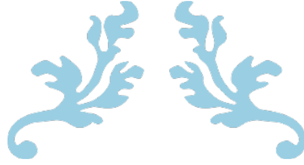
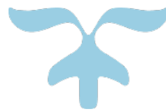


LASSEN COUNTY BEHAVIORAL HEALTH IMPLEMENTATION PLAN

2024-2029



JANUARY 3, 2024
FEBRUARY 4, 2022
MARCH 26, 2021
COUNTY OF LASSEN

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Definitions

AAP—Aid to Adoptive Parents

ABGAR—Annual Beneficiary Grievance and Appeal Report

CCR—California Code of Regulation

Cal-MHSA—California Mental Health Services Authority

CWS—Child Welfare Services

CSOC—Children's System of Care

CPM—Core Practice Model

CCC—Cultural Competency Committee

CLAS—Culturally and Linguistically Appropriate Services

DHCS—Department of Health Care Services

DMC-ODS—Drug Medi-Cal Organized Delivery System

EPSDT—Early and Periodic Screening, Diagnosis and Treatment

EHR—Electronic Health Record

EQRO—External Quality Review Organization

FFPSA—Family First Prevention Services Act

FURS—Family Urgency Response System

FFS—Fee-for-Service

FTE—Full-Time Equivalency

HIPAA—Health Insurance Portability and Accountability Act of 1996

HMIS—Homeless Management Information System

ICC—Intensive Care Coordination

IHBS—Intensive Home-Based Services

MCRT – Mobile Crisis Response Team

MOU—Memorandum of Understanding

MHP—Mental Health Plan

MHSA—Mental Health Services Act

MHSUDS—Mental Health Substance Use Disorder Services

NPI—National Provider Identification

PHP—Partnership HealthPlan

PIP—Performance Improvement Project

POA—Point of Authorization

PHCP—Primary Health Care Physicians

PHI—Protected Health Information

QAPI—Quality Assessment and Performance Improvement

QA—Quality Assurance

QI—Quality Improvement

QIWP—Quality Improvement Work Plan

SMHS—Specialty Mental Health Services

SAMHSA—Substance Abuse and Mental Health Services Administration

SUD—Substance Use Disorder

I. IMPLEMENTATION PLAN CONTEXT AND PURPOSE

As required by the California Code of Regulations, Title 9, Chapter 11, §1810.310, each MHP must submit an Implementation Plan in order to be designated as a Mental Health Plan (MHP) and contract with the Department of Health Care Services (DHCS) to provide or arrange for the provision of specialty mental health services to all eligible Medi-Cal beneficiaries residing in the MHP's county. All MHPs submitted their original Implementation Plans soon after the Medi-Cal specialty mental health services program began in Fiscal Year 1997-98.

Title 9, §1810.310(c) requires that "An MHP shall submit proposed changes to its approved Implementation Plan in writing to the Department for review." Furthermore, §1810.310(c)(1) requires that "An MHP shall submit proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan prior to implementing the proposed changes." This Implementation Plan Update is to fulfill the MHP's requirement to submit proposed changes since the last approved Implementation Plan.

Title 9, §1810.310(a)(1) through (11) provides the content requirements for the Implementation Plan: In accordance with this regulation, the Implementation Plan shall include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.

(2) A description of the process for:

> (A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.
>
> (B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.
>
> (C) Assuring continuity of care for beneficiaries receiving specialty mental health services prior to the date the entity begins operation as the MHP.
>
> (D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

(3) A description of the processes for problem resolution as required in Subchapter 5.

(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435. The entity designated to be the MHP

shall include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH.

(5) Documentation that demonstrates that the entity:

> (A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries that will be served by the MHP, and
>
> (B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP.

(6) A description of how the MHP will deliver age-appropriate services to beneficiaries.

(7) The proposed Cultural Competence Plan as described in Section 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to Section 1810.410(c).

(8) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

(9) A description of the MHP's Quality Improvement and Utilization Management Programs.

(10) A description of policies and procedures that assure beneficiary confidentiality in compliance with State and Federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this Chapter.

The Lassen County Behavioral Health Implementation Plan Update addresses all the required elements outlined in the California Code of Regulations (CCR), Title 9, §1810.310. Care was taken to follow the structure established in the regulation, to ensure all the necessary descriptions of policies, procedures and processes, are included. Elements that were required in the original Implementation Plan but are not applicable to the update are so noted.

The time frames for review, approval and implementation of the proposed changes in this Implementation Plan Update are outlined in §1810.310(c)(3) through (5):

(3) If the changes are consistent with this Chapter, the changes shall be approved by the Department.

(4) The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP.

(5) The MHP may implement the proposed changes 30 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

A. Mental Health Plan Overview

Lassen County Behavioral Health (LCBH), referred throughout this document as the County Mental Health Plan (MHP), has a Mission to promote the prevention of and recovery from mental illness and substance abuse for Lassen County individuals, families, and communities by providing accessible, caring, inclusive, and culturally respectful services.

The MHP's core values include the following:

- Promotion of wellness and recovery
- The integrity of individual and organization actions
- Dignity, worth, and diversity of all people
- The intrinsic worth of beneficiaries as human beings
- Importance of human relationships
- Open and honest communication amongst members
- Creation of an environment by which all persons can thrive and grow

The MHP is dedicated to developing, implementing, monitoring, and reviewing the following eight objectives:

1. Maintain accurate and reliable demographic and service-level data to measure and evaluate the impact of services and outcomes. The MHP expects leadership to promote equity of services through culturally responsive policies, practices, and procedures.
2. Expand the behavioral health workforce by recruiting, promoting, training, and supporting culturally and linguistically diverse leadership and expanding the workforce to include consumers and family members to create a better response for the needs of the community.
3. Provide culturally and linguistically appropriate behavioral health services, in an easy to understand written format in the two prominent languages (Spanish and English), as well as the Medi-Cal Manual in audio (English only). If needed, language assistance is available at no cost to the consumer. The MHP contracts with the AT&T Language Line to provide this no-cost service to non-English speakers.
4. Improve access for all racial, ethnic, and cultural groups, including Hispanic, and Native American populations, TAY, older adults, veterans, LGBTQIA2-S individuals, persons released from jail, homeless individuals, foster care children, and consumer family members.

5. Provide at least four culturally informed trainings per fiscal year for behavioral health staff, contractors, and collaborative community partners.
6. Deliver behavioral health services, including outreach and education, throughout Lassen County in collaboration with other community partners and co-locating services whenever possible, including in diverse community settings known to serve Hispanic and Native populations in the least restrictive environment.
7. Increase the proportion of persons who reflect the diversity of the county by expanding membership for the Quality Improvement Committee (QIC), the Cultural and Linguistic Competence Committee (CLCC), and other committees.
8. Hold personnel and contractors responsible for showing sensitivity to cultural and ethnic differences to ensure that beneficiary's and co-workers feel welcome, safe, understood, and respected at the MHP.

B. Lassen County Geography

Lassen County is located in the northeastern portion of California with a population of 34,895 (2010 US Census Data). Geographically, it is among the largest counties in California incorporating 4,547 square miles. The county's terrain consists of forest land and high desert plateaus. The County seat, Susanville, is the main population center and where most of the services are located. Susanville is located near the center of Lassen County and approximately 80 miles north of Reno, Nevada. There are other small unincorporated outposts throughout the county which are accessible by two-lane roads. They include Bieber, some 80 miles to the north of Susanville, Westwood 22.6 miles to the west and Herlong 40 miles to the south. Major routes leading to Susanville include Highway 395 from the south and Highway 36 from the west and a minor road Highway 139 leads to the Bieber/Big Valley area. Severe winter weather frequently impacts travel on these highways making travel from outlying areas difficult or impossible. Public transportation is available on a limited basis within the Susanville area and transportation services to the outlining areas are generally limited to morning and evening service runs.

The economy of Lassen County is primarily supported by government services, the community hospital and the community junior college. The county hosts two prisons, High Desert State Prison (Population approximately 4,260) and Herlong Federal Prison (Population approximately 1,484). California Correctional Center closed down the Summer of 2023. It should be noted the US Census data incorporates data from the three prison systems which skews Lassen County data (i.e. population, ethnicity, and gender) as it relates to general population services. Lassen County does not have a threshold language.

C. Head of Service Requirements

LCBH designates a Director of Local Mental Health Services in compliance with current state and federal regulations. In addition, organizational providers under contract with LCBH for mental health services designate a Head of Service in compliance with

current state and federal regulations. All SMHS are based out of a Medi-Cal certified Mental Health site.

II. BEHAVIORAL HEALTH PROGRAMS

The MHP mental health services program is comprised of Children's and Transitional Age Youth (TAY) Services (serving beneficiaries ages 0-20), and Adult Services (serving beneficiaries ages 18 and older). Services are delivered in the community through telehealth staffed by the MHP and peer supports.

Mental Health Services Act (MHSA) provides support services for full-service partners. Beneficiaries of all ages can benefit from psychiatric evaluation and medication services, if needed.

A. Children's and TAY Services

Children's Services utilizes EPSDT Medi-Cal services to provide a variety of options for the treatment of children and adolescents such as assessments, individual/ group/ collateral therapies, rehabilitation, case management, mental health treatment in collaboration with substance use disorder (SUD) services as appropriate, Pathways to Wellbeing, ICC, and IHBS for all children who meet criteria and when medically necessary. Also, intensive therapeutic behavioral services (TBS) are available within the network of providers. The MHP is in the initial collaborative stages toward establishing Therapeutic Foster Care (TFC).

In 2018, the Family First Prevention Services Act (FFPSA), was signed into law. The FFPSA aims to enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services, providing increased oversight and requirements for placements, and by establishing requirements for congregate care placement settings. The essential services assigned to the MHP include the Qualified Individual (QI) Assessment, reporting, and fidelity wraparound aftercare services.

In an effort to ensure appropriate placement of youth into congregate care, FFPSA requires MHPs to designate a "Qualified Individual" (QI) to assist with placement determinations. FFPSA Part IV requires that an assessment by a QI be conducted any time a child is placed in a qualified residential treatment program (e.g., short-term residential therapeutic program) to determine if a child's needs can instead be met with family members, in a family home or in one of the other approved settings, and to make other specified determinations.

Family Urgent Response System (FURS) services were fully implemented in fiscal year 20-21. FURS services are available to current and former foster youth, and their caregivers, to reduce the potential for placement disruption, family discord, and crisis evaluation/hospitalization. Youth or their caregivers can contact the FURS Hotline and receive an immediate in-person response from provider agencies. The mobile response team is comprised of Lassen County staff from Behavioral Health, Child Welfare

Services (CWS), and Probation. Each agency provides a lead that rotates responding to after-hours calls, attempts to deescalate situations, and dispatches the team for face-to-face intervention whenever necessary.

B. Adult Services

Adult beneficiaries are provided a behavioral health assessment, wellness and recovery-oriented individual therapy, rehabilitation, and case management services as appropriate.

The MHP ensures that other services are available, as needed, through provider contracts and/or referrals, including crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, psychiatric inpatient hospitalization, and psychiatric nursing facility services.

C. Provision of Specialty Mental Health Care for Adults and Youth/Adolescent and Transitional Age

Mental health services are provided by Medi-Cal certified mental health organizations or agencies and by mental health professionals who are licensed according to state requirements; or by non-licensed providers who agree to abide by the definitions, rules, and requirements for rehabilitative mental health services established by the Department of Health Care Services (DHCS), to the extent authorized under state law. All specialty mental health services are delivered from Medi-Cal certified mental health sites. The MHP implemented a process of ensuring all applicable network providers enroll through DHCS's Provider Applications and Validation Enrollment (PAVE) portal. All required providers were enrolled by July 1, 2021.

D. Mental Health Services

Mental health services are individual, group, or family-based treatment services that help people with mental illness develop coping skills for daily living. These services also include work that the provider does to help make the services better for the person receiving the services. These kinds of things include: assessments to see the need for service and if the service is working; plan development to decide the goals of the mental health treatment and the specific services that will be provided; and "collateral," which means working with family members and important people in the beneficiary's life (if the beneficiary gives permission) to help improve or maintain daily living abilities. Mental health services can be provided in a clinic or provider's office, over the phone or by telemedicine, or in the home or other community setting.

Assessment - A service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health.

Collateral - A service activity to a significant support person or persons in a client's life for the purpose of providing support to the client in achieving client plan goals.

Collateral may include, but is not limited to, consultation and/or training of the significant support person(s) to assist in better utilization of mental health services by client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity.

Therapy – A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.

Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.

Plan Development - A service activity that consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a client's progress.

E. Targeted Case Management Also Known as Case Management Services

This service helps with getting medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with mental illness to get on their own. Targeted case management includes plan development; communication, coordination, and referral; monitoring service delivery to ensure the person’s access to service and the service delivery system; and monitoring the person’s progress.

Limitations/Lockouts: TCM is not reimbursable on days when the following services are reimbursed:

- Psychiatric Inpatient Hospital Services
- Psychiatric Health Facility Services
- Psychiatric Nursing Facility Services

TCM is reimbursable for the day of admission to these services. TCM is reimbursable for discharge planning activities that occur while the client is preparing for discharge from the above listed facilities, when the discharge planning activities are to find an appropriate placement in the community for the client upon being discharged.

F. Crisis Intervention

This service is available to address an urgent condition that needs immediate attention. The goal of crisis intervention is to help people in the community, so they don’t end up in the hospital. Crisis intervention can last up to eight hours and can be provided in a clinic or provider’s office, over the phone or by telemedicine, or in the home or other community setting.

Limitations/Lockouts: Crisis intervention is not reimbursable on days when crisis residential treatment services, psychiatric health facility services, or psychiatric inpatient hospital services are reimbursed, except for the day of the admission to those services. The maximum number of hours claimable for crisis intervention services in a 24-hour period is 8 hours.

G. Crisis Stabilization Services

This service is available to address an urgent condition that needs immediate attention. Crisis stabilization can last up to 20 hours and must be provided at a licensed 24-hour health care facility, at a hospital-based outpatient program, or at a provider site certified to provide crisis stabilization services.

H. Crisis Residential Treatment Services

These services provide mental health treatment and skill-building for people having a serious mental or emotional crisis, but who do not need care in a psychiatric hospital. Services are available 24 hours a day, seven days a week in licensed facilities. Medi-Cal does not cover the room and board cost to be in the facility that offers crisis residential treatment services.

I. Psychiatric Inpatient Hospital Services

These are services provided in a licensed psychiatric hospital based on the determination of a licensed mental health professional that the person requires intensive 24-hour mental health treatment.

J. Psychiatric Health Facility Services

These services are provided in a licensed mental health facility specializing in 24-hour rehabilitative treatment of serious mental health conditions. Psychiatric health facilities must have an agreement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility.

K. Medication Support Services

A face-to-face meeting with a psychiatrist (M.D.) or licensed nurse to determine the benefit of prescribing medication to alleviate symptoms of mental illness. These services include the prescribing, administering, dispensing, and monitoring of psychiatric medicines; and education related to psychiatric medicines. Medication support services can be provided in a clinic or provider’s office, over the phone or by telemedicine, or in the home or other community setting.

Limitations/Lockouts: The maximum number of hours claimable for medication support services in a 24-hour period is 4 hours.

L. Day Treatment Intensive

Day Treatment Intensive is a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three (3) hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Limitations/Lockouts: Mental health services are not reimbursable when provided by day treatment intensive staff during the same time period that day treatment intensive or day rehab services are being provided. Prior authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehab are provided.

M. Day Rehabilitation

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three (3) hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Limitations/Lockouts: Mental health services are not reimbursable when provided by day rehabilitation staff during the same time period that day treatment intensive or day rehab services are being provided. Prior authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehab are provided.

N. Adult Crisis Residential Services (CRS)

Adult crisis residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The Adult crisis residential programs provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

O. Adult Residential Treatment Services

Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and

to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral.

P. Full Service Partnership (FSP)

FSPs are designed for adults diagnosed with a severe mental illness and/or co-occurring diagnoses of substance use disorders and would benefit from an intensive service program that includes comprehensive case management services and frequent contacts. The MHP have several FSP programs including: Transitional Aged Youth (TAY) FSP designed for youth ages 18-26, Adult intensive FSP for ages 18-59, and Older Adults FSP designed for adults over 60 and Xp2 an FSP which is designed for adults with SMI involved in the forensic system. The foundation of FSPs is use of the approach "whatever it takes" to help beneficiaries on their path to recovery and wellness. FSPs embrace beneficiary driven services and supports with each beneficiary choosing services based on individual needs. Unique to FSP programs are a low staff to beneficiary ratio, and a team approach that is a partnership between mental health staff and beneficiaries. Adult FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for beneficiaries with a co-occurring mental health and substance abuse disorder. Services can be provided to beneficiaries in their homes, the community and other locations.

Q. Institute for Mental Disease (IMD)

MHP has contracts for IMD services. IMD also known as Specialty Treatment Programs in Skilled Nursing Facilities, and they provide intensive inpatient treatment programs and close supervision provide medication, psychiatric, rehabilitation, and therapy services to persons with sub-acute psychiatric impairments or chronic and persistent psychiatric impairments. IMD services include psychiatric and medication services, therapy, psychological testing, psycho social education and skill building groups, and recreational activities.

R. Information and Referral

Recommendations, information, and assistance to help use services that may be valuable to the consumer and/or family members of the consumer.

S. Mobile Crisis

Mobile Crisis Response Teams (MCRT) offer support to people experiencing a behavioral health crisis. MCRT is an alternative to law enforcement response and can help:

- Stabilize people in the community
- Connect people to community resources and treatment services
- Avoid a trip to the hospital or jail

MCRT cannot respond to calls involving threats of violence or medical emergencies. Team members are behavioral health experts and include a licensed mental health

clinician, case manager, and peer support specialist. These clinical teams provide assessments, de-escalation, and connect the person to the right services for them. Transportation to local services is also available, if needed.

MCRT services are available countywide for all insurances and serve people of all ages.

T. Recovery and Wellness Centers

The MHP has contracted with Judy House which is a non-clinical peer run drop in centers for adults (over 18-year-old) with mental illness and/or co-occurring substance use disorders. Judy House encourage their members who work together to help each other develop success in friendships, community living, employment and education. The Recovery and Wellness Centers offers a variety of self-help groups, educational groups and classes, as well as social, recreational and community-based activities. Judy House also offers a Warm line and is open when traditional services are closing (4:00 pm-8:00 am) and available 7 days a week.

U. Therapeutic Behavioral Services (TBS)

TBS are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21 with full scope Medi-Cal. Individuals receiving these services have serious emotional disturbances, are experiencing stressful transitions or life crises, and need additional short-term, specific support services to achieve outcomes specified in the beneficiary's plans.

TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs

Limitations/Lockouts: Therapeutic Behavioral Services are not allowable when;

1. Services are solely for the convenience of the family or other caregivers, physician, or teacher; to provide supervision or to assure compliance with terms and conditions of probation; to ensure the child/youth's physical safety or the safety of others, e.g., suicide watch; to address behaviors that are not a result of the child/youth's mental health condition; or for supervision or to assure compliance with terms and conditions of probation;
2. The child/youth can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day;
3. The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision;

4. The children/youth is currently admitted to an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program;
5. On-Call Time for the staff person providing TBS (note, this is different from "non-treatment" time with staff who are physically "present and available" to provide intervention – only the time spent actually providing the intervention is a billable expense);
6. The TBS staff provides services to a different child/youth during the time period authorized for TBS;
7. Transporting a child or youth. (Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances);
8. TBS supplants the child or youth's other mental health services provided by other mental health staff.

V. Intensive Care Coordination (ICC)

ICC is an intensive form of Targeted Case Management (TCM) that is responsible for facilitating assessment, care planning, and coordination of services, including urgent services for children and youth with more intensive needs. ICC may be provided to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and meet he access criteria for Specialty Mental Health Services. BHD will make an individualized determination of each child's/'youth's need for ICC, based on the child's/youth's strengths and needs.

While the key service components of ICC are similar to TCM, a difference between ICC and the more traditional TCM is that ICC is intended for children and youth who:

- Are involved in multiple child-serving systems;
- Have more intensive needs; and/or
- Whose treatment requires cross-agency collaboration.

ICC also differs from TCM in that a CFT is a required service component. The CTF provides feedback and recommendations to guide the provision of ICC services. A key element of ICC is the establishment of an ICC coordinator.

Intensive Care Coordination provides:

- A single point of accountability for ensuring that needed services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, culturally, and linguistically relevant manner;
- Services and supports that are guided by the needs of the youth;
- Facilitation of a collaborative relationship among a youth, his/her family and those involved in child- serving systems;
- Support the parent/caregiver in meeting their youth's needs;

- A care planning process that ensures a care coordinator organizes and matches care across providers and the serving systems to allow the youth to be served in their home community; an
- Facilitated development of the CFT. The CFT includes, as appropriate, both formal supports such as the care coordinator, providers, case managers from child-serving agencies, and natural supports such as family members, neighbors, friends, and clergy.

ICC service components consist of:

Assessment: The CFT completes a strength-based, needs driven, comprehensive assessment to organize and guide the development of a teaming process that determines the needs of the youth for any medical, educational, social, mental health, or other services. ICC may also include the planning and coordination of urgent needs before the comprehensive assessment is completed. The initial assessment will be reviewed as necessary, but at least every 90 days.

Planning: Using the information collected through an assessment, the care coordinator convenes CFT meetings guided by the family's needs and preferences, and the CFT develops a child- and family-centered teaming process that clearly defines the purpose, goal, and agenda for each meeting; determines an agreed upon decision making process; identifies the family's strengths and needs; determines a brainstorming and operating process; and specifies action steps to be carried out by team members. Through this process, the CFT is to articulate the child and family goals and develop a shared plan of intervention strategies to assure that progress is made toward the established goals.

Referral, monitoring, and related activities: The CFT works directly with the youth and family to implement elements of the plan of care. The CFT prepares, monitors, and modifies the plan to determine whether services are being provided in accordance with the plan; whether services in the plan are adequate; and whether there are changes in the needs or status of the youth and if so, adjusting the plan of care as necessary. The ICC coordinator ensures that plans from any of the system partners (child welfare, education, juvenile probation, etc.) are integrated to comprehensively address the plan.

Transition: The CFT develops a transition plan when the youth has achieved the goals of the plan. The ICC coordinator collaborates with the other service providers and agencies on the behalf of the youth and family.

Settings: ICC may be provided to children living and receiving services in the community (including in Therapeutic Foster Care) as well as to children who are currently in a hospital, group home, or other congregate or institutional placement as part of discharge planning.

The MHP has an affirmative responsibility to determine if children and youth who meet criteria for beneficiary access to SMHS need ICC and IHBS.

Limitations/Lockouts: Intensive Care Coordination is restricted as follows:

1. ICC is not reimbursable if:
    a. Provided at a non-hospital facility where the beneficiary is:
    b. an inmate serving time for a criminal offense; or
    c. confined involuntarily in a State or federal prison, jail, detention facility, or other penal facility – (i.e. the beneficiary is an inmate of a public institution, as defined in Section 1905(a)(A) of the Social Security Act and Title 42, Code of Federal Regulations [CFR] Section 435.1009);
2. The client is a child who is residing out-of-state at the time of service;
    a. Counties cannot claim ICC for children/youth in a hospital, psychiatric health facility, group home or psychiatric nursing facility, except when used solely for the purpose of coordinating placement of the child/youth for discharge. Under this condition, a child may receive ICC during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per admission to the facility as part of discharge planning.

W. Intensive Home-Based Services (IHBS)

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child or youth's family's ability to help the child or youth successfully function in the home and community.

IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the CFT in coordination with the family's overall service plan, which may include, but are not limited to assessment, plan development, therapy, rehabilitation, and collateral. IHBS is provided to beneficiaries under 21 who are eligible for full scope Medi-Cal services and who meet medical necessity criteria.

Limitations/Lockouts: Intensive Home-Based Services are restricted as follows:

a) A child/youth may receive the following services, but not during the same hours of the day that the child/youth is receiving IHBS services:

1. Day Rehabilitative,
2. Day Treatment Intensive,
3. Group Therapy,
4. Therapeutic Behavioral Services (TBS);

b) The following services are not reimbursable during the provision of IHBS services:

1. Psychiatric Inpatient Hospital (except on date of admission or discharge),
2. Psychiatric Inpatient Hospital Administrative Days,
3. Psychiatric Health Facility (PHF) (except on date of admission or discharge),

4. Adult Crisis Residential (except on date of admission or discharge);

c) IHBS is not reimbursable if:

1. Provided at a non-hospital facility where the beneficiary is:
    a. an inmate serving time for a criminal offense; or
    b. confined involuntarily in a State or federal prison, jail, detention facility, or other penal facility – (i.e. the beneficiary is an inmate of a public institution, as defined in Section 1905(a)(A) of the Social Security Act and Title 42, Code of Federal Regulations [CFR] Section 435.1009),
2. The beneficiary is a child who is residing out-of-state at the time of service;

d) Counties cannot claim IHBS as services provided for children/youth in group homes. However, counties may claim reimbursement for IHBS for children/youth that are transitioning to a permanent home environment when it is to facilitate the transition during single day and multiple day visits outside the group home setting.

For more information about IHBS, refer to the most recent Medi-Cal Manual for ICC, IBHS, and TFC for Medi-Cal Beneficiaries.

X. Therapeutic Foster Care

The TFC service model allows for the provision of short-term, intensive, trauma-informed, and individualized specialty mental health services for children up to age 21 who have complex emotional and behavioral needs. Services include plan development, rehabilitation, and collateral. In TFC, children are placed with trained, intensely supervised, and supported TFC parents.

Limitations: Therapeutic Foster Care is restricted as follows:

1. Children and youth receiving TFC also must receive ICC and other medically necessary SMHS, as set forth in the client plan;
2. Similar to ICC and IHBS, there must be a CFT in place to guide and plan TFC service provision; and
3. does not include room and board, other foster care services, or other parenting functions (e.g., providing food or transportation).

Lockouts: TFC is not reimbursable under the following circumstances:

1. When the child or youth is receiving Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services, EXCEPT for the day of admission or discharge to/from these facilities;
2. While the child or youth is detained in juvenile hall or is otherwise considered an inmate; or
3. While the child or youth is in an STRTP or other residential setting, EXCEPT for the day of admission or discharge.

Y. Additional Programs and Services Available

- Perinatal Outpatient Treatment (IOT)
- Perinatal After Care Program
- Dual Diagnosis, Co-Occurring Disorders (COD)
- Prevention Services for Adolescent Youth Treatment, Transitional Age Youth
- School Services
- Recovery Group
- Adult Education Group
- Seeking Safety Group
- WHAM Group

Growing a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of beneficiaries that will be served by the MHP

Please refer to the LCBH Medi-Cal Provider list, which is located on the website. LCBH has ensured that the number, mix and geographic distribution of network of providers and the range of services offered is sufficient to meet the needs of the beneficiaries who we will be serving. The diversity of an organization's staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all beneficiaries. Staff diversity at all levels of an organization can play an important role in considering the needs of beneficiaries from various cultural and linguistic backgrounds in the decisions and structures of the organization.

III. OUTREACH AND ACCESS TO SERVICES

The MHP is committed to providing appropriate Specialty Mental Health Services to the diverse populations in the County, including hard-to-reach and underserved groups. The MHP coordinates and participates in multiple outreach efforts to ensure that beneficiaries, community members and providers are informed of the availability of services and how to access services.

A. Marketing and Public Announcements

To ensure public knowledge about how to access services, the MHP communicates to the public through several informational and communication channels, such as:

- Distributing the Guide to Medi-Cal Mental Health Services Booklet
- Program brochures that describe available services and contact information to reach service providers.

B. Mental Health Plan Website

The MHP will notify the public of available services and how to access services through the use of a public website. The MHP maintains a website that includes the MHP addresses and the Access and Crisis line telephone number. The website also contains program descriptions of available mental health services. The website also contains links to resource brochures and forms for beneficiaries to communicate with providers in English and Spanish.

C. Informational and Educational Presentations

The MHP provides informational presentations and exhibits during community events throughout the year. Examples of these events include County sponsored Health and Informational Fairs, such as Out of Darkness and Children' s Fair. These informational and educational presentations highlight the culturally-sensitive services that the MHP delivers. Presentations also focus on stigma reduction, educating the general community about mental illness education, and information regarding the availability of services and treatment options. To identify hard-to-reach individuals, the MHP distributes informational materials at community locations, including Public Health and other agencies; schools and education centers; and the library and post offices. Brochures and informational notices regarding mental health clinic hours, Patient's Rights, available services, informed consent, and medication information are offered in English and Spanish. Special attention is given to brochures to ensure that they are easy to read and understand.

IV. HISTORY & BACKGROUND

Beginning in 1995, the State consolidated Fee-for-Service (FFS) and Short-Doyle/Medi-Cal programs into a single specialty mental health managed care program. This system allowed specialty mental health services to be carved out of Medi-Cal and thereafter became the responsibility of each county mental health plan. Lassen County Behavioral Health (County MHP) was also impacted by the implementation of the Affordable Care Act, which expanded coverage to a large number of individuals. The MHP is now an integrated mental health and substance abuse treatment department, which serves more than 1,100 beneficiaries each year across all ages.

Through several transitions, new leadership team has worked diligently to implement quality assurance measures, quality improvement programs, policies, and up-to-date procedures, and a revamped compliance program.

V. INTEGRATED MENTAL HEALTH AND SUBSTANCE USE SERVICES

LCBH is an integrated Behavioral Health system that provides mental health and substance use disorders services. As the Mental Health Plan, LCBH provides Specialty Mental Health Services (SMHS) to adult Medi-Cal beneficiaries with serious and persistent mental illness and to children and youth beneficiaries with moderate to

severe emotional disturbances. SMHS are provided by LCBH staff and community-based contractors.

VI. MEDI-CAL MANAGED CARE PLANS

Of note, the Medi-Cal population has significantly expanded due to the Affordable Care Act, we include information here about continuity of care for beneficiary's transitioning between the MHP and Medi-Cal Managed Care Plans for mental health services to treat beneficiaries with mild to moderate functional impairments.

As described in response to content requirement (2)(A), Partnership Health Plan administers the Medi-Cal Managed Care Plan in Lassen County and is responsible for providing the mental health benefit for beneficiaries with "mild or moderate" mental health issues.

Effective January 1, 2014, the following new mental health services are covered by MCPs to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders, that are outside of the PCP's scope of practice (MCPs continue to be responsible for the provision of mental health services within the PCP scope of practice):

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies and supplements (excluding medications as described in DHCS All Plan Letter 13-021).

In Lassen County, coverage of Medi-Cal mental health services to beneficiaries with mild to moderate impairments is the responsibility of Partnership Health Plan. Partnership Health Plan sub-contracts with Carelon to arrange for these services through a network of providers.

VII. ACCESS TO TREATMENT

Lassen County Behavioral Health (LCBH) offers an integrated mental health and substance use treatment point of entry for services through the Access Team. The Access Team provides 24/7 information, screenings and referrals by phone as well as walk-in face to face assessments during business hours for adults and children. The Access Team provides referrals and authorizations for Specialty Mental Health Services that may be provided by county programs and/or a network of organizational and individual providers. Callers requesting mental health and/or substance use treatment services may be provided screening, referral, and coordination with services from other entities (such as educational, housing and vocational rehabilitative services) if the

nature and severity of the mental health and/or substance use impairment of the individuals does not require specialty services. Callers may be referred to Partnership Health Plan for primary care or the appropriate Medi-Cal managed care plan mild or moderate services as warranted. The 24/7 Access Team Call Center is operated by LCBH staff during business hours and through a contractor after-hours and on weekends/holidays. Call center staff log all initial requests for specialty mental health services and substance use services, including the name of the beneficiary, the date of the request, and the initial disposition of the request.

Screening and referral for adjunct services occurs at Access as well as every other point along the treatment continuum, since these needs can arise at any and all points of treatment.

For callers seeking substance use treatment services, the Access Team provides information, screening and referral services. Individuals may seek these services directly from the treating providers, and are not required to enter services through the Access Team. The Access Team or designees are, however, responsible for providing authorization for residential substance use treatment services provided through the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, and responds to the initial authorization requests within 24 hours of receipt of the request and extension requests within 72 hours.

Phone: 1-888-530-8688 (24 hours/7 days a week)

VIII. SCREENING, REFERRAL AND COORDINATION WITH PHYSICAL HEALTHCARE PROVIDERS

Partnership Health Plan administers the Medi-Cal Managed Care Plan (MCP) in Lassen County and is responsible for physical health care, as well as providing the mental health benefit for beneficiaries with “mild or moderate” mental health issues. Care coordination and effective communication among providers including procedures for exchanges of medical information are already included in the existing Memorandum of Understanding (MOU) between LCBH and Partnership Health Plan.

Effective January 1, 2014, the following new mental health services are covered by MCPs to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders, that are outside of the primary care physician’s (PCP) scope of practice (MCPs continue to be responsible for the provision of mental health services within the PCP scope of practice):

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and,

- Outpatient laboratory, drugs, supplies and supplements (excluding medications as described in DHCS All Plan Letter 13-021).

In Lassen County, coverage of Medi-Cal mental health services to beneficiaries with mild to moderate impairments is the responsibility of Partnership Health Plan. Partnership Health Plan sub-contracts with Carelon to arrange for these services through a network of providers.

IX. SCREENING, REFERRAL, AND COORDINATION WITH OTHER SERVICES WITHIN LASSEN COUNTY

Screening, referral, and coordination with other services are a critical component to providing excellent care to beneficiaries. The processes for coordinating with other agencies and service providers are as follows:

1. Substance Use Disorders—if the assessment determines that there is a substance abuse issue, mental health staff refer the beneficiary to SUD services. As an integrated department, all clinicians are trained in mental health and substance use disorder diagnoses.
2. Education—if the assessment determines that the beneficiary could benefit from coordinated care with an educational facility (e.g., schools, community college), MHP staff refer/link the beneficiary with the appropriate education professional. MHP staff work closely with the school system to provide specialty mental health services.
3. Physical Health—if the assessment determines that there is a need for health care services, MHP staff refer the beneficiary to Partnership HealthPlan (PHP) for medical care. PHP also provides the mental health benefits for beneficiaries with “mild or moderate” mental health issues. Care coordination and effective communication between MHP and PHP including procedures for exchanges of medical information are included in the Memorandum of Understanding (MOU) between MHP and PHP. The MOU is available upon request. If a beneficiary is assessed by the MHP as not meeting medical necessity criteria for specialty mental health services due to having a mild to moderate impairment, or having a condition that would be more responsive to appropriate physical health care, a referral is made to PHP and a Notice of Adverse Benefit Determination is issued. If a PHP member is screened by PHP as potentially requiring specialty mental health services, they will be referred to the MHP for an assessment to determine medical necessity. MHP staff also coordinates care with hospitals and rural and tribal health clinics.
4. Housing—if the assessment determines that the beneficiary requires assistance in obtaining or changing housing, the MHP staff refers the beneficiary to local housing programs, and/or assists the beneficiary and/or family to secure housing through Lassen County Housing and Grants Departments.

All beneficiaries requiring housing supports are entered into the Homeless Management Information System (HMIS). HMIS is a data system used to record and analyze beneficiary service, and housing data for individuals and families who are experiencing homelessness or at risk of homelessness. HMIS data enables Lassen County organizations to work towards their goals as they measure outputs, outcomes, and impacts. Aggregate HMIS data is used to understand the size, characteristics, and needs of the homeless population at multiple levels: project, system, local, state, and national. HMIS is administered at the local level by Continuums of Care (CoC), collaborations for addressing homelessness issues. The MHP is a member of the seven-county NorCal CoC. The NorCal CoC anticipates using HMIS to assist in implementing a region-wide Coordinated Entry System that will refer individuals to housing resources based on a prioritization list. The HMIS software conducts a vulnerability assessment that scores individuals for this list, prioritizing those with the highest service needs and the greatest barriers to accessing services. The MHP has one dedicated staff responsible for entering this data into the HMIS system and connecting homeless individuals to local resources.

5. Social Services—if the assessment determines he beneficiary requires assistance in obtaining the services of Public Assistance, Child Welfare Services (CWS), or Adult Protective Services, the MHP staff help the beneficiary to access these services.
6. Probation—if the assessment determines that the beneficiary requires assistance with Probation services, the MHP staff collaborate as appropriate.
7. Vocational Services / Employment—if the assessment determines the beneficiary is interested in obtaining or changing employment, the MHP staff refer the beneficiary to an appropriate agency. Referrals are made to the Lassen County CalWORKs program and Lassen Works.

A. “No Wrong Door” Policy

Consistent with LCBH “No Wrong Door” policy, and DHCS Behavioral Health Information Notice (BHIN) 22-011, beneficiaries may access mental health services through multiple points of entry. Beneficiaries may call the Access and Crisis Line (ACL), or walk into a County-operated program. In alignment with the Specialty and Non-Specialty Mental Health criteria, LCBH works closely with the local Managed Care Plans (MCPs) to ensure beneficiary access.

It is the policy of LCBH to provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, and treatment services. These services are covered and reimbursable even when:

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-Specialty Mental Health Services (NSMHS)or SMHS access criteria are met;

2. The beneficiary has a co-occurring mental health condition and Substance Use disorder (SUD); or
3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

NSMHS are delivered by a Managed Care Plans (MCP) and include the following:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, drugs, supplies and supplements

As noted above, referrals are made to MCPs based on the completion of the DHCS required Screening Tool if a beneficiary is seeking non-specialty mental health services. A process has been developed with the MCP, to ensure warm hand-offs when available and sharing of the Screening Tool for referral purposes. A feedback loop has been established, with timeframe requirements identified and agreed upon. For existing beneficiaries transitioning to non-specialty mental health services, the Transition Tool process outlined in the organizational provider handbook is followed.

B. Transition Tool

The Transition of Care Tool ensures that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are being transitioned to the other delivery system, or when services need to be added to their existing mental health treatment from the other delivery system.

MHPs are required to use the Transition of Care Tool to facilitate transitions of care to MCPs for all beneficiaries, including adults aged 21 and older and youth under age 21, when their service needs change. The determination to transition services to and/or add services from the MCP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with MHP protocols. Once a clinician has made the determination to transition care or refer for services, the Transition of Care Tool may be filled out by a clinician or a non-clinician. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.

X. INTERAGENCY AGREEMENTS

The MHP has multiple interagency agreements for beneficiaries who require a system of care approach. These agencies include Public Health, Social Services, Child Welfare

System, Probation, County Jail, Public Defender, the District Attorney, Office of Education, and Fairchild Medical Center.

Public Health— the MHP relies on the assistance of the Public Health to provide mental health service brochures, referrals, and outreach information to the outlying areas of the County.

Social Services— the MHP works with Social Services to provide CalWORKS group and individual services to beneficiaries who meet CalWORKS criteria. Additionally, the MHP and Social Services both participate in providing homeless services.

Child Welfare System (CWS) — the MHP and CWS have a longstanding relationship ensuring that foster youth are provided with mental health assessments and on-going care when medical necessity is met. Additionally, LCBH monitors the use of psychotropic medications, the use of antipsychotic medications, and the use of multiple concurrent psychotropic medications for foster youth. LCBH is also reviews SB 1291 HEDIS measures for medication monitoring for foster youth.

Probation — the MHP works closely with probation and works collaboratively on projects.

A. Member Services Handbook Brochure

In standard access procedures, MHP beneficiaries are offered the Member Services Handbook and brochure. Beneficiaries are educated about how they can access services, what services are available, and the steps in the beneficiary problem resolution process.

B. Provider Handbook

The MHP provider handbook includes the required components of procedures for requesting authorization of services, procedures for submitting claims for payments, the beneficiary problem resolution process, and the provider problem resolution process.

MHP staff providers are given access to the provider handbook during the onboarding process, and the handbook is available electronically along with all of the agency policies and procedures.

C. 24-Hour Access and Crisis Line

The MHP contracts with Crisis Support Services of Alameda County for the 24/7 Access and Crisis line. Translation is available in more than 140 languages including teletype (TDD) services for deaf and hearing-impaired individuals.

XI. CONTINUITY OF CARE

A. Procedures for Transition of Services

The MHP is fully operational and provides a range of specialty mental health services to Medi-Cal beneficiaries to assure continuity of care for all persons needing medically-necessary mental health services.

Medi-Cal beneficiaries who meet medical necessity criteria for specialty mental health services (SMHS) have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the MHP or a contracted organizational or network provider). SMHS will continue to be provided, at the request of the beneficiary, for a period not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP in consultation with the beneficiary and the provider, and consistent with good professional practice

B. Interface with Physical Health Care

The MHP psychiatrist is available to Primary Health Care Physicians (PHCP) for consultation and distribution of educational materials related to medications or other mental health care issues. During regular clinic hours and days, consultation with the psychiatrist is available at the MHP clinic site or by phone.

During non-business hours, urgent psychiatric issues are evaluated by the therapist in conjunction with medical providers at the local emergency department (Banner Emergency).

As required by Title 9 Section 1810.370(a), there is an MOU between MHP and PHP. Following Section 1810.370(a) (2), the MHP provides the availability of clinical consultation, including consultation on medications, to PHCP for beneficiaries whose mental health conditions are being treated by PHCP.

Regulations regarding the management of confidential information and records, as per mental health laws and regulations and Welfare and Institutions Code, Section 5328, are adhered to when a specific MHP beneficiary is involved.

The MHP also provides intensive services to beneficiaries that have both Severe Mental Illness (SMI) and co-occurring physical health conditions. The beneficiary’s physical health problems include conditions such as diabetes, chronic pain, stroke, lung disease, liver disease, traumatic brain injuries, and memory care issues. These medical conditions require the care of multiple specialists, such as cardiologists, neurologists, pulmonologists, urologists, nephrologists, and others to ensure their medical needs are addressed properly. The MHP offers these beneficiaries case management and peer

services to assist them in navigating through complex coordination of the medical and mental health care systems. The MHP also advocates for beneficiaries to access services as needed that support their medical and mental health treatment goals.

C. Access, Cultural Competence, & Age Appropriateness

Under a 1915(b) waiver from the Health Care Financing Administration, access to Medi-Cal MHP services must be maintained or enhanced under the waivered program. Section 14684 W&I Code requires the delivery of culturally competent and age-appropriate services to the extent feasible.

D. Level of Access

The MHP does not currently use the same health record system that was utilized prior to consolidation and is unable to compare pre and post-consolidation levels of access data. As of July 2023, the MHP began utilizing the Credible Electronic Health Record (EHR), which allows for more consistent and accurate data collection and reporting than was previously possible.

In 2023, the MHP began utilizing a level of service tool within the EHR to ensure that beneficiaries are accessing the appropriate levels of care. The tool assists in identifying areas of need and allows for more relevant and targeted program planning and service delivery throughout the county.

E. Geographic Access, and Special Populations

Geographical Access

The MHP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of its beneficiaries by ensuring compliance with the State's Network Adequacy Standards.

The majority of specialty mental health services are delivered by the MHP because there are a limited number of providers available in Lassen County. On-going data demonstrates that MHP serves a large number of people and the proportion of persons served analyzed by age, gender, and race/ethnicity closely resembles the proportion of persons served by rural MHP's across California.

As required by DHCS MHSUDS Information Notice No. 18-011 and 20-012 regarding Network Adequacy, Lassen County's time and distance standards are 60 miles and 90 minutes for psychiatric services for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. The mental health services must either be within 60 miles from the beneficiary's residence or be within a 90-minute drive from the beneficiary's residence to meet the standards, unless the MHP is approved for a time and distance waiver.

Information Notice No. 20-012 requires MHPs to submit documentation to DHCS reported on a Network Adequacy Certification Tool on an annual basis that it complies with the following requirements:

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the county; and,
- Maintains a network of providers, operating within the scope of practice under State law, which is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the county.

Special Populations

The MHP is committed to providing specialty mental health services to the diverse populations in the county, including the Native American community, monolingual Spanish speaking community, homeless individuals, the criminally involved, and hard-to-reach individuals who may need behavioral health services, but who have not accessed them. Other unserved or underserved special populations and ethnic minorities are identified annually through the MHSA Community Partnership Planning process and penetration reports.

The MHP provides informational presentations and exhibits during community events throughout the year. Examples of these events include community health fairs, the county fair, veterans' events, and focus groups. These presentations are focused on the Native American and homeless communities and offer educational information for the general public about mental illness, reducing stigma, and inform the community about the availability of services and treatment options.

To reach homeless and other hard-to-reach individuals, the MHP distributes informational materials through Community Resource Centers (CRC), Judy Wellness center, internet, churches and Salvation Army. BH staff are available to assist unserved and under-served individuals in accessing specialty mental health services and provide a variety of prevention services on site. The MHP collaborates with other county and community resources to hold multi-disciplinary team meetings for individuals experiencing homelessness and plans to reach additional unserved and under-served populations through the collaboration of community Faith-based organizations.

XII. MHP WILL DELIVER AGE-APPROPRIATE SERVICES TO BENEFICIARIES.

A. Child Adolescent Needs and Strengths

The LCBH Children's System of Care (CSOC) utilizes the Child Adolescent Needs and Strengths (CANS) tool for use at treatment initiation and yearly and as necessary, thereafter. The CANS is a multipurpose assessment tool which supports care planning and level of care decisions, as well as monitoring outcomes of services. CANS information is entered in the health record which allows for immediate scoring and

flexible use of CANS data to guide individual treatment, program oversight and outcomes reporting. LCBH has implemented the use of CANS-50.

B. Beneficiaries Under Age 21

The MHP ensures that the needs of each age category are addressed. Age-appropriate services are available, including individual/family therapy, group therapy, medication support, rehabilitation services, and case management services. The MHP staff work closely with the schools and offer a range of services to meet the needs of children and their families by age, gender, race/ethnicity, and primary language.

The MHP tries to ensures that each child/youth in the foster care system receives appropriate mental health services depending on the child's needs. This population includes children (ages 0-15) and Transition Age Youth (ages 16-25).

MHP clinicians are recruited with a focus on being a general practitioner prepared to work with individuals of all ages. The MHP provides each beneficiary with services guided by behaviors, attitudes, and policies that enable effective service provision in cross-cultural and age-appropriate settings to the fullest extent within the medical necessity criteria. If there is a specialized service needed for a beneficiary that the MHP cannot meet, the MHP oversees the provision of the service through referral. The goal of the MHP is for all clinicians be certified in Trauma-Focused Cognitive Behavioral Therapy.

C. Katie A/Pathways to Wellbeing Process and Services

As a result of the Settlement Agreement in Katie A. v. Bonita, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services.

The MHP has implemented the Pathways to Wellbeing (Katie A Settlement Agreement) to serve children and youth who are eligible for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) services, including those who have been identified as Katie A subclass members. The MHP provides ICC and IHBS under the Core Practice Model (CPM) for beneficiaries under the age of 21 who are eligible for full-scope Medi-Cal, when medically necessary. The MHP is in collaboration with the County Department of Social Services as they seek a provider for TFC.

The CPM is a set of practices and principles that promotes a set of values shared by all who seek to support children, youth, and families involved in child-serving agencies including, but not limited to, the child welfare system, special education, probation, drug and alcohol, and other health and human services agencies or legal systems with which the child or youth is involved. To effectively provide ICC and IHBS, the MHP utilizes the principles of the CPM, in which the services are provided in conjunction with a Child and Family Team.

It is the policy of the MHP that children and youth are screened to determine their mental health needs and whether Katie A eligibility criteria have been met during the assessment process. ICC and IHBS may be provided to children and youth as EPSDT services, regardless of whether the child/youth is a Katie A subclass member, consistent with DHCS guidance in Information Notice No. 16-004.

D. Procedures for 24-Hour Availability of Services

For urgent conditions, services are available 24-hours per day, 7 days per week via phone and walk-in at the hospital emergency room and at the county jail. The MHP contracts with a 24-hour crisis hotline to ensure that calls are answered and accurate information is provided to the beneficiaries. The MHP also has clinicians and therapists that are available to respond to urgent and emergent services outside of standard business hours.

Previously, the MHP treated all emergent and urgent requests as a crisis and offered immediate crisis service within two hours. In an effort to better meet the needs of beneficiaries, new procedures were developed in 2021 to allow for urgent requests for services to be reviewed by a clinical supervisor and provided within 48 hours for services that do not require prior authorization and 96 hours for those that do.

For foster involved youth and families, FURS is also available 24-hours per day, 7 days per week.

E. Services for Out-of-County Youth

The MHP is responsible for authorizing or providing medically necessary specialty mental health services to children/youth who receive Aid to Adoptive Parents (AAP) or Kin-GAP funding/services. The MHP will provide medically necessary specialty mental health services to a child in an AAP or Kin-Gap aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System.

A service authorization request is submitted by the provider within three working days following the date of receipt of the request for services for children/youth in an Aid to Adoptive Parents (AAP) or Kin-GAP placement. The MHP will make an authorization decision (approve or deny services) within three working days following the date of receipt of the request for services. Clinical Supervisor or designee notifies the MHP in the child's county of residence host county, the MHP in the child's adoptive parents' county of residence (if applicable), and the requesting provider of the approval decision within three working days or less following the date of receipt of the request for services.

F. Inpatient Services Out-of-County

The MHP authorizes psychiatric inpatient services, as needed, from out-of-county providers. Beneficiaries who require inpatient care are referred to an inpatient facility

that best meets their unique needs. Inpatient services for both adults and children are provided through contracts with approved hospitals and psychiatric health facilities, whenever possible. Access team is responsible for the inpatient authorizations.

XIII. SERVICES/PROBLEM RESOLUTION TO BOTH YOUTH, ADOLESCENTS AND ADULTS

A. Languages, Visual/Hearing Information

The MHP does not currently meet criteria for a threshold language but can provide informing materials in Spanish upon request. The MHP also has large-print Medi-Cal Beneficiary handbooks available and is ensuring that all documents put on the MHP website are accessible for electronic readers.

The MHP strives to deliver culturally and linguistically appropriate services to beneficiaries and their families. This approach is reflected in the Division's mission statement, informing materials, and beneficiary plans. Cultural discussions are an integrated component of the child, youth, adult, and older adult service delivery systems. The MHP has adopted specific standards and processes for providing and monitoring culturally and linguistically competent services, including a Cultural Competency Committee (CCC); annual cultural and linguistic competence plan updates; promotion of the national standards on Culturally and Linguistically Appropriate Services (CLAS); and staff and interpreter training. The Cultural Competency Plan is available on the LCBH website.

The MHP CCC is a cross-agency committee that is comprised of mental health and substance use disorder providers, administration, and consumer representatives. The CCC members work closely together to review data, organize cultural activities, promote culture and healing to help balance the lives of the persons served by the MHP, and the committee contributes to the overall planning and implementation of services in the county.

At least annually, the MHP provides cultural competence training to staff, including administrative and management staff, direct service providers, clerical/front office staff, and organizational providers. Covered topics include cultural diversity and sensitivity; CLAS standards and implementation; using culture-specific approaches to treatment and recovery; understanding client culture; and other subjects.

B. Beneficiary Rights

In accordance with the contractual agreements between Lassen County Behavioral Health (LCBH) and the Department of Health Care Services (DHCS), LCBH develops, implements and maintains written policies that address the beneficiary's rights in accordance with State and Federal regulations and the MHP Contract, and communicates these policies to its beneficiaries and providers.

LCBH provides its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service or a substance use disorder treatment service from the MHP or its contract providers, as described in LCBH *Policy BH #18-73 Beneficiary Rights* and DMC-ODS Provider Manual. This responsibility applies to the beneficiary's receipt of any specialty mental health service or substance use disorder treatment service, including an assessment/evaluation. The content of the booklet and provider list are updated as required by Title 9 §810.360(f) and (g). The beneficiary booklet (Guide to Medi-Cal Mental Health Services), Welcome Guide are available on the LCBH website: Mental Health and Substance Use Disorder services. The Medi-Cal Provider List are provided are available on the website.

The LCBH Mental Health Services Act (MHSA) Plan describes the outreach efforts utilized through the MHSA stakeholder and public meeting process, which obtains input on MHSA programs and also serves to provide information to beneficiaries, providers and the public regarding access to specialty mental health services. This includes suicide prevention outreach materials, housing programs, prevention and early intervention, through forums such as recovery fairs, public hearings, fliers, newsletters, and the Community Intervention Program targeting historically under-served populations through targeted outreach. The MHSA Plan also describes many innovative programs serving cultural and age-specific groups that were historically under-served.

C. Consumer Problem Resolution Processes

LCBH has made the problem resolution process accessible and easy for beneficiaries. LCBH requires that all LCBH service sites including contract providers post notices in their lobbies with information about the problem resolution process and beneficiary rights, and have forms with self-addressed envelopes available to complete, without having to make a verbal or written request to anyone. There is also information about the availability of the problem resolution process, including Notices of Adverse Benefit Determination (NOABD), appeals, grievances and State Fair Hearings in the "Guide to Medi-Cal Mental Health Services" beneficiary informing materials brochure.

The LCBH policies and procedures for the consumer problem resolution process are consistent with State and Federal requirements. More detailed information about the Lassen County grievance and appeal process can be found in Policy BH #18-27 Client Problem Resolution Process, Consumer Grievance Resolution.

Please refer to Problem Resolution process. For additional details, please refer to LCBH Policy BH #18-36 Notice of Adverse Benefits Determination, Notice of Adverse Benefit Determination (NOABD) to Medi-Cal Beneficiaries.

Grievance, appeal and expedited appeal data is collected, categorized, assessed and analyzed by LCBH Quality Management Staff to look for trends, systemic issues, training needs, and ways to make improvements in services. Findings will be presented to the LCBH Quality Improvement Committee (QIC). The QIC focuses specifically on the following areas of analysis:

A. Designated LCBH Quality Management staff compiles data and reports on the number, types and dispositions of grievances, appeals and State Fair Hearings. The QIC makes recommendations for improvement.
B. For SMHS, LCBH submits an annual report to DHCS that summarizes beneficiary grievances, appeals and expedited appeals filed during a fiscal year by beginning of the second quarter (October 1) of the following fiscal year. The report includes the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.
C. For DMC-ODS Services, LCBH submits a quarterly report to DHCS that summarizes the number of grievances, appeals and expedited appeals filed during each quarter. The report includes the total number of grievances, appeals and expedited appeals by type
D. Designated LCBH Quality Management staff tracks the Consumer Grievance and Appeal Resolution Process using the Grievance Log and submits an annual report to the QIC for review.

Notice of Adverse Benefit Determination (NOABD) policies and procedures are consistent with Title 9, §1850.210 and 1850.212. The appropriate NOABD is provided to beneficiaries in the following circumstances:

A. When after a face-to-face assessment, it is determined that the beneficiary does not meet medical necessity requirements for Medi-Cal specialty mental health services.
B. Whenever LCBH denies or modifies a payment authorization request from a provider for a specialty mental health service to a beneficiary.
C. Whenever LCBH denies or modifies a payment authorization request from a provider for a specialty mental health service that has already been provided.
D. When LCBH fails to act within the established timeframes, set out in CCR, Title 9, for disposition of standard grievances, standard appeals, or expedited appeals.
E. If LCBH fails to provide a covered specialty mental health service within the established timeframe for delivery of the service.

Both individual and organizational providers may contact LCBH at any time by phone (888) 530-8688 (24/7 Access Line) or by mail to begin the problem resolution process. The mailing address is:

Lassen County Behavioral Health: Quality Management
555 Hospital Lane
Susanville, CA 96130

LCBH staff will work with the individual or providers to resolve problems and concerns as quickly and as easily as possible. The individual or provider may institute an appeal at any time during this process. Providers may appeal denied requests for authorization or payment, in writing, directly to LCBH Quality Management at the above address. A

written appeal shall be submitted to LCBH Quality Management within 60 calendar days of the date of receipt of the non-approval of the request for authorization or payment. LCBH Quality Management shall have 30 calendar days from receipt of the appeal to inform the provider, in writing, of the decision and its basis. LCBH

Quality Management shall use personnel not involved in the initial decision to respond to the provider's appeal.

XIV. PROVIDER CHOICE AND SECOND OPINIONS

A. Provider Choice

Whenever feasible and requested, beneficiaries of the MHP shall have an initial choice of provider from the list of individuals who have been identified by MHP as qualified providers for services authorized by the MHP, including the right to use culturally-specific providers.

Also, whenever feasible and requested, enrolled beneficiaries of the MHP shall have the opportunity to change to another individual provider who has been identified by MHP as a qualified provider for services authorized by the MHP.

Cases may be transferred from one provider to another either due to beneficiary request or clinical indication. All MHP beneficiaries may request a change of provider, including the right to use culturally-specific providers. Change of provider forms, in both English and Spanish, are available in the lobby at each MHP site.

2. Second Opinions

If services are denied or modified due to medical necessity or other allowable reasons, the MHP shall arrange for the beneficiary to obtain a second opinion about their mental health condition, if requested by the beneficiary. The second opinion is provided at no cost to the beneficiary, and is provided by specific licensed mental health professionals who are either employed by the MHP or under contract with the MHP.

XV. WRITTEN LOG OF INITIAL CONTACT

The MHP maintains written logs of initial requests for specialty mental health services that are made via phone, in person, or in writing (CCR. Title 9, chapter 11, section 1810.405(f)). The written logs contain the name of the beneficiary, date of the request, and the initial disposition of the request.

When services are requested for mental health or medication services, an electronic access form is completed for each beneficiary to monitor the timeliness of the request. The access form in the EHR includes the beneficiary's name, date of birth, request date, contact information and mailing address, Medi-Cal information, contact attempts/outcomes, first date offered, scheduled date, date of attended assessment, and post-assessment referral information.

XVI. CONFIDENTIALITY

All staff hired by, or volunteering with the MHP must review and sign an acknowledgment of understanding of all HIPAA policies and procedures before they make any contact with beneficiaries or their confidential information. The policies encompass all state and federal laws and regulations pertaining to the confidentiality of protected health information (PHI), including Title 42 Part II. These policies and procedures not only inform MHP staff about appropriate regulations regarding beneficiary confidentiality but also include how to report breaches in confidentiality and sanctions for these types of breaches.

All MHP staff are required upon hire, and annually thereafter, receive HIPAA training. This course reviews regulations for the protection of PHI. Staff must complete and pass an examination indicating their comprehension of covered materials.

All MHP staff are required upon hire, and annually thereafter to complete a compliance training of which confidentiality standards are a major component.

The MHP staff are required to obtain informed consent from beneficiaries prior to the onset of services. Informed consent includes the limits of confidentiality.

All group services provided by the MHP require sign-in sheets that contain an agreement for the confidentiality of information shared during group be kept private amongst group members. This agreement is to inform group members of the importance of confidentiality.

XVII. QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT PROGRAMS

The MHP has implemented a quality improvement (QI) program in accordance with federal regulations and the MHP Contract for evaluating the appropriateness and quality of services, including over-utilization and under-utilization of services. The QI program meets these requirements through the following processes:

A. Quality Assessment and Performance Improvement

The MHP has implemented an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it provides to beneficiaries. The MHP QAPI Program strives to improve the MHP's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

The MHP maintains a written description of the QAPI Program that clearly defines the QAPI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The MHP evaluates the impact and effectiveness of its QAPI Program annually and updates the Program as necessary.

The QAPI program includes the collection and submission of performance measurement data required by DHCS, which may include performance measures specified by the federal Center for Medicare and Medicaid Services. The MHP measures and annually reports to DHCS its performance, using the standard measures identified by DHCS.

The MHP conducts performance monitoring activities throughout the MHPs' operations. These activities include, but are not limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. The MHP has mechanisms to detect both underutilization of services and overutilization of services.

The MHP implements mechanisms to assess beneficiary/family satisfaction. The MHP assesses beneficiary/family satisfaction by:

a) Surveying beneficiary/family satisfaction with the MHP's services at least annually;
b) Evaluating beneficiary grievances, appeals, and fair hearings at least annually; and
c) Evaluating requests to change persons providing services at least annually.
d) The MHP informs providers of the results of beneficiary/family satisfaction activities.

The MHP implements mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism is under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring occurs at least annually.

The MHP has implemented mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The MHP takes appropriate follow-up action when such an occurrence is identified. The results of these interventions are evaluated by MHP at least annually. The MHP's QAPI Program will include Performance Improvement Projects.

B. QI Committee and Program

The MHP QI program monitors the service delivery system to improve the processes of providing care and better meeting the needs of its beneficiaries.

The MHP has established a QI Committee to review the quality of specialty mental health services provided to beneficiaries. The QI Committee recommends policy decisions; reviews and evaluates the results of QI activities, including performance improvement projects; institutes needed QI actions; ensures the follow-up of QI processes; and documents QI Committee meeting minutes regarding decisions and actions taken.

The QI Program is accountable to the MHP Director. The operation of the QI program includes substantial involvement by licensed mental health professionals. The QI Program includes active participation by MHP practitioners and providers, as well as beneficiaries and family members, in the planning, design, and execution of the QI Program.

QI activities will include:

a) Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified;
b) Identifying opportunities for improvement and deciding which opportunities to pursue;
c) Identifying relevant committees internal or external to the MHP to ensure appropriate exchange of information with the QI Committee;
d) Obtaining input from providers, beneficiaries, and family members in identifying barriers to the delivery of clinical care and administrative services;
e) Designing and implementing interventions to improve performance (including required performance improvement projects [PIPs]);
f) Measuring the effectiveness of the interventions;
g) Incorporating successful interventions in the system, as appropriate; and
h) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required.

It is the goal of the MHP to build a structure that ensures the overall quality of services. This goal is accomplished by meaningful, realistic, and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumer/family QI committee members; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified and policy and system-level changes are implemented, when appropriate.

The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate on-going quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

C. Utilization Review

The quality assurance department is responsible for all utilization management (UM) activities. Assessments will be provided to children and adults to determine medical necessity, level of care, and appropriateness of services by either the MHP or contracted providers. Additionally, utilization review activities are conducted retrospectively by the quality assurance and health information departments. Any problems or issues identified throughout the quality management system will be reviewed in the QIC. Charts may also be referred to the QA department by the QIC and by any other staff when there are concerns about the quality of care; specifically, the

authorization, provision, or documentation of specialty mental health services to a particular beneficiary.

D. QI Work Plan

The MHP maintains an annual QI work plan that includes the following:

1. An annual evaluation of the overall effectiveness of the QI program covering the current contract cycle with documented revisions as needed, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and beneficiary service;
2. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review;
3. Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
4. A description of completed and in-process QI activities, including performance improvement projects. The description will include:
5. Objectives and activities for the coming year;
6. Monitoring previously identified issues, including tracking issues over time; and
7. Targeted areas of improvement or change in service delivery or program design.
8. A description of mechanisms the MHP has implemented to assess the accessibility of services within its service delivery area. This will include goals for responsiveness for the MHP's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and
9. Evidence of compliance with the requirements for cultural competence and linguistic competence.

The QI work plan is provided to the External Quality Review Organization (EQRO) during its annual review of the MHP system. It is also provided to DHCS at yearly updates and updated on the agency website.

Annual Work Plan

The Quality Improvement Work Plan (QIWP) and QIWP Evaluation are revised annually and are available online at https://www.lassencounty.org/dept/behavioral-health/data-analysis-quality-assurance.

E. Utilization Management Program

The MHP performs documentation reviews to monitor the utilization of services and timely and appropriate documentation for Service Authorization Requests, of Treatment Authorization Requests, and active caseload for utilization and peer reviews combined.

The QA Analysts provides new clinical staff documentation training and documentation review. Documentation training is also provided to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.

For utilization review, cases are selected through random sampling by the quality department and forwarded to the clinical supervisor or consultant for review. Targeted reviews occur when trends are identified. Utilization review of documentation by contract or organizational providers is conducted by the QAM or designee and all appeals follow the process outlined in the provider manual.

XVIII. PROBLEM RESOLUTION PROCESS

The MHP works to resolve any problem identified by beneficiaries in a sensitive and timely manner, utilizing the beneficiary problem resolution process. The resolution process includes procedures for addressing grievances, standard appeals, and expedited appeals. Beneficiaries and the MHP have rights and responsibilities specific to each type of process. These rights and responsibilities relate to how a problem is filed, regulatory notification and documentation requirements, and timeframes for filing and responding to grievances and appeals.

The MHP will follow all the requirements and procedures from the Code of Federal Regulations, Chapter 42, Section 438, Subpart F; the MHP Contract, Exhibit A, Attachment 12; and DHCS MHSUDS Information Notice No. 18-010E.

A. Grievance Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the grievance and send written notice of receipt to the beneficiary. Upon disposition of the grievance, the Behavioral Health Director (or designee) will log the disposition and send written notice of the disposition within 90 days to the beneficiary.

B. Standard Appeal Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the standard appeal and send written notice of receipt to the beneficiary. Upon disposition of the appeal, the Behavioral Health Director (or designee) will log the disposition and send written notice of the disposition to the beneficiary within 30 days of receipt. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the MHP determines that there is a need for additional information and that the delay is in the beneficiary’s interest. If the extension is due to the MHP's request for a delay, the beneficiary is given written notice of the reason for the delay.

C. Expedited Appeal Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the expedited appeal and send written notice of receipt to the beneficiary. Within two calendar days of receipt the Behavioral Health Director (or designee) will notify the

beneficiary orally and in writing if the MHP denies a request for an expedited resolution of an appeal, at which point it would convert to the standard appeal process. The Behavioral Health Director (or designee) will log the disposition and then notify the beneficiary orally and in writing of the disposition within 72 hours of receipt.

The MHP has designated the Patient's Rights Advocate or a designated supervisor to aid beneficiaries in the problem resolution process. This individual also provides the status of a beneficiary's grievance or appeal, upon request.

The MHP has authorized the Clinical Supervisor or designee to make decisions regarding appeals. These individuals have not been involved in any previous level of review or decision making. If the situation is clinical, the person(s) making the decision must be a licensed mental health professional with the appropriate clinical expertise in treating the beneficiary's condition. Such situations requiring clinical expertise include appeals based on lack of medical necessity; grievances regarding denial of expedited resolution of an appeal; and/or grievances/appeals that involve clinical issues.

The Clinical Supervisor designee confidentially maintains a grievance and appeal log for tracking purposes. The log entry includes the beneficiary's name; the date of receipt; the nature of the problem; and the final disposition of the grievance or appeal (e.g., the date the decision is sent to the beneficiary, or documentation explaining the reason for lack of a final disposition).

beneficiaries have the right to request a state fair hearing after completing the MHP problem resolution process.

XIX. NETWORK OF PROVIDERS

A. Provider Selection Criteria

To ensure delivery of the highest quality mental health services, the MHP is committed to selecting and retaining qualified providers that meet strict standards and regulations surrounding beneficiary care, availability of services, cultural competence, and beneficiary rights. The MHP reviews potential providers for acceptable licensing and compliance with state and federal regulations. In addition, providers are routinely reviewed for licensing and compliance with standards.

The MHP requires that providers are licensed, or registered/waivered per the State of California standards related to their practice or scope of work. The following information must be verified by the MHP unless the required information has been previously verified by the applicable licensing, certification, and/or registration board:

- The appropriate license and/or board certification or registration, as required for the particular provider type;
- Evidence of graduation or completion of any required education, as required for the particular provider type;

- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition to licensing standards, all contract providers must maintain a safe facility, store and dispense medications in compliance with all applicable state and federal laws and regulations, maintain beneficiary in a manner that meets state and federal standards, meet the standards and requirements of the MHP Quality Improvement Program, and meet any additional requirements that are established by the MHP as part of a credentialing or evaluation process.

B. Organizational Providers

Organizational Providers will meet the requirements of Title 9, §1810.435(c). Organizational providers are contractually responsible to ensure written policies and procedures are in place for selection, retention, credentialing and re-credentialing of providers according to LCBH contract and State and Federal regulations.

LCBH additionally requires Organizational Providers to:

1. Have a head of service that meets Title 9 requirements.
2. Use only licensed, registered and waivered providers for services to Medi-Cal beneficiaries.
3. Have sound accounting/fiscal practices that meet the standards of LCBH and DHCS requirements.
4. Provide initial and ongoing staff credentialing.
5. Will certify that all staff and/or subcontractors have not been excluded/suspended or sanctioned from Federal or State Medicare or Medicaid services. Specific requirements of the databases and frequency of these checks are outlined in the Professional Services Contract.
6. Will certify that all staff are in good standing with licensing boards at time of hire and verify at time of licensure renewal.
7. When requesting staff ID for their staff, the organization will submit a New User Request form and include information necessary for verification of credentialing, to the LCBH QI/QM program.

Organizational providers must also provide for appropriate supervision of staff, have as Head of Service a licensed mental health professional or another appropriate individual as described in state regulations, possess appropriate liability insurance, have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to state code, and permit an on-site review at least every three years.

The MHP will verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

- Work history;

- Hospital and clinic privileges in good standing;
- History of any suspension or curtailment of hospital and clinic privileges;
- Current Drug Enforcement Administration identification number;
- National Provider Identifier number;
- Current malpractice insurance in an adequate amount, as required for the particular provider type;
- History of liability claims against the provider;
  Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi; and
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

The MHP routinely verifies provider information through:

- Online verification of licenses to determine that they are current and clear of any formal actions, negative reports, or limitations monthly and at the time of hiring;
- Online verification that providers are not on the Medi-Cal List of Suspended and Ineligible Providers, and the Federal OIG List of Excluded Individuals/Entities and Excluded Parties List System on the System Award Management database.
- Checks of the National Plan and Provider Enumeration System to confirm that ordering, rendering, and referring providers have a current National Provider Identification (NPI) number; and
- Checks of the Social Security Death Master File at the time of hiring.

The MHP does not discriminate against particular providers who service high-risk populations or specialize in conditions that require costly treatment. A provider is not excluded from eligibility solely based on the type of license or certification that the provider possesses.

C. LCBH staff

1. Upon receipt of the New User Request and the supporting documentation, QI/QM designated staff will confirm that the correct taxonomy has been selected, verify license status using California State BreEZe website and National Plan and Provider Enumeration System (NPPES), and will assign scope of practice guidelines. Information Technology staff will generate staff accounts and provide access to the Electronic Health Record (EHR) as is appropriate to licensure, role and scope of practice, in accordance with Title 9. (https://www.breeze.ca.gov, https://nppes.cms.hhs.gov/)

3. After initial verification, QI/QM staff maintains a list of LCBH staff licensure information and expiration dates; sends due date notice reminders to LCBH employees and verifies current licensure annually on the California State BreEZe website.

Each LCBH provider staff meets all the criteria listed above. In the event that a current provider is found on an excluded list, LCBH stops claiming State and Federal funds for this provider and may terminate their employment.

Hospital Selection Criteria

The MHP requires that each hospital complies with federal Medicaid laws, regulations, guidelines, State statutes, regulations, and not violate the terms of the MHP contract between the MHP and DHCS. The Hospitals must sign a provider agreement with DHCS, provide psychiatric inpatient hospital services (within its scope of licensure) to all beneficiaries who are referred by the MHP, refer beneficiaries for other services when necessary, and not refuse an admission solely based on age, sex, race, religion, physical or mental disability, or national origin.

The MHP may also consider (but is not limited to) any or all of the following in selecting hospitals:

- History of Medi-Cal certification, licensure, and accreditation.
- Circumstances and outcomes of any current or previous litigation against the hospital.
- The geographic location(s) that would maximize beneficiary participation.
- The ability of the hospital to:
    - Offer services at competitive rates.
    - Demonstrate positive outcomes and cost-effectiveness.
    - Address the needs of beneficiaries based on factors including age, language, culture, physical disability, and specified clinical interventions.
    - Serve beneficiaries with severe mental illness and serious emotional disturbances.
    - Meet the quality improvement, authorization, clinical and administrative requirements of the MHP.
    - Work with beneficiaries, their families, and other providers in a collaborative and supportive manner.

If the MHP decides not to contract with a Traditional Hospital or Disproportionate Share Hospital, during the appropriate time of year when hospital contracts are negotiated, the MHP will submit a Request for Exemption from Contracting to DHCS including the information required by CCR, Title 9, §1810.430(c).

D. PAVE Enrollment

Mental health services are provided by Medi-Cal certified mental health organizations or agencies and by mental health professionals who are licensed according to state requirements; or by non-licensed providers who agree to abide by the definitions, rules,

and requirements for rehabilitative mental health services established by the DHCS, to the extent authorized under state law. All specialty mental health services are delivered from Medi-Cal certified mental health sites. The MHP implemented a process of ensuring all applicable network providers enroll through DHCS's Provider Applications and Validation Enrollment (PAVE) portal. All required providers were enrolled by July 1, 2021.

E. Inpatient Services

The Nurse or designee is responsible for the authorization for payment of inpatient services and is the designated "Point of Authorization" for Lassen County MHP. Hospitals have 10 days to notify the MHP of an inpatient admission unless otherwise specified in the contract. In 2019, the MHP initiated concurrent review policies and procedures for psychiatric inpatient hospital services and psychiatric health facility services as outlined in BHIN 19-026. The MHP ensures that all medically necessary covered SMHS are sufficient in amount, duration and scope to achieve the purpose for which the services are rendered. The MHP does not require prior authorization for emergency admission to a psychiatric inpatient hospital or PHF. Following the date of admission, hospitals must request authorization for continued stay. Determinations will be made based on the criteria for acute or administrative day placements.

XX. PAYMENT AUTHORIZATION FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES

In accordance with Title 9, §1820.220, LCBH has designated a Point of Authorization (POA) where psychiatric inpatient hospitals submit written requests for MHP payment authorizations for Medi-Cal psychiatric inpatient hospital services provided to Lassen County beneficiaries. The contact information for the LCBH POA is:

Lassen County Behavioral Health- Quality Management
555 Hospital lane
Susanville, CA 96130
Phone: (530) 251-8108
Fax: (530) 251-8394

The procedures for payment authorization by the POA is by review of a Treatment Authorization Request (TAR) from the psychiatric inpatient hospital where a Lassen County beneficiary is admitted, through a retrospective review. This is a review of medical records and other supporting documents. Timely response to the initial TAR occurs within 14 days of receipt of the TAR. Entry of TAR information in the LCBH data base supports a timely response. For more information please refer to policy BH #18-37 *Treatment Authorization Request (TAR's) for Inpatient Services.*

- Timing for receipt of the TAR in relation to the hospital discharge event can vary. The response to a payment authorization request must occur within 14 days of receipt of the TAR.

- A timely TAR response to a TAR received with a first-level appeal is either within 30 days of the date of the first-level appeal determination or, if no determination is made, at 60 days after receipt of the TAR. The TAR includes notation of receipt with a first-level appeal, indicating the date the appeal was received and the 60-day response due date. If the hospital has not submitted a TAR with the appeal but submits a TAR after notification of the appeal determination, the MHP must respond to the TAR within 14 days of receipt of the TAR.

- Retroactive Medi-Cal eligibility is approved. The hospital must submit a TAR within 60 days of discovery of eligibility. LCBH responds within 14 days of receipt of the TAR.

- Retroactive LCBH responsibility occurs (Private insurance/ Medicare- claims processing concludes and Medi-Cal becomes the next responsible payer). The hospital must submit a TAR within 60 days of discovery of eligibility. LCBH responds within 14 days of receipt of the TAR.

The same payment authorization policy applies to psychiatric inpatient hospital services provided by Short-Doyle Medi-Cal (SD/MC) hospitals, as well. For SD/MC hospitals, the LCBH

Short Doyle authorization form is used instead of a TAR. Initial prior approval of Short Doyle authorization is provided through the Crisis Team- 24/7 and the remainder of the stay is approved based on medical necessity.

Further detail about the POA payment authorization process for psychiatric inpatient hospital services can be found in LCBH policy BH #18-37.

A. Payment Authorization for Outpatient Services

Authorization for outpatient specialty mental health services is accomplished by the Access team authorizing the Assessment/medical Necessity. Documentation of medical necessity is done via progress note which is presented to Access Team for authorization. The procedure is described in more detail in the LCBH Clinical Documentation Guide and also in *Policy BH#22-04 Criteria for Beneficiary Access to Specialty Mental Health Services, Medical Necessity and other Coverage Requirements.* There are separate policy and procedures for authorization of Day Treatment, Therapeutic Behavioral Services (TBS) and Wraparound Services, which are described below.

Title 9, Chapter 11, Section 1810.310(a)(1) The “Outpatient Point of Authorization” is the function within the MHP which receives provider communications 24 hours per day,

seven days per week, regarding requests for MHP payment authorization for outpatient Specialty Mental Health Services.

The mailing address for the Outpatient Point of Authorization is:

Lassen County Behavioral Health
Access Team
555 Hospital Lane
Susanville, CA 96130

The Outpatient Point of Authorization's telephone number is:
Toll Free: (888) 530-8688 or 530-251-8108
TDD: 711
The Outpatient Point of Authorization's FAX number is: (530) 251-8394

MHP beneficiaries who wish to receive Tier III outpatient Specialty Mental Health Services may arrange to do so by contacting one of the following:

1) The Access Team (Outpatient Point of Authorization).

2) Any MHP outpatient clinic or contract agency.

For standard authorization decisions, the MHP provides notice within 14 calendar days following receipt of the request for service or, when applicable, within 14 calendar days of an extension. For expedited authorization decisions, the MHP provides notice within three working days following receipt of the request for service or, when applicable, within 14 calendar days of an extension. The authorization is approved or denied only by licensed/waivered/registered mental health professionals of the MHP.

B. Payment Authorization for Day Treatment (Lassen County currently does not have Day Treatment Program)

The Director or designee(s) will authorize payment for Day Treatment and additional specialty mental health services for Lassen County beneficiaries only when it has been determined that both medical necessity and service necessity exist.

Prior authorization by the Division Director or designee(s) is required for Day Treatment Intensive, Day Rehabilitation, Medication Support Services, TBS and all other allowable specialty mental health services that will be provided in conjunction with Day Treatment. Initial authorization will be for up to 90 days for Day Treatment Intensive and up to 180 days for Day Rehabilitation. Providers will not be reimbursed for any services that are provided without prior authorization from the Director or designee.

Requests for reauthorization should be submitted the Director or designee(s) prior to the expiration of the existing authorization. Reauthorizations are monitored for goals and progress toward goals as related to the mental health needs of the child.

C. Payment Authorization for Therapeutic Behavioral Services

Typically, referrals come from clinicians, Child and Family Service, and community-based organizations (CBOs), although anyone can make a referral. Prior Authorization Requests may also come directly from TBS providers.

The beneficiary first must be confirmed as a member of the certified class for TBS and the referral form is approved by the MCHB care coordinator. TBS is typically pre-approved for a 30-day assessment period. The first authorization request, after the assessment, is to be submitted 7 days before the end of the 30-day period. Reauthorizations are to be submitted 10 days prior to requested start of services.

D. Payment Authorization for Intensive Home-Based Services (IHBS)

Referrals to IHBS come from child welfare, juvenile probation and LCBH. Referrals are accepted to Access team which meets twice a week or more frequently if needed in order to ensure immediate response. LCBH supervisor, provides pre-authorization for the provider to initiate the assessment for services. The provider submits completed treatment plan to LCBH supervisor for authorization within a 60-day time line. Dates of services to authorize will start from date of episode opening and ending in six months.

XXI. TRAINING SCHEDULE

A. Compliance

This training includes what needs to be covered every year:

- Health Insurance Portability and Accountability Act (HIPAA)
    - Information on confidentiality, anonymity, and non-retaliation for compliance-related questions or reports of potential non-compliance.
- Fraud, waste, abuse and neglect including the False Claims Act and the Fraud Enforcement and Recovery Act
- Auditing: review and examine records or accounts to check the accuracy of the information.
    - Monitoring: test processes on an ongoing basis to document compliance with policies, procedures, laws, or regulations.
    - Fraud: an intentional deception or misrepresentation that an individual knows, or should know, to be false that could result in some unauthorized benefit to the individual or another.
    - Waste: the extravagant, careless, or needless expenditure of funds, or
    - Consumption of resources that results from deficient practices, poor systems controls, or bad decisions. Waste may or may not provide any personal gain.
- Compliance Program
    - Compliance Hotline
    - Whistleblower

- Code of Conduct
- Review of the disciplinary guidelines for non-compliant or fraudulent behavior.
- Review of potential conflicts of interest and LCBH's disclosure/attestation system.
- Privacy and EHR System

B. Coding and Billing Training

Training on accurately documenting services is an ongoing mission of Lassen County. Coding requirements;

- Claim development and submission practices;
  - Double billing: Submitting more than one claim for the same service.
  - Lacking a case note: An authorized service for an eligible beneficiary provided by an appropriately licensed clinician but lacking a proper case note that documents the service and establishes medical necessity.
  - Case note lacking a signature and/or date: Same as # 2 but lacks the clinician's signature and/or date.
  - Out of scope practice: An authorized service for an eligible beneficiary with all appropriate documentation being completed but performed by a clinician lacking the necessary training and license (or registration).
  - Expired license or registration: Any clinical service that requires a licensed or registered clinician but is provided by a person with an expired, suspended, or revoked license or registration.
  - Upcoding: Using an inaccurate diagnosis or claiming an inaccurate procedure code that has a higher reimbursement rate than is appropriate for the beneficiary's condition or the service actually rendered.
  - Overcharging: Claiming more minutes (or other applicable reimbursement criteria) than actually provided.
  - False claim: Claiming for a service that was never provided.
- Signing a form required to be authorized by a physician without the physician's authorization;
- Proper documentation of services rendered;
- Proper billing standards and procedures and submission of accurate bills for services;
- Legal sanctions for submitting deliberately false or reckless billings;
- Ongoing training for staff on policy changes;
- Unit meeting agendas to include discussions of compliance activities and Quality Improvement system level issues, when applicable; and
- New staff orientation training including specific discussion and training on compliance issues.

C. Cultural Humility

This training includes what needs to be covered every year:

- How to use the Language Line/Using an Interpreter
- CLAS Standards
- Cultural Humility Training (Unserved and Underserved) Populations
- LCBH Written Material in Spanish
- Unconscious Bias in the Workplace
- Culture-specific approaches to treatment and recovery; Understanding client culture; and other subjects.
- Cultural Competency: 6 hours of training