

IMPLEMENTATION PLAN

May 2016



*Department of
Behavioral
Health*

INTRODUCTION AND PURPOSE

The purpose of the Implementation Plan for psychiatric inpatient hospital services and outpatient Specialty Mental Health Services, submitted in 1994 and 1998, and under Healthcare Reform in 2014 respectively, was to describe the procedures to be followed in establishing the San Bernardino County Mental Health Plan (MHP), and in transitioning from a State administered Medi-Cal system to a system which is coordinated by the County. The Implementation Plan outlines the process of service delivery and utilization review by the MHP.

The Implementation Plan responds to the regulatory requirements found in Title 9, Chapter 11, Section 1810.310. Regulation citations are included at the beginning of each section of the Implementation Plan. This plan is a living document and may be updated in the event that the Mental Health Plan (MHP) makes systemic changes. Per Title 9 regulations, all updates to the Implementation Plan will be submitted to Department of Health Care Services (DHCS) for approval.

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POINT OF AUTHORIZATION- Inpatient Treatment Services

Title 9, Chapter 11, Section 1810.310(a)(1)

The "Inpatient 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 psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facilities services. The San Bernardino County MHP Inpatient Point of Authorization is physically located at:

**San Bernardino County Department of Behavioral Health
Inpatient Authorization Unit
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026**

The Inpatient Point of Authorization's mailing address is:

**San Bernardino County Department of Behavioral Health
Inpatient Authorization Unit
P. O. Box 2610
San Bernardino, CA 92406-2610**

The Inpatient Point of Authorization's telephone number is:

(909) 386-8227

The Inpatient Point of Authorization's FAX number is:

(909) 890-0658

In order to be eligible to receive payment for psychiatric inpatient hospital services to a Medi-Cal beneficiary, all contract and provider hospitals (except San Bernardino County's Arrowhead Regional Medical Center) must do the following:

- 1) Within 10 days of the beneficiary's admission, submit a "24-Hour Notification" to the Point of Authorization.
- 2) Within 14 days of the beneficiary's discharge, submit a ***Treatment Authorization Request (TAR)*** and a copy of the beneficiary's complete and entire medical record to the Point of Authorization's physical or mailing address. **Beneficiaries' medical records should not be faxed to the Point of Authorization.**
- 3) Submit a ***99 Day TAR*** when there have been ninety-nine days of continuous service to the beneficiary and the hospital stay exceeds that period of time.

Inpatient Authorization Unit staff will review the medical record and the TAR. The following criteria must be met before payment may be considered:

- 1) The hospitalized individual was an enrolled San Bernardino County Medi-Cal beneficiary during the inpatient hospitalization stay and had insurance coverage which included psychiatric inpatient hospital services;
- 2) A 24-Hour Notification was submitted within 10 days of the beneficiary's admission;
- 3) A correctly completed TAR was submitted within 14 days of the beneficiary's discharge, together with a complete and entire medical record for that hospital stay;

- 4) Documentation for acute days has been found to meet medical necessity criteria (see additional information below);
- 5) Documentation for administrative days has been found to meet administrative day service criteria (see additional information below); and
- 6) All other applicable Title 9 requirements have been met.

The Point of Authorization will either approve or deny the TAR within 14 calendar days of the receipt of the TAR—unless it has been necessary to return the TAR and the medical record to the provider hospital for some reason (e.g., TAR filled out incorrectly, beneficiary has other health coverage, provider not in compliance with contractual agreement, or factual documentation missing). If the Point of Authorization determines that necessary factual documentation was not submitted with the TAR, it will notify the provider hospital, which will then have 60 calendar days in which to submit the requested material.

Provided below is additional information regarding medical necessity criteria for reimbursement of psychiatric inpatient hospital services.

Medical Necessity Criteria for Admission

- 1) The beneficiary must have a covered diagnosis from among the following:
 - Pervasive Developmental Disorders
 - Dementia (Vascular Dementia only)
 - Disruptive Behavior and Attention Deficit Disorders
 - Feeding and Eating Disorders of Infancy or Early Childhood
 - Tic Disorders
 - Elimination Disorders
 - Other Disorders of Infancy, Childhood or Adolescence
 - Cognitive Disorders (Only Dementias with Delusions, or Depressed Mood)
 - Substance Induced Disorders (Only with Psychotic, Mood or Anxiety Disorder)
 - Schizophrenia and Other Psychotic Disorders
 - Mood Disorders
 - Anxiety Disorders
 - Somatoform Disorders
 - Dissociative Disorders
 - Eating Disorders
 - Intermittent Explosive Disorder
 - Pyromania
 - Adjustment Disorders
 - Personality Disorders

- 2) In addition to having a covered diagnosis, the focus of the treatment plan and the documentation of the treatment provided to the beneficiary must be consistent with the diagnosis and address symptoms by utilizing therapeutic interventions designed to make behavioral change in the beneficiary's psychiatric condition for which they are being treated.
- 3) The beneficiary cannot be treated safely at a lower level of care or less restrictive environment. There should be documentation as to why the beneficiary cannot be treated safely and effectively at a lower level of care or less restrictive environment.
- 4) The beneficiary requires inpatient treatment because they are:

- a. **Danger to Self**

Charting should include documentation of general risk factors including previous suicide attempts due to a mental disorder, as well as current risk factors including serious threats, intent to harm/kill self, a specific plan, or command hallucinations to harm/kill self.

- Danger to Others**

Charting should include documentation of general risk factors, including previous homicide attempts due to a mental disorder, as well as current risk factors, including serious threats, intent to harm/kills others, a specific plan, means/resources to implement the plan, or command hallucinations to harm/kill others.

- b. **Poses a Risk of Significant Property Destruction**

Charting should include documentation of general specific risk factors, including detailed previous attempts at significant property destruction due to a mental disorder, as well as current risk factors, including serious threats, intent, a specific plan, actions, and the means or necessary resources to complete the plan, or command hallucinations to damage and/or destroy property.

- c. **Gravely Disabled**

Documentation should describe clearly which of the beneficiary's behaviors require the need for the type of 24-hour supervision provided on the inpatient unit. It is important to remember that many beneficiaries, although unable to provide for their basic needs, are able to utilize food, clothing or shelter which is offered to them. Documentation should indicate why beneficiaries in this category could not be treated safely and effectively at a lower level of care or not be able to live independently.

- d. **Severe Risk to His/Her Physical Health**

Documentation should include a description of the behavioral factors which pose a danger to the beneficiary's health and which are the result of the beneficiary's mental disorder, such as:

- Refusal to take life-sustaining medication;
- Grossly inappropriate use of prescribed medications resulting in serious threats to health;
- Engaging in high-risk behaviors.

- e. **Exhibits a Recent, Significant Deterioration in Ability to Function**

Documentation should include:

- Description of the beneficiary's previous level of functioning;
- Description of precipitating or aggravating events;
- Description of the resulting behavioral or emotional changes which resulted in deterioration;
- A statement as to why the beneficiary could not be safely and effectively treated at a lower level of care or live independently.

f. Requires Further Psychiatric Evaluation

Documentation should include a statement of the diagnostic questions to be answered by the inpatient psychiatric evaluation, as well as reasons why the information needed to answer these questions could not be obtained at a lower level of care or until now. Included within this criteria section are beneficiary's conditions which require medication treatment that can only be provided in an inpatient setting as well as other treatments which can only be provided if the beneficiary is hospitalized. Documentation should include a clear statement as to why an inpatient level of care is required for medication adjustments or stabilization, as well as a description of past adverse reactions or emergency situations related to medication adjustments.

Continued Stay Criteria

In order to qualify for continued stay criteria, the beneficiary must meet one of the following:

- 1) Continued presence of indications which meet medical necessity criteria as specified above;
- 2) Exhibits a serious adverse reaction to medications, procedures or therapies requiring continued inpatient treatment;
- 3) Presence of new indications which meet medical necessity criteria as specified above;
- 4) Need for continued medical evaluation or treatment which can only be provided in a psychiatric inpatient hospital.

Administrative Day Criteria

In order to qualify for administrative days, the following criteria must be met:

- 1) During the hospital stay, the beneficiary had previously met medical necessity criteria for reimbursement of acute psychiatric inpatient services for at least one day.
- 2) There is no appropriate, non-acute treatment facility placement within a reasonable geographic area.
- 3) For adults, the following types of non-acute treatment facility placements meet criteria:
 - a. Augmented Board and Care Facilities (Non-augmented board and care facilities do NOT qualify for administrative day reimbursement.)
 - b. Cedar House—The TAPP Program
 - c. Skilled Nursing Facilities With a Psychiatric Component
 - d. Institutes for Mental Diseases (IMDs)
 - e. State Hospitals
- 4) For children, the following types of non-acute treatment facility placements meet criteria and should be arranged through the authorized placement agency (e.g., Children and Family Services or Probation):
 - a. Community Treatment Facility (CTF) [i.e., licensed by Community Care Licensing as a combination of a Psychiatric Health Facility (PHF) and an RCL14 Group Home, with a portion of the facility being locked].
 - b. Group Homes (i.e., RCL 9 Through 14 Facilities licensed by Community Care Licensing or Out-of-State facilities)
 - c. Foster Homes
- 5) The hospital must document contacts with a minimum of five appropriate, non-acute treatment facilities per week appropriate for the level of care that the Beneficiary requires as the least restrictive environment to meet their Behavioral Health treatment needs.
- 6) If there are fewer than five appropriate, non-acute treatment facilities available as placement options, the Point of Authorization may waive the requirement of five contacts per week. However, in no case shall there be less than one contact per week.

The documented contact with potential placements must include the following information:

- a. Status of the placement option;
- b. Date of the contact;
- c. Name and title of the person contacted;
- d. Signature and title of the person making the contact.

POINT OF AUTHORIZATION- Outpatient Treatment Services

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 Tier III outpatient Specialty Mental Health Services.

The mailing address for the Outpatient Point of Authorization is:

**San Bernardino County Department of Behavioral Health
Access Unit
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026**

The Outpatient Point of Authorization's telephone number is:

**Toll Free: (888) 743-1478
TDD: (888) 743-1481**

The Outpatient Point of Authorization's FAX number is:

**General: (909) 386-0770
For Authorizations Only: (909) 386-0775**

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 Unit (Outpatient Point of Authorization).
- 2) Any MHP outpatient clinic or contract agency.
- 3) Any Department of Behavioral Health credentialed Fee-For-Service (FFS) provider of the San Bernardino County MHP.

DBH outpatient clinics and contract agencies are authorized to provide Tier III outpatient services as clinically warranted, guided by the *Outpatient Chart Manual* and *Scope of Practice and Billing Guide*. Services available at each location may vary depending upon the nature of the program; however, all outpatient Specialty Mental Health Services are available through the MHP system of care. Each Medi-Cal certified service site has procedures to authorize treatment for beneficiaries; however, provision of Day Rehabilitation or Day Treatment Intensive must be authorized by the Access Unit.

The MHP FFS Providers are required to submit authorization requests prior to providing treatment modalities, with the exception of the initial clinical assessment.

Each FFS Provider is permitted to provide one (1) initial assessment session without preauthorization for a Medi-Cal beneficiary. All services after this initial visit must be preauthorized by the Quality Management Division, Access Unit (888)743-1478. The following Specialty Mental Health Services are provided through the MHP's FFS Provider network:

- 1) Psychiatric Diagnostic Interview
- 2) Pharmacologic Management (Medical Support Services)
- 3) Individual Psychotherapy
- 4) Group Psychotherapy

5) Case Consultation

All services except for pharmacologic management (which is provided by psychiatrists only) are provided by psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, and or licensed professional clinical counselor.

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.

SCREENING, REFERRAL AND COORDINATION

Title 9, Chapter 11, Section 1810.310(a)(2)(A)

The goal of the MHP service delivery system is a seamless system of care which affords equal access to all eligible persons based on individual treatment needs. In order to assure this access for individuals the MHP works closely with all providers at the different levels of care (e.g., Acute Psychiatric Inpatient Hospital Services, Coordinated Outpatient Mental Health Programs, and Fee-For-Service Network). This collaboration is done at the individual treatment provider level, the specific agency level, and through more formal collaboration and arrangements. Collaborations serve to ensure beneficiaries are served in the most appropriate manner and encourage awareness of service options and support care transitions between MHP providers. For example, the engagement with the Fee-For-Service network of care ensures contractor and MHP clinic awareness of other services available and facilitates transitions for high needs individuals who have progressed to a more stable level of recovery.

The medical necessity criteria which must be met for a beneficiary to qualify for Specialty Mental Health Services are as follows:

- 1) Beneficiary must be diagnosed by the MHP with an included diagnosis as specified in the list of Medi-Cal included mental health diagnoses provided by Department of Health Care Services.
- 2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
 - a. A significant impairment in an important area of life functioning.
 - b. A probability of significant deterioration in an important area of life functioning.
 - c. Except as provided in Section 1830.210 of Title 9 of the California Code of Regulations, a probability a child will not progress developmentally as individually appropriate. (For the purpose of this section, a child is a person under the age of 21 years.)
- 3) Must meet each of the intervention criteria listed below:
 - a. The focus of the proposed intervention is to address the condition identified in (2) above.
 - b. The expectation is that the proposed intervention will:
 - Significantly diminish the impairment, or
 - Prevent significant deterioration in an important area of life functioning, or
 - Except as provided in Section 1830.210 of Title 9 of the California Code of Regulations, allow the child to progress developmentally as individually appropriate.
 - c. The condition would not be responsive to physical healthcare based treatment.
 - d. When the medical necessity criteria above are met, beneficiaries shall receive Specialty Mental Health Services for a diagnosis included in subsection (1) even if a diagnosis that is not included in subsection (1) is also present.

Access Unit

- 1) The MHP's Access Unit is available to all beneficiaries and providers 24-hours a day, seven days per week, via the toll-free number: **(888) 743-1478**. The Access Unit provides all beneficiaries with referrals to specialty mental health services available within the MHP which meet the specific needs of the beneficiary.

- a. When a beneficiary contacts the Access Unit with request for services, the Access Unit staff assesses the nature of the beneficiaries' request, cultural and linguistic needs, provide crisis intervention via telephone as needed, and links beneficiaries to specialty mental health services treatment providers.
- b. Minors with full-scope Medi-Cal residing outside San Bernardino County in group home, foster home, adoptive or kinship placement who meet medical necessity criteria should arrange for Specialty Mental Health Services through the Administrative Service Organization.

Psychiatric Inpatient Hospital Services

Screening and Assessment Process

There are multiple access points by which beneficiaries may either access or be screened for the need for Psychiatric Inpatient Hospital Services (e.g., Community Crisis Response Team, Crisis Walk-In Clinic, and any outpatient program); however, prior to admission the inpatient facility staff conduct an assessment to ensure other service options are not more appropriate.

Discharge and Referral Process

The Department of Behavioral Health Case Management Services provide placement, linkage and consultation, transportation, discharge consultation, information, and referral, with the goal of assisting the beneficiary and the hospital in planning for the return of the beneficiary to the least restrictive environment community or in locating appropriate placement.

- 1) If a Beneficiary has been identified as a high user of inpatient services, the Department of Behavioral Health Case Management Services staff evaluates impediments to maintaining community tenure, and work to reduce the likelihood of readmission. Staff also work to develop a realistic treatment and aftercare plan with hospitals and outpatient services, and to provide clinical and service delivery information as appropriate to coordinate the care of San Bernardino beneficiaries. The MHP also has an innovative program, Recovery Based Engagement and Support Team (RBEST), which is designed to partner with beneficiaries who demonstrate frequent use of crisis services but are disengaged from ongoing behavioral health treatment options. RBEST operates through field based relationship building and engagement strategies which provide ongoing connection between the beneficiary and the MHP and assist with linkage to ongoing outpatient specialty mental health services treatment.
- 2) For Dependents and Wards of the Court, there is collaborative discharge planning with the agency of responsibility (e.g., Children and Family Services or Probation). In most instances this is completed through the collaboration of the hospital, the placement agency, and the outpatient program intended to provide ongoing care; however, it is also feasible to include the DBH Children's System of Care coordinating staff to help facilitate this process.
- 3) For beneficiaries with complex discharge needs (e.g., parents refusing to pick up a child or adults with high needs) then the inpatient hospital may access additional help through the proper system of care to facilitate discharge plans.

Outpatient Specialty Mental Health Services

Screening and Assessment Process:

All entry points into the MHP system of care provide for screening of behavioral health needs. If the beneficiary is determined not to require the level of service which the program offers the program will

then refer the beneficiary to another MHP program with a less intensive service delivery. If the beneficiary is found to not meet medical necessity for specialty mental health services then a Notice of Action is provided and the beneficiary is referred to their Managed Care Plan (MCP) for beneficiaries with assigned Medi-Cal or the State Medi-Cal System for beneficiaries with unassigned Medi-Cal.

Beneficiaries may also present for services after contacting their Managed Care Plan (MCP). San Bernardino County MCPs screen beneficiaries who contact the MCP for services. The MCP screening may find that the beneficiary's impairments are severe and in these cases the MCP will initiate a referral to the MHP. The MHP processes these referrals and provides linkage to an appropriate care provider within the MHP system of care.

Discharge and Referral Process:

MHP providers conduct informal assessments of functional impairments and progress on goals at every encounter with a beneficiary. The process of discharge is clinically begun at the first session with a beneficiary as the MHP providers work to support the beneficiary in gaining self-sustaining stability which allows them to transfer to natural supports. Once a beneficiary is determined to have consistent and sustained stability the MHP provider will work with the beneficiary on a smooth care transition.

Specialty programs within the MHP, which target the most severe mental health impairments, will transition the beneficiary from the intensive specialty services to traditional outpatient behavioral health clinic or a Fee-For-Service Provider.

MHP will facilitate a warm hand off between the MHP provider and the MCP when a beneficiary no longer demonstrates medical necessity for Specialty Mental Health Services. MHP will maintain an open case with the beneficiary until complete linkage to the MCP is accomplished, in order to avoid a lapse in care for the beneficiary.

Interagency Agreements and Collaborative Efforts

DBH has Memoranda of Understandings with local agencies and programs. Some of these programs include Inland Regional Center, San Bernardino County Transitional Assistance Department, San Bernardino County Juvenile Probation Department, County Department of Public Health, Inland Empire Health Plan, Molina Health Plan, San Bernardino County Unified School District, Department of Vocational Rehabilitation, DBH Alcohol and Drug Services Division, DBH Housing Services, and DBH Employment Services Programs. Some specific examples of collaborative efforts which aid in this process are as follows:

Children's Network

A county-wide collaboration of departments which collectively attempt to ensure access to the spectrum of services needed by children and youth. This effort is chaired by Children's Network with the support of the Board of Supervisors, Department of Behavioral Health, Human Services System, Juvenile Court Judges, Education, Public Health, Department of Children's Services, Probation, County Library, Preschool Services Department, County Schools, Court Appointed Special Advocates (CASA), District Attorney, Public Defender, and other child-serving agencies.

Children's Assessment Center (CAC)

The Children's Assessment Center (CAC) is one manifestation of the collaborative efforts within San Bernardino County. The CAC facilitates the assessment, triage, and crisis interventions for children and youth who have been victimized. This is done through collaborative efforts by Children's Network, Loma Linda University Pediatric Group, San Bernardino Sheriff's Department, Children and Family Services, the District Attorney, and DBH. The co-located DBH staff represents the system of care;

providing direct services as appropriate and facilitating access to the entire system of care for these victimized children and youth.

Children and Family Services (CFS)

Collaboration with CFS is primarily focused upon the needs of Court Dependents; however, these are all beneficiaries with complex needs. The CAC, outlined above, is one manifestation of this collaboration. Other examples include Children's Residential Intensive Services (ChRIS), Wraparound, and Success First/Early Wrap; the three programs which were designed to meet the needs of high level Dependents across an elevated continuum of care. Close collaboration is also evident in the co-location of DBH staff at regional CFS offices to facilitate screenings, assessments, and referrals.

Probation

Collaboration with the Probation Department is demonstrated in a variety of programs, including their involvement with IPC, an intensive Children's outpatient program (see below). Perinatal programs Juvenile Justice Community Reintegration (JJCR) and Integrated New Family Opportunities (INFO).

Programs implemented by DBH and CFS may be available to Wards; however, the unique programs collaboratively implemented by Probation and DBH are available to serve Wards not in a position to benefit from other program. Programs within the Juvenile Assessment and Detention Center (e.g. Forensic Adolescent Services Team (FAST), Juvenile Justice Community Reintegration (JJCR)) provide stabilization for youth returning from the hospital to detention. Additional outpatient programs provide high support options for Wards eligible for services outside the Hall and facilitate proper discharge from an inpatient hospital (see below for details).

The Children and Families Commission for San Bernardino County (First 5 San Bernardino)

First 5 San Bernardino and DBH are collaborating closely for the expansion of services to young beneficiaries through two distinct, but related programs. Screening, Assessment, Referral, and Treatment (SART) provides thorough assessments for children less than 6 years old deemed at risk for early trauma (e.g., 100% of CFS children). Early Identification and Intervention Services (EIS) provides both Specialty Mental Health Services and broader early intervention services to children who are struggling emotionally or behaviorally, but not to the same extent or due to the same level of trauma.

Department of Public Health (DPH)

The Department of Public Health is a primary participant in the Screening, Assessment, Referral and Treatment (SART) program, with Public Health Nursing serving as a primary service staff within the program design.

Inland Regional Center (IRC)

Inland Regional Center (IRC) is tasked with serving a wide array of children, youth, and adults. The monthly line staff meeting mentioned in the previous section clearly aids in addressing the outpatient service needs of children and youth. The program level collaboration between IRC, DBH, and CFS also aid in this process.

Coalition Against Sexual Exploitation (CASE)

The San Bernardino County Coalition Against Sexual Exploitation (C.A.S.E.) is a partnership of public and private entities who have joined together to develop resources in the county to educate, prevent, intervene and treat victims of sexual exploitation. The CASE goal is to coordinate services tailored to the characteristics and circumstances of these children, train law enforcement on investigation and detection, educate the public and create awareness to protect children from abuse and exploitation.

Participants include: The Sheriff's Department, District Attorney, Public Defender, Children's Network, Children and Family Services, Probation Department, County Schools, and DBH.

Collaborative Partnerships

Formal arrangements exist with a variety of agencies to meet a variety of needs, as is clear from the list above. Additionally, there are less formal partnerships with organizations with the intention of helping children access services. Some examples of these include

Our House

Youth Shelter with special outreach by local MHP contract agency

Special Education Local Planning Areas (SELPA)

Six Local SELPAs access services for beneficiaries with assistance from local or centralized MHP representatives

Inland Empire Perinatal Mental Health Collaborative

Collective of private and public agencies focused on increasing awareness and treatment for perinatal mental health conditions.

Access for Special Populations

Language

The MHP continues to have a range of providers with special language and cultural competencies available to assist beneficiaries (including American Sign Language). In those cases where MHP staff is not available with a particular language competence, arrangements are made to ensure that a qualified interpreter is present.

OUTREACH AND ACCESS

Title 9, Chapter 11, (a)(2)(B)

The MHP has distributed copies of its Beneficiary Guide to Mental Health Services and other beneficiary protection materials in both English and Spanish to all of the psychiatric inpatient hospitals under contract with it, to all of the DBH and contract clinics, and to all of the fee-for-service providers. All service sites have been informed that beneficiaries must be given a complete set of informational materials (Beneficiary Guide, Notice of Privacy Practices, Advance Directive brochure, and a list of providers) upon request or upon first accessing services.

MHP ensures that the DHCS issued Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT) brochure, which includes information about accessing Therapeutic Behavioral Services (TBS) to Medi-Cal beneficiaries under 21 years of age and their representative in the following circumstances: At the time of admission to a Skilled Nursing Facility (SNF) with a Specialized Treatment Program (STP) for the mentally disordered; at the time of admission to a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD); at the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home; and at the time of placement in an RCL 12 foster care group home when the MHP is involved in placement.

All contract hospitals have been informed via written notification and training sessions that all Medi-Cal beneficiaries under 21 years of age admitted with an emergency psychiatric condition must be given notices regarding EPSDT and TBS at the time of admission. In addition, the Medi-Cal beneficiary's representative must also be given a copy of these notices at the time of admission.

The MHP also provides each beneficiary written notice of any significant changes in the information specified in Sections 438.10(f)(6) and (g) of Title 42 of the Code of Federal Regulations at least 30 days before the intended effective date of the change. In the case of providers, a "significant change" is defined as a 25% change in providers. In addition, all service sites have been informed of the beneficiary protection materials and other items which must be available in the waiting room (grievance forms, envelopes addressed to the Access Unit, appeal forms, form for requesting a change of provider). Written materials are also available in alternative formats (e.g., large print or audio tape) for those who are visually limited.

COORDINATION WITH PHYSICAL HEALTH CARE

Title 9, Chapter 11, Section 1810.310(a)(2)(D)

The MHP plan and the Managed Care Plans (Inland Empire Health Plan (IEHP) and Molina) have developed procedures which facilitate the coordination of care between physical and behavioral healthcare providers.

MHP holds monthly coordination meetings with IEHP and Molina. Additionally, the MHP conducts periodic trainings for IEHP and Molina primary care physicians (PCPs) on diagnosis and psychopharmacological management. MHP psychiatrists are available to provide clinical consultation to IEHP and Molina PCPs. In addition, IEHP also conducts periodic trainings which are attended by their PCPs as well as psychiatrists from the MHP.

DBH has supported the licensed clinicians and psychiatrists within the Fee-For-Service network in becoming credentialed with IEHP and Molina and thereby creating a network of "cross paneled" providers who can maintain uninterrupted care of a beneficiary while they transition between DBH managed specialty mental health benefits to MCP managed benefits.

MHP has created a specialized unit, Managed Care Coordination (MCC) Unit, with the goal of facilitating care coordination between the MHP and outside systems for those beneficiaries with severe and complex behavioral health and physical health conditions. The MCC staff members support payment authorizations, placements, communication and joint decision making between MHP providers and other healthcare providers/entities involved in the beneficiaries integrated treatment plan.

PROBLEM RESOLUTION

Title 9, Chapter 11, Section 1810.310(a)(3)

Grievance Procedure

Beneficiaries who are receiving Specialty Mental Health Services through the MHP are entitled to file a grievance—either orally or in writing—about the services they have received. The grievance may be filed with the beneficiary’s care provider, with the Access Unit, or with the Patients’ Rights Office.

Beneficiaries have the right to authorize another person to act on his/her behalf during a grievance or appeal procedure. Beneficiaries may also identify a staff person or other individual to assist him/her with the grievance or action appeal process (See “Action Appeal Procedure” section on the next page.).

Staff should make every effort to resolve grievances at the proper level. Resolution may be achieved through disclosures between the beneficiary and the therapist/case manager, clinic supervisor, program manager or the Access Unit. The Patient’s Rights Office is also available as a resource.

If grievances cannot be resolved at the provider level, a grievance form may be completed by the beneficiary and sent to the Access Unit or the Beneficiary may call the Access Unit to attempt to resolve the issue. After receiving a verbal or written grievance, the Access Unit sends a letter to the beneficiary acknowledging the grievance has been received. The Access Unit has 60 days in which to assist in resolution of the issue. After resolution is achieved, the Access Unit sends a letter to the beneficiary describing what has occurred. A 14-day extension may be granted if this is in the best interest of the beneficiary. Once a grievance has been closed, it is forwarded to the Continuous Quality Improvement Committee (CQIC).

A grievance log is maintained by the Access Unit in order to monitor the progress and resolution of each grievance.

Contacts for filing a grievance:

Access Unit

San Bernardino County Mental Health Plan
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026
Phone – (888) 743-1478
TDD – 711
FAX – (909) 421-9272

Patients’ Rights Office

San Bernardino County Department of Behavioral Health
850 East Foothill Blvd
Rialto, CA 92376
Phone – (800) 440-2391
TDD – 711
FAX – (909) 421-9258

Action Appeal Procedure

The following are procedures to be used when the beneficiary’s dissatisfaction is the result of an “Action” taken by the MHP and the beneficiary wishes to request an Appeal to the “Action.” An Action Appeal is essentially a request for review of an Action, as defined below:

An Action occurs when the MHP does at least one of the following:

- 1) Denies or modifies an MHP payment authorization of a requested service, including the type or level of service;
- 2) Reduces, suspends, or terminates a previously authorized service;
- 3) Denies, in whole or in part, payment for a service prior to the delivery of the service or denies, in whole or in part, payment for a service after service delivery but before payment has occurred based upon a determination that the service was not medically necessary or otherwise not a service covered by the MHP's contract with the State Department of Mental Health;
- 4) Fails to provide services in a timely manner, as determined by the MHP; or
- 5) Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals

An Action for denial of Specialty Mental Health Services based on medical necessity will entail review of a provider's determination to deny, in whole or in part, a beneficiary's request for a covered specialty mental health service or for review of a determination by the MHP or its providers that the medical necessity criteria in Title 9 of the California Code of Regulations, Section 1830.205(b)(1), (b)(2), and (b)(3)(C) have not been met and the beneficiary is not entitled to any Specialty Mental Health Services from the MHP.

A beneficiary may complete an Action Appeal Form, which is to be forwarded to the Access Unit, or may initiate an Action Appeal orally with the Access Unit. Verbal appeals must be followed up in writing by the Beneficiary within 45 calendar days of the date on which the verbal Appeal was communicated.

The beneficiary and his or her representative have the right—before and during the appeals process—to examine the beneficiary's case file, including medical records, and any other documents and records considered during the appeals process.

A written acknowledgement of the Action Appeal is sent to the beneficiary. This acknowledgement also contains information on how the beneficiary may pursue subsequent requests for additional review. A written response to the Appeal is made within 45 calendar days from the date of receipt of the form and is mailed to the beneficiary. A 14-day extension may be granted if it is determined to be in the best interests of the beneficiary.

Expedited Appeal

An expedited review process for Appeals occurs if the MHP determines that the time usually taken for a standard resolution would seriously jeopardize the beneficiary's life, health, or ability to function. Under the expedited process, the MHP notifies the parties no later than three working days after the MHP has received the Appeal.

An Appeal Log is maintained by the Access Unit to monitor the progress and resolution of Appeals.

Following resolution, Appeals are forwarded to the Continuous Quality Improvement Committee (CQIC).

State Fair Hearing Procedure

Beneficiaries who have received a Notice of Action (NOA) may request a State Fair Hearing at any time before, during, or after the action appeal process. In addition, beneficiaries whose requests for Specialty Mental Health Services have been denied by a provider because the provider finds that the service is not medically necessary may file an Appeal with the MHP. If the Action Appeal decision is not

in favor of the beneficiary, the beneficiary may request a State Fair Hearing regarding the denial of service even though he or she did not receive an NOA. The beneficiary has 90 days from the date on which the Notice of Action was postmarked or 90 days from the day on which the Notice of Action was personally given to the beneficiary. The beneficiary may also be eligible to continue receiving services pending the outcome of the State Fair Hearing if the request for a State Fair Hearing is made within 10 days of the date on which the Notice of Action was postmarked or was personally handed to the beneficiary or before the effective date of the change, whichever is later.

The "Fair Hearing Tracking Log" is maintained by the Access Unit to monitor the progress and resolution of each request for a State Fair Hearing.

Information regarding State Fair Hearings is forwarded to the Continuous Quality Improvement Committee (CQIC).

The Access Unit is responsible for coordination with the State Department of Social Services, State Department of Mental Health, providers, and beneficiaries regarding the State Fair Hearing process. The ACCESS Unit also oversees compliance with the State Fair Hearing decisions.

State Fair Hearings may be requested by calling or writing:

Public Inquiry and Response
744 – "P" Street, M.S. 16-23
Sacramento, CA 95814
(800) 952-5253
TDD – (800) 952-8349

Provider Problem Resolution Process

The MHP's provider problem resolution process includes a verbal or complaint process, and a written or grievance process. Providers are encouraged to contact the MHP at the telephone numbers given below to discuss concerns or problems they may be experiencing so that these can be resolved on as simple and informal a basis as possible.

- 1) Providers may appeal a denied, terminated or reduced request for MHP payment authorization for psychiatric inpatient hospital services or for outpatient services. The procedures and timelines for the provider appeals process are outlined below.
- 2) The provider must submit a written appeal to the MHP within 90 calendar days of the date of receipt of the MHP's non-approval of payment or within 90 days of the MHP's failure to act on the provider's request.
- 3) The MHP has 60 calendar days from its receipt of the written appeal to inform the provider in writing of the decision. If the appeal is not granted in full, the provider is notified of any right to submit an appeal to the State Department of Mental Health.
- 4) If the MHP does not respond within 60 calendar days to the provider's appeal, the appeal is considered denied.
- 5) The provider has 30 calendar days from receipt of the MHP's decision to approve the provider's payment authorization request to submit a revised request. In the case of psychiatric inpatient hospital services, the MHP has 14 calendar days from the date of receipt of the provider's revised request to submit the treatment authorization request to the fiscal intermediary for processing.

- 6) When an appeal concerning the denial or modification of a payment authorization request for psychiatric inpatient hospital services in an emergency situation is denied in full or in part by the MHP on the basis that the provider did not comply with required timelines or did not supply documentation which established medical necessity, the provider may appeal to the State Department of Mental Health.
- 7) Providers' appeals of an MHP's denial or modification of a payment authorization must be submitted in writing within 30 calendar days of the date of the MHP's written decision of denial. The provider may appeal to the State Department of Mental Health within 30 calendar days after 60 calendar days from the date of the original submission of the appeal to the MHP if the MHP fails to respond.
- 8) The State Department of Mental Health notifies the MHP and the provider of its receipt of a request for an appeal within seven calendar days.
- 9) The MHP then has 21 days in which to submit requested documentation to the State Department of Mental Health.
- 10) The State Department of Mental Health then has 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP in writing of its decision.
- 11) Finally, the provider has 30 calendar days from receipt of the State Department of Mental Health decision in which to submit a revised request for MHP payment authorization, if applicable. The MHP then has 14 calendar days from receipt of the provider's revised request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

The MHP contact information for provider appeals related to psychiatric inpatient hospital services:

Inpatient Authorization Unit
San Bernardino County Mental Health Plan
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026
Phone – (909) 421-9253
FAX – (909) 873-4441

The MHP contact information for provider appeals related to outpatient services:

ACCESS Unit
San Bernardino County Mental Health Plan
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026
Phone – (888) 743-1478
FAX – (909) 386-0770

PROVIDER SELECTION

Title 9, Chapter 11, Section 1810.310(a)(4)

Hospitals

The San Bernardino County MHP has, in accordance with Section 1810.430(a) of Title 9 of the California Code of Regulations, offered a contract to all hospitals which are either (1) Disproportionate Share Hospitals, and provide services to a disproportionate share of low-income individuals as determined annually by the Department of Health Services, or (2) Traditional hospitals which account for five (5) percent or \$20,000, whichever is more, of the total psychiatric inpatient hospital payments for the MHP's beneficiaries. Contracts are now in place with all of the hospitals which were offered contracts, except for one out-of-County facility, which declined.

Individual Providers

The following steps describe the provider selection process for individual fee-for-service providers:

- 1) Licensed clinicians who express an interest in becoming a fee-for-service provider with the MHP are presented with a credentialing application which must be completed by the candidate.
- 2) The prospective provider must submit a copy of his/her license and malpractice insurance verification.
- 3) The MHP Credentialing Committee reviews the National Practitioners Data Bank information system to obtain information regarding the prospective provider.
- 4) The Credentialing Committee contacts the appropriate California licensing board to verify current licensure and good standing. The Credentialing Committee also completes verification of that providers are not on the Office of Inspector General List of Excluded Individuals/Entities (LEIE), the DHCS Medi-Cal List of Suspended or Ineligible Providers nor the Social Security Administration's Death Master File.
- 5) Providers who are prohibited from federal participation according to the list maintained by the Office of the Inspector General, Department of Health and Human Services, are not accepted or recertified as fee-for-service providers of the MHP.
- 6) The above data is collected, packaged and sent to a credentialing company for review and recommendations. If the credentialing company confirms good standing status for the applicant, the Committee approves the applicant to be a member of the MHP's fee-for-service provider network.
- 7) Once approved, the provider signs a San Bernardino County MHP Provider Service Agreement.
- 8) Each new provider must read the Medi-Cal Fee-for-Service Provider Manual online and sign a training acknowledgement form to place in agency record.
- 9) All providers are maintained and renewed every three (3) years on the basis of their compliance with Title 9 regulations.
- 10) Any changes to the Provider's license or board action must be reported to the MHP within seven (7) days from the date action was reported and a judgment rendered.

NETWORK ADEQUACY

Title 9, Chapter 11, Section 1810.310(a)(5)(A)(B)

DBH conducts Access Studies for all portions of the MHP including Adult Access, Children's Access and Substance Use Disorders. Included in the Access Studies are geographic maps which identify the population density of San Bernardino County residents, Medi-Cal beneficiaries and DBH clients. DBH utilizes the studies of the geographic regions of the county in order to compare the density of Medi-Cal beneficiaries with DBH consumers and ensure that service delivery was located within those regions with the highest density of eligible beneficiaries.

DBH provides a system in which access to behavioral health care is not limited to the first appointment at the clinic/site where client will receive ongoing care. DBH has a sophisticated crisis response network:

- 1) Crisis Walk-In Centers (CWIC) with extended hours and immediate access to a psychiatrist.
- 2) Community Crisis Response Teams (CCRT) who provide mobile response in the field.
- 3) Triage, Engagement, and Support Teams (TEST) with teams which are community based, placed in crucial points of access such as Jail Discharge and Sheriff Stations.
- 4) Recovery Based Engagement Support Team (RBEST) which provide field based case management to link the most difficult to engage beneficiaries with appropriate ongoing treatment.

AGE APPROPRIATE SERVICES

Title 9, Chapter 11, Section 1810.310(a)(6)

Older Adult Population

Outreach to older adult populations is provided through the AGEWISE Program. Services are provided using peer counseling provided by trained senior citizen volunteers. Consultation to agencies working with the elderly is also available through AGEWISE. Older adults in need of mental health services are also identified through local Senior Outreach Teams.

Children

Access for children occurs through DBH outpatient clinics, contract agencies, the fee-for-service provider network, and the Administrative Services Organization (Value Options) for those children who are in out-of-County placements. A full continuum of care is available for youth from screening and early intervention to intensive services provided in the home and community or, if needed, within a residential setting. IPC makes a recommendation regarding support letters for new group homes and changes to current licenses.

Local MHP community clinics provide a full array of outpatient services for children and families throughout the County. The MHP maintains its broad spectrum of County-wide children's services, including Wraparound Services, Residentially Based Services (RBS), Therapeutic Behavioral Services (TBS), the Home and Hospital Intervention Program (HHIP), assistance with interagency out-of-home placement, placement contracts with RCL 12 and 14 group homes, the MHRC level of placement, case management, and intensive outpatient services.

Transitional Age Youth

The MHP has developed programs and services for other special populations, including two programs designed to serve Transitional Age Youth (TAY). The regional TAY One Stop Centers serve individuals age 16 to 25 experiencing mental and/or emotional problems that may be emancipating from: foster care, group homes, the juvenile justice system, or County Jail. The TAY Youth Hostel, a short-term, 14-bed, crisis residential program, provides crisis stabilization services, with particular emphasis on diverse, former system-involved youth. Both TAY programs address the transition domains of employment, educational opportunities, living situations, community life, medication, mental health, physical well-being, drug and alcohol use, trauma, domestic violence, and physical, emotional and sexual abuse, hopefully resulting in greater independence. Services are gender specific, culturally and linguistically appropriate.

CULTURAL COMPETENCY

Title 9, Chapter 11, Section 1810.310(7)

Description of Culturally Competent and Age-Appropriate Services for Beneficiaries

The San Bernardino County MHP has a Cultural Competency Implementation Plan which has been approved by the State Department of Mental Health. The County of San Bernardino, Department of Behavioral Health (DBH) uses National Culturally and Linguistically Appropriate Services (CLAS) Standards, various organization assessment tools, and the Department of Health Care Services' (DHCS) Cultural Competence Plan Requirement (CCPR) to improve outreach efforts and program planning to underserved groups. The DHCS- CCPR requires all County Mental Health Plans (MHP) across the State to develop a Cultural Competence Plan that works toward the development of the most culturally and linguistically competent programs and services to meet the needs of the County's diverse racial, ethnic, and cultural communities in the mental health system of care. The original CCPR (2002) addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) addresses all mental health services and programs throughout the County Mental Health System. Updates are completed for the CCP on an annual basis. The revised CCPR includes the most current resources and standards available in the field of cultural and linguistic competence, and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The CCPR addresses eight domains that include organizational values; policies/procedures/governance; planning/monitoring/evaluation; communication; human resource development; community and beneficiary participation; facilitation of a broad service array; and organizational resources. The MHP continually uses the Cultural Competence Plan for the development and improvement of outreach efforts and programs for underserved groups. Efforts outlined in the plan include:

- 1) Commitment to Cultural Competence and Humility;
- 2) Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic mental health disparities;
- 3) Culturally Competent Training Activities;
- 4) Language Capacity; and
- 5) Community-based outreach/engagement strategies to increase delivery of services to underserved populations

The MHP also has a community-driven Cultural Competency Advisory Committee (CCAC) with twelve (12) subcommittees. The CCAC and its subcommittees were instrumental in developing the original Cultural Competence Plan and are involved in all subsequent updates to the plan.

The MHP continually uses the Cultural Competence Plan for the development and improvement of outreach efforts and programs for underserved groups. An example of efforts under this plan include the development of behavioral health programs within already existing community health organizations targeted at serving specific underserved and cultural groups. DBH will also be coordinating ongoing educational forums to increase mental health awareness and provide informational materials in preferred languages spoken in specific communities.

These advisory groups engage in outreach activities by recruiting members of the community to attend scheduled forums to address the needs of their community and develop strategies to address those needs. This community outreach and engagement approach assists the MHP in producing a plan that is

community driven, informed and developed. Also, these advisory groups are not only involved in the development of updates to the plan but are also involved in the implementation of the updated plan.

The following are the names of the community-driven CCAC subcommittees/coalitions:

- 1) Asian/Pacific Islander (API) Awareness Subcommittee
- 2) Co-Occurring and Substance Abuse Awareness Subcommittee (COSAC)
- 3) Disabilities Awareness Subcommittee
- 4) African American Awareness Subcommittee
- 5) Latino Awareness Subcommittee
- 6) Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Awareness Subcommittee
- 7) Native American Awareness Subcommittee
- 8) Spirituality Awareness Subcommittee
- 9) Transitional Age Youth (TAY) Awareness Subcommittee
- 10) Veterans Awareness Subcommittee
- 11) Women Awareness Subcommittee
- 12) Consumer and Family Members Awareness Subcommittee

Below are examples of Cultural Specific Programs provided by the MHP:

Promotores de Salud Mental and Community Health Workers

Community-based volunteers providing culturally/linguistically appropriate mental health education and resource/referral to Latino, African American, API, Native American and LGBTQ populations.

Resilience Promotion in African American Children Services Program

School based and community based program serving African American children and their families. This program utilizes the Peacemakers and Effective Black Parenting curricula.

Native American Resource Center

Serves all age groups within the local Native American Indian communities and provides a variety of behavioral health services and programs in natural settings.

Asian and Pacific Islander Pilot Program

Behavioral Health Awareness Program aims to serve the API communities services are provided in Vietnamese, Cambodian, and Tagalog. The goal of the program is to increase awareness, reduce stigma and increase access to behavioral health services.

The MHP's Cultural Competency Plan has detailed analysis of the following: penetration dynamics, language needs assessment, diagnostic parameters, outreach strategies, education needs, resource availability and constraints, population trends, quality improvement strategies, and budgetary considerations. All of these elements serve as a stage for continued development and implementation of cultural competence proficiency, which is a work in progress.

Providers are challenged to plan, develop and implement an inclusive, accessible and relevant system of care for beneficiaries of diverse populations, which provide culturally and linguistically appropriate services.

It should be noted that an age appropriate and culturally competent system of care emphasizes the importance of age, culture, acculturation, language, gender/gender identity and cultural values in the service delivery system. Age appropriate services and cultural competence are integrated into all aspects of the MHP implementation and evaluation process. The MHP's capacity to provide culturally competent services relies on the following:

- 1) Multilingual and multicultural staff (recruitment/retention)
- 2) Responsive community outreach and education
- 3) Staff development/training in cultural diversity, geriatric and children's service
- 4) Development, implementation, and utilization of cultural/age competency assessments for providers with annual review
- 5) Collection and analysis of patient data, including penetration rates for diverse populations
- 6) Culturally appropriate program design
- 7) Identification of, and outreach to, resources currently used by both populations
- 8) Availability of grievance procedures, medications, and treatment information in the beneficiary's primary language

ADMISSIONS TO NON-CONTRACTED HOSPITALS

Title 9, Chapter 11, Section 1810.310(a)(8)

For planned admissions to non-contract hospitals, the following must be submitted to the MHP's Medical Director or designee; within 14 days of discharge:

- 1) A written request for MHP payment authorization
- 2) Supporting documentation indicating that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services
- 3) A statement describing the need for the planned admission

QUALITY IMPROVEMENT PROGRAM

Title 9, Chapter 11, Section 1810.310(a)(9)

The San Bernardino County MHP Quality Improvement Program is accountable to the Director of Behavioral Health. The QIP is overseen by the Quality Management Action Committee (QMAC), which meets monthly. The QIPP is the Quality Improvement Work Plan for the Quality Management Division (QMD) of DBH. The QIPP meets the contractual requirements of the Mental Health Plan Contract with DHCS as well as additional areas of performance improvement as identified by California External Quality Review Organization (CAEQRO), the County Business Plan, and DBH Strategic Plan. The QMD is accountable to the DBH Director and is responsible for ensuring that the QIPP is evaluated annually and updated as necessary.

The QMD conducts performance-monitoring activities throughout the MHP's operations. These monitoring activities are designed to improve the access, quality of care, and outcomes of the DBH service delivery system. The QIPP has been organized into sections which relate to structure, implementation, and quantitatively measurable outcomes used to assess performance and to identify and prioritize areas for improvement. Outlined throughout the QIPP are the goals, objectives, and outcomes for key areas that have been identified in the MHP. They include access to service, service delivery capacity, beneficiary satisfaction, technology infrastructure, clinical issues, previously identified issues, provider appeals, continuity of care, and integration with physical health care.

MHP practitioners, providers, consumers, and family members actively participate in QMD activities.

Committee Composition

The Quality Management Action Committee is composed of a multidisciplinary team, including psychiatrists, psychologists, psychiatric social workers, marriage and family therapists, and nurses. Moreover, it also includes a representation from a family or beneficiary. QMAC members are representative of the entire MHP system of care and include regional programs, medical services, administrative services, substance use disorder services, workforce/education, compliance, research/evaluation and cultural competency office.

Committee Functioning and Meeting Frequency

The Quality Management Action Committee functions as the coordinator of any Quality Improvement subcommittees. It implements both MHP PIP's, QIPP and oversees the activities of any subcommittees. It also recommends policy, reviews chart documentation standards and insures follow-up of the quality improvement process.

Workgroups/Subcommittees

The committees may create workgroups or subcommittees as necessary. These special work groups will be task-specific and include staff, beneficiaries and providers, as appropriate. All committees meet on a monthly basis, but may meet more frequently, or as needed, to complete actions. Dated and signed minutes and sign in sheets reflect all quality improvement committee decisions and actions.

The MHP works closely with the San Bernardino County Behavioral Health Commission, which is composed of diverse providers, consumers and family members in the development of the implementation plan and quality improvement process. Moreover, input from this group is included in the development of the outcome measures for the quality improvement system. Beneficiary input is included in the development of outcome measures for the quality improvement system. The

Behavioral Health Commission is active in the planning process, and has input into the quality improvement plan.

The MHP solicits information from diverse providers, beneficiaries and family members by means of questionnaires and satisfaction surveys (available in both English and Spanish) on a regular basis. The regularly scheduled tools are the California Consumer Perception Survey, Life Satisfaction Survey, and annual CAEQRO focus groups. Additionally questionnaires and surveys are administered on an as-needed basis throughout the year. A variety of outcomes measures implemented across our system also gather feedback directly from beneficiaries and family members in order to directly impact treatment planning. Examples include the Child and Adolescent Needs and Strengths (CANS), Behavior and Symptom Identification Scale (BASIS-24), and Addiction Severity Index (ASI). The questionnaires include items concerning quality of care issues to determine consumer perceptions and levels of satisfaction with available services and suggestions for improvement. The MHP uses the results of these surveys to make improvements in the provision of services as appropriate so these groups have input into the continuous quality improvement processes.

Delegation

The MHP does not delegate any quality improvement activities to a separate entity.

Plan Submissions

The MHP submits annual Quality Improvement Work Plans as required.

UTILIZATION MANAGEMENT PROGRAM

Authorization Process For Services Provided Through the Fee For-Service Provider Network

The MHP's Access Unit is responsible for preauthorizing all non-emergency Tier III outpatient Specialty Mental Health Services for San Bernardino County Medi-Cal beneficiaries who receive services through the Fee-For-Service provider network. Beneficiaries without currently approved network services from the MHP are required to contact the Access Unit or one of the Fee-For-Service providers for a screening of their service needs.

Following the initial assessment, which does not require preauthorization, the beneficiary's provider submits a Treatment Authorization Request (TAR) to the Access Unit for authorization of additional SMHS services. The TAR is reviewed for medical necessity criteria by a licensed/waivered/registered member of the Access Unit. Upon receipt of an approved TAR, the Fee-For-Service provider may initiate treatment services until the TAR service period expires or the pre-approved number of sessions has been exhausted. If these service contacts are sufficient to resolve the presenting problem, the provider closes the episode and submits to the MHP the required treatment documentation along with all relevant claims information. If these contacts are not sufficient, the provider must submit a new TAR requesting reauthorization of services.

Reauthorizations are processed by following the same steps for review as the initial authorization. In the case of reauthorizations, Access Unit staff also alert to the potential that the beneficiary may require a higher complexity of service delivery than the Fee-For-Service provider can supply and, if this is determined, additional services and/or transition to more complex care, is coordinated at this time.

In the event of an Access Unit modification or denial, the appropriate Notice of Action is issued.

Authorization Process For Day Treatment Services Provided Through DBH Clinics/Contract Agencies

When a DBH or contract agency indicates a desire to establish day treatment services for the beneficiary, a treatment authorization request (TAR) must be submitted to the Access Unit.

- 1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week;
- 2) At least every three months for continuation of day treatment intensive.
- 3) At least every six months for continuation of day rehabilitation.
- 4) Access unit shall also require providers to request authorization for mental health services, as defined in California Code of Regulations, Title 9, Section 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in California Code of Regulations, Title 9, Section 1810.216 and Section 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.

DBH does not delegate the payment authorization function to providers.

When DBH is the day treatment intensive or day rehabilitation provider, DBH assures that the payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.

In the event of an Access Unit modification or denial, the appropriate Notice of Action is issued.

CONFIDENTIALITY

Title 9, Chapter 11, Section 1810.310(a)(10)

The MHP has guidelines, standard operating policies and procedures designed to protect beneficiary confidentiality and privacy, all of which are in accordance with HIPAA requirements. Notice of Privacy Practices is provided to all beneficiaries to inform them about their rights.

A Code of Conduct policy has been created to provide guidance to all members of the MHP workforce and contract agency staff to recognize and deal with ethical issues including areas of confidentiality. The MHP also provides a Compliance Hotline which allows individuals to report any activity which may violate confidentiality rights of beneficiaries.

The MHP's Quality Management Division and Compliance Division conduct audits to ensure compliance with established Federal and State laws and regulations.