SECTION 5, CHAPTER 10, POLICY 009

COORDINATION AND TRANSITION OF CARE

POLICY NUMBER:	5-10-009
SYSTEM OF CARE:	MENTAL HEALTH
FINALIZED DATE:	04.25.2023
EFFECTIVE:	01.01.2023
SUPERSEDES # :	5-1-011 Intake and Care Coordination (policy sections related to Coordination of Care)

A. PURPOSE: To establish guidelines for coordination of care and utilizing the Transition of Care Tool for Medi-Cal Mental Health Services for Specialty Mental Health services (SMHS) to ensure Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) and Network Providers are following state requirements.

B. FORMS REQUIRED/ATTACHMENTS:

1. Transition of Care Tool for Medi-Cal Mental Health Services (Transition of Care Tool)

C. DEFINITIONS:

1. **Clinician:** For the purpose of this policy, a clinician refers to a practitioner that meets one of the qualifications below:
   a. Physician
   b. Licensed or Waivered Psychologist
   c. Licensed, Registered, or Waivered Social Worker, Marriage & Family Therapist, or Professional Clinical Counselor

2. **Mental Health Plan (MHP):** Yolo County HHSA BH delivery system, which administers the Medi-Cal SMHS benefit.

3. **Medi-Cal Managed Care Health Plan (MCP) Delivery System**: Publicly or commercially run entities that administer the Non-Specialty Mental Health Services (NSMHS) benefit of Medi-Cal.

4. **Network Providers**: Any provider, group of providers, or entity that has a network provider agreement with the MHP and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract with the MHP (42 C.F.R. § 438.2)

5. **Prescriber**: Health Care Practitioner licensed in California who possesses a valid DEA Registration Certificate

6. **Specialty Mental Health Services (SMHS):** Defined by Title 9 C.C.R. § 1810.247

D. POLICY:

1. **Coordination of Care**

   a. Each beneficiary shall have an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary.
      i. The beneficiary shall be provided information on how to contact their designated person or entity.

   b. Services furnished to the beneficiary shall be coordinated:
      i. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
      ii. Between services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries.

   c. The MHP or Network Provider shall share with the Department of Health Care Services (DHCS) or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.

   d. The MHP shall make clinical consultation and training, including consultation and training on medications, available to the beneficiary's health care provider, for beneficiaries whose mental illness is not being treated by the MHP and/or Network Provider, or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP.

   e. The MHP shall make a good faith effort to give written notice of termination of a contracted provider to each beneficiary who was seen on a regular basis by the terminated provider. Notice to the beneficiary must be provided by the

later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice.

2. **Transition of Care Tool**: The Transition of Care Tool for Medi-Cal Mental Health Services is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when either: (1) their existing services need to be transitioned to the other delivery system; or (2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies regarding concurrent treatment (Welfare and institutions Code [W&I]section 14184.402(f),DHCS Information Notice [BHIN 22]-011, and All Plan Letter [APL] 22-005) and continuity of care requirements (Mental Health Substance Use Disorder Services [MHSUDS] Information Notice 18-059 and APL 18-008, or subsequent updates).

   a. The Transition of Care Tool documents beneficiary needs for a transition of care referral or a service referral to the MCP or MHP.

   b. The Transition of Care Tool does not replace:
      i. MHP P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
      ii. MHP protocols that address clinically appropriate, timely, and equitable access to care.
      iii. MHP clinical assessments, level of care determinations, and service recommendations.
      iv. MHP requirements to provide EPSDT services.

   c. Completion of the Transition of Care Tool is not considered an assessment.

   d. The Transition of Care Tool is designed to leverage existing clinical information to document a beneficiary's mental health needs and facilitate a referral for a transition of care to, or addition of services from, the beneficiary's MCP or MHP, as needed. The Transition of Care Tool documents the beneficiary's information and referring provider information. Beneficiaries may be transitioned to their MCP or MHP for all, or a subset of, their mental health services based on their needs. The Transition of Care Tool is designed to be utilized for both adults and youth alike.

   e. The Transition of Care Tool provides information from the entity making the referral to the receiving delivery system to begin the transition of the beneficiary's care. The Transition of Care Tool includes specific fields to document the following elements:
      i. Referring plan contact information and care team.

ii. Beneficiary demographics and contact information.
iii. Beneficiary behavioral health diagnosis, cultural and linguistic requests. Presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications.
iv. Services requested and receiving plan contact information.

f. Referring entities may provide additional documentation, such as medical history reviews, care plans, and medication lists, as attachments to the Transition of Care Tool.

g. The MHP is required to utilize the Transition of Care Tool to facilitate transitions of care to MCPs for all beneficiaries, including adults age 21 and older and youth under age 21, when their service needs change.

h. The MHP shall have a Memorandum of Understanding (MOU) in place between the MHP and the MCP that addresses referral protocols, including:
i. How the MHP shall provide a referral to the MCP when the MHP determines that the beneficiary's mental illness would be responsive to physical health care-based treatment.
ii. How the MCP will provide a referral to the MHP when the MCP determines SMHS covered by the Administrators may be required.
iii. The process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved.

E. PROCEDURE:

1. The determination to transition services to and/or add services from Yolo County HHSA BH's delivery system shall be made by a clinician via a patient centered shared decision-making process in alignment with MHP protocols.

2. Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or prescriber.

3. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice

4. The Transition of Care Tool may be completed in person, by telephone, or by video conference.

5. The Transition of Care Tool is provided as a PDF document, but MHPs and Network Providers are not required to utilize the PDF format to complete the tool. The tool may be built into their electronic health record (EHR).

a. If built into an EHR, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain intact.

b. The information shall be collected and documented in the order it appears on the Transition of Care Tool, and additional information shall not be added to the forms but may be included as attachments (i.e., medical history reviews, care plans, and medication lists).

c. Providers documenting in the Yolo County's EHR shall utilize the electronic version once available.

6. All appropriate consents shall be obtained in accordance with accepted standards of clinical practice.
   a. Ensure each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R., to the extent that such provisions are applicable.

7. After the tool is completed, the beneficiary shall be referred to their MCP, or directly to an MCP provider delivering NSMHS where appropriate processes have been established in coordination with the MCP. The MHP shall coordinate beneficiary care services with MCPs to facilitate care transitions or addition of services, including ensuring that:
   a. The referral process has been completed;

   b. The beneficiary has been connected with a provider in the new system;

   c. The new provider accepts the care of the beneficiary; and

   d. Medically necessary services have been made available to the beneficiary.

F. REFERENCES:

1. DHCS BHIN 22-065: Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services
2. DHCS BHIN 22-011: No Wrong Door for Mental Health Services Policy
3. APL 22-005: No Wrong Door for Mental Health Services Policy
4. W&I section 14184.402(f): California Advancing and Innovating Medi-Cal Act
5. DHCS MHSUDS Information Notice 18-059: Federal Continuity of Care Requirements for Mental Health Plans
6. APL 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care
7. 45 C.F.R. § 160 and § 164, subparts A and E
8. DHCS Yolo County Mental Health Plan Contract
9. 42 C.F.R. § 438.208
10. 42 C.F.R. § 438.10

11. 9 C.C.R. § 1810.370
12. 9 C.C.R.§ 1810.415
13. 11 C.C.R. § 820

Approved by:

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04/25/2023

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Date