LASSEN COUNTY BEHAVIORAL HEALTH IMPLEMENTATION PLAN

2021-2025

FEBRUARY 4, 2022
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COUNTY OF LASSEN

Table of Contents

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.

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,

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#18-08 Medical Necessity Criteria*. 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.

Payment Authorization for Day Treatment (Lassen County 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.

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 client 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.

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.

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.

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 Beacon Health Options (Beacon) to arrange for these services through a network of providers.

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)

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 § 1810.360(f) and (g). The beneficiary booklet (Guide to Medi-Cal Mental Health Services), Welcome Guide are available on our website: Mental Health and Substance Use Disorder services. The Medi-Cal Provider List are provided are available on our website.

The LCBH Mental Health Services Act (MHSA) Plan for Fiscal Year 2020-2021 – FY2022/23 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.

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 clients transitioning between the MHP and Medi-Cal Managed Care Plans for mental health services to treat clients 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 Beacon to arrange for these services through a network of providers.

Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

As discussed above, Lassen County has one managed care health plan operating within the County, Partnership Health Plan. As required by Title 9 § 1810.370(a), LCBH and Partnership Health Plan have entered into an MOU. The MOU addresses referral protocols between the two plans. In accordance with § 1810.370(a)(2), LCBH provides the availability of clinical consultation, including consultation on medications, to the CCAH for beneficiaries whose mental illness is being treated by the Partnership Health Plan or its sub-contractors.

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 client 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.

Provider Selection Process

Managed Care "Network" Providers

1. Providers will meet the requirements of Title 9, § 1810.435(b) and be credentialed and approved by Quality Improvement/Quality Management (QI/QM) prior to acceptance into the LCBH network. The approval will be based on information received from the county-contracted credentialing provider.

2. When it is determined that there is a need for the addition of a provider with particular qualification, then Management will determine whether minimum eligibility requirements are met. Once determination has been made, the QI/QM team will conduct credentialing verification. If LCBH declines to include the provider in the network, then Management Analyst will notify the applicant as to the reasons for the decision.

3. Credentialing requires that the following be on file for each provider or member of a group:

   a. Completed application with liability statements

   b. Copy professional license

   c. Copy DEA certificate (serves as verification)

   d. Copy liability insurance (serves as verification)

   e. Curriculum Vitae/Resume

   f. Educational Commission for Foreign Medical Graduates (ECFMG) - certificate number for graduates of foreign medical schools.

   g. Education/Medical School Graduation is assumed by license.

4. In order for an individual to contract with LCBH and meet the LCBH credentialing standards, the following conditions will be met:

   a. Providers will be licensed to practice psychotherapy independently:

      i. Psychiatrists (M.D. and D.O.) Physicians who have successfully completed an accredited psychiatric residency program and have a current DEA certificate.

      ii. Registered Nurses with a Master's Degree in Psychiatric Nursing (MSN), such as a Clinical Nurse Specialist in Community Mental Health.

      iii. Psychologists (PhD, Psy.D and Ed.D).

iv. Licensed Clinical Social Workers (LCSW).

v. Marriage and Family Therapists (MFT).

vi. Licensed Professional Counselors (LPC).

b. Providers will have minimum professional liability insurance of the following:

i. Psychiatrists-$1,000,000 individual occurrence/$3,000,000 aggregate.

ii. All other allied mental health professionals--$1,000,000/$3,000,000.

iii. Group Providers --$1,000,000/$3,000,000.

c. Providers will be in good standing with the appropriate licensing board.

d. Medical providers will be in good standing with Drug Enforcement Agency (DEA).

e. Providers will have clinical privileges in good standing at the institution designated by the provider for those providers who have privileges.

f. Providers will have graduated from an accredited professional school and/or highest training program applicable to the academic degree, discipline and licensure of the provider.

g. Providers will have Board certification if provider states he/she is board certified.

h. Providers will have not been identified as an excluded/suspended or ineligible entity or individual on any of the Federal or State Exclusions lists including:

i. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions.

ii. www.sam.gov/portal/SAM - GSA Exclusions Extract.

iii. www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List.

iv. www.ssdmf.com/ – Social Security Death Master File.

i. Providers will be of good moral character as evidenced by the absence of such issues: conviction of a felony; termination of hospital privileges; dismissal from hospital employment for conduct; and other areas as are deemed necessary.

j. Providers will have prior experience working with populations served by LCBH and this will be verified through answers to the question in the application along with review of the Curriculum Vitae.

k. Providers with actions by their licensing Board and/or outstanding malpractice claims will be evaluated on a case-by-case basis.

5. Responsibilities - Providers will agree to comply with all conditions of LCBH contract, participate in the LCBH Quality Management Program, and meet the quality standards of LCBH including:

a. Providers will maintain a safe facility in accordance with State and Federal standards.

b. Providers will store and dispense medications according to State and Federal standards.

c. Providers will maintain client records in a manner that meets State and Federal standards.

d. Providers will provide access to client records for clinical and financial audits within the guidelines of State and Federal standards for confidentiality.

Organizational Providers

Organizational Providers will meet the requirements of Title 9, § 1810.435(c). Organizational provider 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.

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.

Range of Specialty Mental Health Services

The following services are available in English and Spanish for Older Adults, Adults, and Youth/Children. Other language resources are available as needed and will be provided for free.

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 if you need the service and if the service is working; plan development to decide the goals of your mental health treatment and the specific services that will be provided; and “collateral,” which means working with family members and important people in your life (if you give permission) to help you improve or maintain your daily living abilities. Mental health services can be provided in a clinic or provider’s office, over the phone or by telemedicine, or in your home or other community setting.

Targeted Case Management

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.

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.

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.

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.

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.

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.

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.

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.

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.

Information and Referral

Recommendations, information, and assistance to help you use services that may be valuable to you

Services for Children, Adolescents, and/or Young Adults

Beneficiaries under age 21 are eligible to get additional Medi-Cal services through a benefit called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

To be eligible for EPSDT services, a beneficiary must be under age 21 and have full scope Medi-Cal. EPSDT covers services that are necessary to correct or improve any mental health condition or to prevent a mental health condition from getting worse.

Ask your provider about EPSDT services. You may get these services if your provider and the MHP find that you need them because they are medically necessary.

If you have questions about the EPSDT benefit, please call 530-251-8108 or 1-888-530-8688.

The following are also available from the MHP for children, adolescents, and young people under the age of 21: Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services.

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 their client plans.

Intensive Care Coordination (ICC)

ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

ICC service components include assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems.

The CFT includes formal supports (such as the care coordinator, providers, and case managers from child-serving agencies), natural supports (such as family members, neighbors, friends, and clergy), and other individuals who work together to develop and implement the client plan and are responsible for supporting children and their families in attaining their goals. ICC also provides an ICC Coordinator who:

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.

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.

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

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 our 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 clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization.

MHP will deliver age-appropriate services to beneficiaries.

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.

Katie A Implementation

As a result of the Settlement Agreement in Katie A. vs. Bonta, 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.

LCBH has implemented the Pathways to Wellbeing (Katie A. Settlement Agreement) to serve children and youth who are eligible for Intensive Care Coordination (ICC) and Intensive Home- Based Services (IHBS) services, including those who have been identified as Katie A. subclass members. LCBH 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 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, MHPs utilize the principles of the CPM. Specifically, the services must be provided in conjunction with a Child and Family Team (CFT).

Katie A. Shared Management/System Collaboration and Coordination

The management of the Lassen County Child Welfare System (CWS) and LCBH CSOC, along with respective staff who provide Katie A. services participate in monthly meetings where general procedures and challenging cases are discussed. This has been a very successful format for consistent and effective communication and collaboration. Procedures for Katie A. were jointly written and implemented between CWS and CSOC and are updated as needed through this forum.

CWS and CSOC hold many formal and informal meetings among staff regarding the care and support of foster children in our system. These meetings also provide a forum for discussing and applying updated DHCS and CDSS regulations regarding foster children. CSOC clinician function as the case coordinator for Katie A clients, participate in CFT meetings and ensure children/youth receive the services they need. ICC and IHBS are provided as appropriate.

Cultural Competence Plan as described in Section 1810.410

The Lassen County Cultural Competence Plan was submitted in accordance with the terms of the MHP Contract and DMH Information Notice No. 10-02. As required by Title 9 § 1810.410, LCBH updates its Cultural Competence Plan annually. The Cultural Competence Plan Update can be located on our website.

Planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

Planned admissions to non-contract hospitals occur very rarely or not at all, but if they do, they will be arranged by contacting the LCBH Point of Authorization described under “Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization,” which may be found in the first section of this Implementation Plan Update. Medical necessity criteria for acute psychiatric inpatient services apply to planned admissions.

Quality Improvement and Utilization Management Programs.

The LCBH Quality Improvement (QI) Department is an integrated Mental Health and Substance Use department, responsible for providing Quality Improvement (QI) and Quality Management (QM) support to the delivery of Behavioral Health Services and to all areas of MPH operations by providing oversight, monitoring and quality improvement

functions. The QI Department's activities are guided by the relevant sections of Federal and California State regulations, including the Code of Federal Regulations Title 42, the California Code of Regulations Title 9, the California Code of Regulations Title 22, Welfare and Institutions Code, as well as the DHCS/MCHB DMC-ODS Intergovernmental Agreement, DMC-ODS Standard Terms and Conditions, and MHP contract and performance contract with DHCS.

The Quality Improvement Manager, who reports to the Behavioral Health Director, is responsible for ensuring that LCBH fulfills all State and Federal requirements regarding quality of care, including but not limited to: DHCS contract compliance, provider credentialing, site certifications, utilization review and management, initiating performance improvement projects and monitoring and maintaining the accessibility, timeliness and quality of clinical care. The Quality Manager or designee chairs the Quality Improvement Committee (QIC).

The QI Department's includes licensed staff who perform utilization review, administrative support staff, and information technology (IT) staff. The QI clinical staff facilitate quarterly Quality Improvement Committee (QIC) meeting. The QIC is comprised of a diverse group of stakeholders, including representatives from MHP administration and clinical programs, peers/family members, and contractors/community partners. The QIC reviews findings from a range of compliance and quality improvement activities, policy, and provides input into these and other areas for improvement.

To track and monitor continuous quality improvement (QI) activities within LCBH and in meeting the requirement for a QI Work Plan in the MHP Contract with DHCS, LCBH develops a Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The purpose of the LCBH QI Work Plan is to create systems whereby data relevant to the performance of the MHP is available in an easily interpretable and actionable form. The current QI Work Plan is available on the LCBH website. This year's plan will continue to build on the foundation of the previous plan's work of improving the MHP's data collection and analysis capabilities, improving accessibility of services via telehealth, cultural competence, outcomes, and other data by all levels of staff is a continuing focus. The intent is to provide resources to all levels of staff so that they may utilize continuous quality improvement principles in their daily work of supporting the recovery and resiliency of the consumers we serve.

The QIC membership has expanded to include both mental health and substance use providers as a result of the Drug Medi Cal Organized Delivery System, and activities included examining opportunities for improved coordination of care between these treatment areas, and medication monitoring.

The Lassen County Behavioral Health (LCBH) Utilization Review (UR) Program exists within the overall Quality Improvement program. The responsibilities of the UR program include:

•Evaluation of medical necessity and the appropriateness of services

•Assessment of service capacity including the monitoring of number, type, and geographic distribution of services

•Assurance that Medi-Cal beneficiaries have access to appropriate specialty mental health services

•Monitoring quality of care

Additionally, LCBH Prescribers began additional Utilization Review of psychotropic medications prescribing practices. Please review *Policy BH #18-35 Medication Chart Review.*

The Lassen County MHP abides by and complies with all applicable State and Federal laws and regulations regarding confidentiality. LCBH, its offices, programs and facilities have in place policies and procedures for appropriate administrative, technical and physical safeguards to reasonably protect health information from intentional or unintentional unauthorized use or disclosure. This applies to protected health information (PHI) held in any medium including paper, electronic, oral, or visual. The most stringent California law or other Federal law provisions, including HIPAA, are applied to the handling of protected client health information.

Please visit the Lassen County Behavioral Health Quality Improvement website for additional information.

Quality Improvement Activities

BH #18-05 Client Treatment Plans and Standards

- Quarterly chart reviews are conducted by designated Quality Improvement (QI) staff and include a compliance check to ensure that Treatment Plans meet the content, timeliness, and signature standards of LCBH. Findings are documented on the QI Chart Review Checklist, which is maintained by QI staff. Issues identified are reviewed at the Quality Improvement Committee (QIC) meetings to track and mitigate trends.

BH #18-08 Medical Necessity Criteria

- Quarterly chart reviews are conducted by designated Quality Improvement (QI) staff and include a compliance check to ensure that medical necessity was fully documented. Findings are noted on the QI Chart Review Checklist, which is maintained by QI staff.
- Identified issues are reviewed at the Quality Improvement Committee (QIC) meetings to track and mitigate trends. Any compliance issues will be reported to the compliance team.

BH #18-09 Access Line

Access Log Review

- In addition to the test call review, designated QI staff periodically conduct random Access Log checks to ensure that the required documentation is being completed by both daytime and after-hours staff.

Quality Management Review

- Designated LCBH QI staff regularly review the test call and Access Log information to identify issues and trends; urgent issues are addressed by the Management Team.

- The Quality Improvement Committee (QIC) reviews the quarterly Test Call Report that is submitted to the Department of Health Care Services (DHCS).

- Identified issues are mitigated to ensure compliance with Medi-Cal and other standards.

BH #18-10 Informing Materials in Threshold Language

- At least annually, designated Quality Improvement (QI) staff review the informing materials against current state and federal standards and contract requirements. Materials are promptly updated as necessary to ensure compliance.

BH #18-15 Progress Note

- Quarterly chart reviews are conducted by designated Quality Improvement staff and include a compliance check to ensure that Progress Notes meet the content, timeliness, and signature standards of LCBH. Findings are documented on the QI Chart Review Checklist, which is maintained by QI staff. Identified issues are reviewed and documented quarterly at the Quality Improvement Committee (QIC) meetings to track and mitigate any trends.

BH #18-22 Network Adequacy

- The LCBH Director, in collaboration with designated Quality Improvement (QI) staff, is responsible for maintaining and monitoring the network adequacy standards and complying with the reporting requirements. QI staff conduct ongoing monitoring of the LCBH network adequacy standards and immediately report any issues and areas of non-compliance to the LCBH Director.

- The Quality Improvement Committee (QIC) reviews the most recent NACT information at least quarterly, to identify any network adequacy issues and develop strategies to address these concerns. In addition, the QIC discusses changes in provider availability as needed, to immediately identify issues and to prompt active recruiting to meet the time and/or distance needs of clients. QIC network adequacy monitoring activities are recorded in the QIC minutes.

BH #18-23 Out of Network Access

- The LCBH Director, in collaboration with designated Quality Improvement (QI) staff, is responsible for maintaining and monitoring the network adequacy standards. QI staff conduct ongoing monitoring of the LCBH network adequacy standards and immediately report any issues and areas of non-compliance to the LCBH Director and compliance team. The Quality Improvement Committee (QIC) discusses changes in provider availability as necessary, to immediately identify access issues. Identified issues are mitigated to ensure compliance with Medi-Cal regulations.

BH #18-27 Client Problem Resolution

- At least quarterly, the Quality Improvement Committee (QIC) reviews documentation related to new grievances, standard appeals, or expedited appeals.

- The QIC reviews the resolutions and focuses on analyzing the appropriateness of the LCBH response, or other concerns. Overall trend issues are analyzed as part of the QIC monitoring process.

- QIC recommendations and findings are documented in the QIC minutes for LCBH Director review, and delegation of plans of action, including system changes as necessary.

BH #18-28 Client and Family Satisfaction Survey

➢ ***Data Analysis and Quality Improvement Activities***

- Prior to mailing the completed surveys to DHCS, LCBH retains copies of the completed surveys for a local evaluation.
    - This analysis may be completed by LCBH

- The survey results are returned to LCBH.

    - The results are shared with the LCBH Quality Improvement Committee (QIC), staff, and LCBH providers, as appropriate.

    - Significant trends are identified by the QIC, and policy and system-level changes are implemented, when appropriate.

        - The QIC minutes reflect the review of the survey results, as well as action items and follow-up activities, as necessary.

BH #18-29 Client Choice of Provider and Change of Provider

- At least annually, a summary of the Log, including change of provider requests and outcomes, is reviewed at the QIC to identify and track trends. Meeting minutes and the Change of Provider Log reflect when change requests were reviewed by the QIC. Trends and action items related to change of provider requests are also noted in the QIC minutes and tracked over time.

BH #18-52 Consent for Services and Consent for Treatment with Medications

- At least twice annually, chart reviews are conducted by designated Quality Improvement (QI) staff and include a compliance check to ensure that consents meet the content, timeliness, and signature standards of LCBH. Findings are documented on the QI Chart Review Checklist, which is maintained by designated QI staff. Issues are reviewed at the Quality Improvement Committee (QIC) meetings to track and mitigate any trends.

BH #18-68 Prescribing Psychotropic Medications to Children/Youth in Foster Care and Out-of-Home Placements

On a regular basis, Quality Improvement (QI) staff reports collected information, data, and trends relevant to the standards outlined in this policy to the Quality Improvement Committee (QIC). Issues are identified and mitigated as soon as possible to ensure compliance with Medi-Cal and other state and federal regulations.

Training Schedule: Compliance

This training includes what needs to be covered every year:

- Health Insurance Portability and Accountability Act (HIPAA)
- 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
- Code of Conduct
- Information on confidentiality, anonymity, and non-retaliation for compliance-related questions or reports of potential non-compliance.
- 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
- Compliance Hotline
- Whistleblower

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 client 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 client 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 client'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.

Training Schedule: 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.

***Bilingual Staff-Interpreter Training* (only for Bilingual Staff)**

A. Each bilingual/bicultural person who functions as an interpreter for Spanish-speaking clients during therapy will receive training prior to serving as an interpreter.

B. Semi-annual training is scheduled on the use of bilingual/bicultural staff and other interpreters to address the cultural and linguistic needs of our clients. Trainings on using the Language Line bilingual interpreters are available any time through a video and an instructional handout.

C. County-sponsored training on cultural humility will be made available to staff at least once a year at the All Staff meeting.