ECM and all CS requirements determined by DHCS.
   b. KHS shall ensure Members are receiving appropriate and coordinated services.

3. KHS shall ensure care coordination with Kern BHRS is addressed in interagency Kern/Kern BHRS Collaboration Meetings to ensure:
   a. Provision of all Medically Necessary Covered Services; and
   b. Identification and referral of eligible Members to LTSS based on Member's Plan of Care.

c. When KHS is determined to be responsible for covered Behavioral Health Services, KHS shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the Kern BHRS.
d. Transition of care is provided for Members transitioning to or from KHS or Kern BHRS Mental Health services in compliance with APL 22-005 (No Wrong Door for MHS) requirements. Kern BHRS clinical consultation, including consultation on medications, shall be provided to KHS PCPs who are treating Members with mental illness.
e. KHS will use the DHCS approved Screening and Transition of Care Tools for youth and adults[1,2,3] and offer timely access to screening for all members. See KHS Policy Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services and KHS Policy Care Coordination and Care Management.

4. Coordination of care for Inpatient Mental Health treatment:
   a. KHS will set up notification process with inpatient psychiatric facilities to send daily census within twenty-four (24) hours of admission and discharge from an inpatient Mental Health treatment to arrange for appropriate follow-up services.
   b. To facilitate transition of care for Members transiting to or from Kern BHRS Mental Health services, KHS PCPs and the outpatient Behavioral Health Providers treating Members with serious mental illness shall receive clinical consultation, including consultation on medication from Kern BHRS.
   c. KHS and contracted Health Network PCPs and the outpatient Behavioral Health Provider shall review and update the care plan of the Member as clinically indicated.

5. Services provided Simultaneously by KHS and Kern BHRS (APL 22-005 No Wrong Door for MHS)
   a. Kern BHRS and KHS will coordinate provision of prescribing psychiatrists and psychiatric NPs who are serving KHS members; and
   b. Ensure non-duplicated specialty Mental Health services provided through Kern BHRS, including psychiatric medication management, can be provided simultaneously with Mental Health services provided by KHS network providers when clinically appropriate.

6. Psychiatric Emergency Services
   a. KHS provides access to the afterhours Nurse Advice Line to assist with members with psychiatric emergencies. The Nurse Advice Line is available 24/7/365 to members.
   b. Members in need of urgent and emergency psychiatric care during non-business hours, will be triaged for urgent and emergent needs, including person-to-person telephone transfers to the Mental Health Plan crisis hotline. A toll-free telephone hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available 24 hours a day.
   c. KHS Behavioral Health (BH) department will receive the referrals from the Nurse's Advice Line for any members that require follow up. BH staff will add member to

monitoring caseload and screen for potential longer-term monitoring and management. BH staff will ensure that member is reconnected when stable and safe for linkage to BH services as soon as possible.

7. Information Exchange
   a. KHS shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and Behavioral Health care coordination pursuant to Title 9, California Code of Regulations (CCR), section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.
   b. Medi-Cal Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Kern BHRS Specialty Mental Health Provide); and
   c. Medi-Cal Members are receiving services from Kern BHRS and/or Drug Medi-Cal program.

C. EPSDT REQUIREMENTS

Pursuant to the requirements for coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, KHS will ensure our members have access to information on EPSDT and that our network providers receive standardized training on EPSDT utilizing the newly developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.

For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

And "[such other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US ['Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)).

In accordance with California Welfare and Institutions Code (W&I Code) sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "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. For children under the age 21, KHS will provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01

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.

KHS provide or arrange for the provision of the NSMHS listed above for the following populations:

1. 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.

2. Members who are under the age of 21, 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; 6 and

3. Members of any age with potential mental health disorders not yet diagnosed.

However, for children under the age 21, KHS is required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by Kern BHRS.

D. PROVISION OF SERVICES DURING DISPUTE PROCESS

1. As outlined in APL-21-013, guidance is defined for KHS on how to submit a service delivery dispute to the Department of Health Care Services (DHCS) when the dispute cannot be resolved at the local level with a Mental Health Plan (KBRS). Guidance to KBRSs is provided in Behavioral Health Information Notice (BHIN) No: 21-034. 9

2. Any decision rendered by DHCS regarding a dispute between KHS and KBRS concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

3. The provision of medically necessary services must not be delayed during the pendency of a dispute between Kern BHRS and KHS and sets forth rules for determining financial responsibility for services provided to a member during that period.

4. In addition, KHS is contractually responsible for the provision of care management and care coordination for all medically necessary services a member needs, including those services that are the subject of a dispute between KHS and Kern BHRS. KHS is responsible for

working with Kern BHRS in order to ensure that there is no duplication of SMHS, for which KHS also provides case management.

E. ROUTINE DISPUTE RESOLUTION PROCESS

1. Regardless of MOU status, KHS and Kern BHRS must complete the plan level dispute resolution process within 15 business days of identifying the dispute. Within three business days after a failure to resolve the dispute during that timeframe, either Kern BHRS or KHS must submit a written "Request for Resolution" (see content requirements below) to DHCS. If KHS submits the Request for Resolution, it must be signed by the KHS's Chief Executive Officer (CEO) or his/her designee. The information submitted must contain the following:
   a. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party member by either KHS or KBRS and the expected rate of payment for each type of service.
   b. A history of the attempts to resolve the issue(s) with KBRS.
   c. Justification for KHS's desired remedy; and
   d. Any additional documentation that KHS deems relevant to resolve the disputed issue(s), if applicable.

2. The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov.

3. Within three business days of receipt of a Request for Resolution from KHS, DHCS will forward a copy of the Request for Resolution to the Director of the affiliated Kern BHRS via secure email ("Notification").

4. Kern BHRS will have three business days from the receipt of Notification to submit a response to KHS's Request for Resolution and to provide any relevant documents to support Kern BHRS's position.

5. If Kern BHRS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS.

6. Conversely, if Kern BHRS submits a Request for Resolution to DHCS, DHCS will forward a copy of the Request for Resolution to KHS, within three business days of receipt. KHS will have three business days to respond and provide relevant documents.

7. If Kern BHRS requests a rate of payment in its Request for Resolution, and Kern BHRS prevails, the requested rate shall be deemed correct, unless the KHS disputes the rate of payment in its response. If KHS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by Kern BHRS.

8. Conversely, if KHS requests a rate of payment in its Request for Resolution, and KHS prevails, the requested rate shall be deemed correct, unless Kern BHRS disputes the rate of payment in its response. If Kern BHRS fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS.

9. At its discretion, DHCS may allow both KHS and Kern BHRS representatives of KHS and KBRS the opportunity to present oral arguments.

10. The Managed Care Quality and Monitoring Division and the Medi-Cal Behavioral Health Division will make a joint recommendation to the DHCS' Director, or the Director's designee, based on their review of the submitted documentation; the applicable statutory, regulatory, and contractual obligations of KHS and Kern BHRS; and any oral arguments presented.

11. Within 20 business days from the third business day after the Notification date, DHCS will communicate the final decision will be communicated via secure email to KHS's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and Kern BHRS's Director (or the Director's designee, if the designee submitted the Request for Resolution). DHCS' decision will state the reasons for the decision, the determination of rates of payment (if the rates of payment were disputed), and any actions KHS and Kern BHRS are required to take to implement the decision. Any such action required from either KHS or Kern BHRS must be taken no later than the next business day following the date of the decision.

F. EXPEDITED DISPUTE PROCESS

1. KHS and Kern BHRS may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and KHS and/or Kern BHRS determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.

2. Under this expedited process, KHS, and Kern BHRS will have one business day after identification of a dispute to attempt to resolve the dispute at the plan level. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.

3. If Kern BHRS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by KHS.

4. Conversely, if KHS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by Kern BHRS.

5. DHCS will provide a decision no later than one business day following DHCS' receipt of Request for Resolution from both parties and affirmation of the stated jeopardy to the member.

G. ACCESS REQUIREMENTS

KHS monitors the accessibility of contracted providers to members to obtain covered services and implements corrective measures when necessary. Refer to KHS Policy 4.30-P Accessibility Standards.

H. DELEGTION AND MONITORING

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors. Any problems identified in coordination of care are reported to the Chief Medical Officer and Chief Compliance and Fraud Prevention Officer for intervention/resolution. The Chief Medical Officer and/or Chief Compliance and Fraud Prevention Officer may submit the problem to the KHS Quality Improvement/Utilization Management (QI/UM) Committee for review and action, as appropriate.

I. REIMBURSEMENT

Reimbursement for mental health services is made per contract agreement. Claims must be submitted in accordance with KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement and other KHS policies specific to the type of service/supplies provided.
Kern BHRS sub-contractors should not submit claims directly to KHS.

Kern BHRS must submit all DHCS required encounter data to KHS with transmitted claims.
Providers under contract with KHS must meet the requirements outlined in KHS Policy and Procedure #4.01 – P, Credentialing.

KHS provides mental health services through health care providers who are acting within the scope of their licensure and acting within their scope of competence, established by education, training and experience. KHS providers are educated regarding mental health carve-outs, PCP responsibilities, licensed mental health professionals' responsibilities, and referral procedures through orientations and through this policy and procedure which is included in the KHS Provider Manual.

REFERENCE:

Revised 2024-02: Updates made to signatories. **Revised 2023-10:** Policy updated for additional clarity (added definitions and other minor changes). DHCS approval received 11/27/23 by Quality & Health Equity Transformation and 2024 OR, Exhibit A, Attachment III, 22-20201, Section 5.5.2, pages 393-398 of 611. **Revised 2023-06**: Updated to comply with DHCS Audit CAP. **Revised 2023-05:** Policy updated to comply with 2024 Readiness, R.0207 (DHCS approved 06/21/2023). **Revised 2023-04:** Policy developed for 2024 Contract Readiness, R.0061 (DHCS approved 05/12/2023).