Siskiyou County
Behavioral Health Division
Specialty Mental Health Services
Implementation Plan Update

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The Implementation Plan is required by CCR Title 9, Chapter 11, §1810.310. In accordance with § 1810.310(c)(1), a 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.

INTRODUCTION AND OVERVIEW

SISKIYOU COUNTY HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH DIVISION

The Siskiyou County Health and Human Services Agency Behavioral Health Division (BHD), also referred in this document as the County Mental Health Plan (MHP), has a Mission to promote the prevention of and recovery from mental illness and substance abuse for Siskiyou County individuals, families, and communities by providing accessible, caring, inclusive, and culturally respectful services.

The MHP's core values include the following:

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

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

1. Maintain accurate and reliable demographic and service-level data to measure and evaluate the impact of services and outcomes. The MHP expects leadership to promote equity of services through culturally responsive policies, practices, and procedures.
2. Expand the behavioral health workforce by recruiting, promoting, training, and supporting culturally and linguistically diverse leadership and expanding the workforce to include consumers and family members to create a better response for the needs of the community.
3. Provide culturally and linguistically appropriate behavioral health services, in an easy-to-understand written format., as well as the Medi-Cal Manual in audio (English only). If needed, language assistance is available at no cost to the consumer. The MHP provides face to face translation services, as well as contracting with the AT&T Language Line to provide this no- cost service to our non-English speakers.
4. Improve access for all racial, ethnic, and cultural groups, including Hispanic, and Native American populations, Transitional Age Youth (TAY), older adults, veterans, LGBTQIA2-S individuals, persons released from jail, homeless individuals, foster care children, and consumer family members.
5. Provide at least two culturally informed trainings per fiscal year for behavioral health staff, contractors, and collaborative community partners.
6. Deliver behavioral health services, including outreach and education, throughout Siskiyou County in collaboration with other community partners and co-locating services whenever possible, including in diverse community settings known to serve Hispanic and Native populations in the least restrictive environment.

7. Increase the proportion of persons who reflect the diversity of the county by expanding membership for the Quality Improvement Committee (QIC), the Cultural and Linguistic Competence Committee (CLCC), and other committees.
8. Hold personnel and contractors responsible for showing sensitivity to cultural and ethnic differences to ensure that clients and co-workers feel welcome, safe, understood, and respected at the MHP.

Siskiyou County Geography

Siskiyou County is a geographically large, rural frontier county with a population of approximately 44,076 persons (based on 2020 US Census data), located in the Shasta Cascade region of Northern California. Approximately 6400 square miles in size, Siskiyou County is geographically diverse with lakes, dense forests, desert, and mountainous terrain. The county seat, Yreka, is located on I-5 approximately 20 minutes south of the Oregon border; however, access to the majority of towns and cities is primarily by two-lane road, with minimal public transportation to outlying areas in east county (the Butte Valley area) and west county (down Klamath River toward Happy Camp).

Geography and distance play important roles in determining service delivery. Siskiyou County does not have a central urban area but has a few towns along the main travel corridor of Interstate 5 and multiple small communities dispersed across the remaining 6300 square miles of the county. Only nine cities are incorporated. The county's public transportation system operates buses connecting the more populated areas; however, due to long distances, trips may be limited to once a day and in outlying areas may be limited to once a week. The primary Siskiyou County Behavioral Health clinic is located in Yreka and a smaller satellite clinic is located in Mt. Shasta, the second-largest city in the county.

The current make-up of Siskiyou County differs significantly from that of many California counties in that it is less racially and ethnically diverse with the significant majority of inhabitants identifying as Caucasian (74%) followed by Hispanic (14%), Native American/Alaskan Native (5%), Asian/Pacific Islander (2%), and African American/Black (1.5%). From the 2010 to 2020 census, the Caucasian group reduced by five percentage points (79% to 74%) and the Hispanic group increased from 10% to 14%.

The county has a large population of Spanish speakers who reside in the eastern portion of the county, and Spanish is identified as the threshold language. The per capita income for all residents in 2020 was $29,563 (U.S. Census 2020 Inflation-Adjusted Dollars) in comparison to a statewide per capita income during that period of $41,276. The median household income in Siskiyou County was $49,857 compared to $84,097 statewide. Ninety percent of Siskiyou County residents have earned a high school degree and 21.5% have obtained a Bachelor's degree or higher. Approximately 16.8% of residents live at or below the poverty line.

Services Provided

The MHP provides or coordinates outpatient mental health services and contracts with outside providers to deliver outpatient and inpatient treatment services. The MHP directly provides the following services:

- Rehabilitative mental health services include assessment, plan development, individual, group, and family therapy, rehabilitation services, individual and group, and collateral services.

- Medication support services include assessment of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education, collateral services, and plan development.
- Crisis intervention services include assessment, therapy (individual and/or collateral), and referral services.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services include assessment, plan development and treatment through mental health services, medication support services, crisis intervention services, Therapeutic Behavioral Services (TBS); Intensive Care Coordination (ICC); and Intensive Home-Based Services (IHBS).

The MHP has designed its intake and authorization process to ensure timely access to the system and appropriate utilization of services. When services are requested, the MHP schedules psychiatric services no later than 15 business days of the request date and non-psychiatric services are scheduled no later than 10 business days of the request date.

Behavioral Health Division Programs

The MHP mental health services program is comprised of Children's and TAY Services (serving clients ages 0-20), and Adult Services (serving clients ages 18 and older). Services are delivered in the community through satellite offices staffed by the MHP, via contracted providers, family resource centers, and at two clinics located in north and south Siskiyou County.

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

Children's and TAY Services

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

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

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

The MHP identified its FFPSA team in October 2021. This team is comprised of a QI, a Wraparound Coordinator, and a FFPSA Supervisor. In addition, the MHP updated bill coding, which will assist with data reporting, and will add the electronic copy of the QI Assessment and Report into the Electronic Health Record (EHR).

Family Urgent Response System (FURS) services were fully implemented in fiscal year 20-21. FURS services are available to current and former foster youth, and their caregivers, to reduce the potential for placement disruption, family discord, and crisis evaluation/hospitalization. Youth or their caregivers can contact the FURS Hotline and receive an immediate in-person response from provider agencies. The mobile response team is comprised of Siskiyou County staff from Behavioral Health, Child Welfare Services (CWS), and Probation. Each agency provides a lead that rotates responding to after-hours calls, attempts to deescalate situations, and dispatches the team for face-to-face intervention whenever necessary.

Adult Services

Adult clients are provided a behavioral health assessment, wellness and recovery-oriented individual therapy, rehabilitation, and case management services as appropriate. The Adult System of Care Department successfully concluded the Integrated Care Innovation Project, and the MHP embedded a Whole Person Care philosophy throughout the agency. A mental health wellness program is available through a contracted service provider to clients and consumers in the community as part of the mental health plan's continuum of care.

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

The MHP fully implemented Mental Health Diversion pursuant to Penal Code Section 1001.36. This is a court-supervised treatment program for mentally ill adult offenders whose mental illness was a contributing factor in their offense. The program is provided in partnership with the Superior Court, Public Defender, District Attorney, and the Probation Department.

In January 2020, the MHP joined a 4.5-year Multi-County Full Service Partnership (FSP) Innovation Project designed to improve FSP outcomes. In collaboration with cohort counties, the MHP is endeavoring to increase consistency, address the wide variety of needs among FSP participants, and help clients set SMART goals. The MHP trained staff in the evidenced based practice of Strengths-Based Case Management to better address FSP clients' needs and support them in working toward active graduation to a more stable and independent life. A third-party evaluator will study the impact of these changes on staff, county, and FSP clients over the next 2.5 years.

In 2021, the MHP began working with stakeholders to implement Assisted Outpatient Treatment (AOT). AOT is sustained and intensive court-ordered treatment in the community for those most overcome by the symptoms of severe mental illness. The treatment mechanism is only used until a person is well enough to maintain their own treatment regimen. The program provides a bridge to recovery for those released from inpatient facilities, it can be an alternative to hospitalization, and stops the repeated use of emergency department visits, incarceration, and homelessness.

ORGANIZATIONAL CHART

The following organizational chart of the Siskiyou County Health and Human Services Agency, Behavioral Health Division shows the governance structure and reporting relationships of the Executive Group, managers, operational leads and program staff:

HEALTH AND HUMAN SERVICES AGENCY (HHSA) ORGANIZATION CHART

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SUD

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Loraine Wisler C AODC II
Thomas Bains C AODC I
Joshua Lagrange C AODC I
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VACANT C AODC II
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CSOC

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Diana Barton BHS II
Kariel Pickens BH Specialist I
Jacquiline Swain BH Specialist II EH
Sarabecca Barnett BH Specialist I EH
VACANT CL IV
VACANT CL III
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VACANT CL I

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Kim Romero BHS CW II
Jay Levie BHS CW II
Amanda Mathie BHS II
Samantha Schlieter BHS II
Vincent Lown BHS II
Sierra Smith BHS I
Joseph Mott BHS I
Steven Stott BHS I
Tina Wilcox BHS I
Krystl Harkins BHS I
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Elvia Amezcua EH CL II
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VACANT CL IV
VACANT CL III
VACANT CL III
VACANT CL III

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Paloma Saldana CL II
Amanda Reiber BHS I
Julie Butler EH CL I
Quincy Tatum EH CL I
VACANT CL III
VACANT CL III

Peer Specialists

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Elke Head BH Peer Specialist EH
Adamine Harms BH Peer Specialist EH
VACANT EH Peer Specialist XBPS01

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Rae Ellen Bendix Driver
Janice Tenns Driver

MHSSA

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Andrea Ryder Psych Aide SPSA01
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Elizabeth Zandona LVN EH XLVN03
VACANT Psych Aide SPSA02
VACANT EH BHN II X2BN02

TOTAL: 91

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VACANT Clin III
VACANT EH Clin II
VACANT EH Clin III
VACANT EH Clin III
VACANT SSA III

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VACANT FT II

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Office of
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Amy Hippler

Office of
Public Administrator

Karen Goyeneche

Office of
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TOTAL: 127

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VACANT ETW II
VACANT SSA III
VACANT HS SUPERVISOR
VACANT HS SUPERVISOR
VACANT ETW III

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Susan Hamdan SW III EH
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VACANT SW III

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IMPLEMENTATION PLAN CONTEXT AND PURPOSE

As required by the California Code of Regulations, Title 9, Chapter 11, § 1810.310, each Mental Health Plan (MHP) must submit an Implementation Plan in order to be designated as a 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 clients 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 will submit proposed changes to its approved Implementation Plan in writing to the Department for review." Furthermore, § 1810.310(c)(1) requires that "An MHP will 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 will 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 clients and providers regarding access under the MHP.
    (C) Assuring continuity of care for clients receiving specialty mental health services prior to the date the entity begins operation as the MHP.
    (D) Providing clinical consultation and training to clients' 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 §§ 1810.425 and 1810.435. The entity designated to be the MHP will include a Request for Exemption from Contracting in accordance with § 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH (Disproportionate Share Hospital).
(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 clients 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 clients that will be served by the MHP.
(6) A description of how the MHP will deliver age-appropriate services to clients.
(7) The proposed Cultural Competence Plan as described in § 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 § 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 client confidentiality in compliance with State and Federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to clients.
(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to clients as described in this Chapter.

The Siskiyou County Behavioral Health Division 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 will be approved by the Department.
(4) The Department will 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.

IMPLEMENTATION PLAN UPDATE

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

Requirements Applicable to Authorization of All Specialty Mental Health Services

The Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the Specialty Mental Health Services (SMHS) requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary for reasons related to medical necessity. BHD shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary.

A decision to modify an authorization request will be provided to the treating provider(s), initially by telephone, portal or facsimile, and then in writing, and will include a clear and concise explanation of the reasons for the BHD's or its designee's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision will also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision. If BHD or its designee modifies or denies an authorization request, BHD or its designee will notify the beneficiary in writing of the adverse benefit determination. The notice to the beneficiary will meet the requirements pertaining to notices of adverse benefit determinations (NOABDs).

BHD or its designee will notify the requesting provider in writing and give the beneficiary written notice of any decision by BHD or its designee to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the beneficiary will meet the requirements pertaining to NOABDs.

The BHD and its designee has mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate.

BHD and its designee will also comply with the following requirements:

- Notify the Department of Health Care Services (DHCS) and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
- Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization;
- Prior authorization or BHD referral is required for the following services:
    - Intensive Home-Based Services
    - Day Treatment Intensive
    - Day Rehabilitation

    - Therapeutic Behavioral Services
    - Therapeutic Foster Care
- No prior authorization will be required for mental health assessment services, nor for outpatient services other than those services listed above. See “Prior Authorization or BHD Referral for Outpatient SMHS” below.
- Disclose to DHCS, organizational providers, beneficiaries and members of the public, upon request, the utilization management or utilization review policies and procedures that BHD or its designee use to authorize, modify, or deny SMHS. These policies and procedures shall be available through electronic communication means by posting them online;
- Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

Compensation to individuals or entities that conduct utilization management activities are not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

All BHD authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42, Code of Federal Regulations (CFR), part 438.910.

Point of Authorization for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services

Payment authorization for Acute Psychiatric Inpatient Hospital and Psychiatric Health Facility (PHF) services occurs through a Point of Authorization (POA). In accordance with Title 9, California Code of Regulations (CCR) § 1820.220, BHD has designated a POA where psychiatric inpatient hospitals and PHFs submit written requests for MHP payment authorizations for services provided to Siskiyou County clients. The contact information for the BHD POA is:

Siskiyou County Behavioral Health
2060 Campus Drive
Yreka, CA 96097-3321
Phone (530) 841-4100
1-800-842-8979 Evenings
Fax (530) 841-2790

Requirements Applicable to Authorization of Inpatient SMHS

BHD will ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate. BHD may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the Mental Health Plan (MHP) Contract with DHCS for specialty mental health services.

Also, please refer above to "Requirements Applicable to Authorization of all SMHS" above, which also apply to authorization of Inpatient SMHS.

Concurrent Review for Psychiatric Inpatient Hospital/Psychiatric Health Facility (PHF) Services

The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities (PHFs) certified by DHCS as Medi-Cal providers of inpatient hospital services. General acute care hospitals, psychiatric hospitals and PHFs are collectively referred to as "hospital or PHF" in the procedures below. This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, these requirements supersede California Code of Regulations, Title 9, Sections 1820.215, 1820.220, 1820.225 and 1820.230.

MHPs (including BHD), hospitals, and PHFs are required to exchange protected health information by any method compliant with the Health Insurance Portability and Accountability Act (HIPAA) and agreed upon by both parties to the exchange, which may include fax, portal, telephone and electronic transmission. BHD or its designee will consult with the beneficiary's treating provider as appropriate. While reviewing an authorization request, BHD or its designee may communicate with the treating provider and the treating provider may adjust the authorization request prior to BHD or its designee rendering a formal decision regarding the authorization request.

I. Admission and Authorization

A. Notification of beneficiary admission and request for treatment authorization

BHD or its designee will maintain portal access to receive admission notifications and initial authorization requests 24-hours a day and 7 days a week. Within 24 hours of admission of a Siskiyou County Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital or PHF is required to provide BHD or its designee the beneficiary's admission orders, initial plan of care, a request to authorize the beneficiary's treatment, and a completed face sheet. The face sheet must include the following information (if available):

- Hospital name and address
- Patient name and DOB
- Insurance coverage
- Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System (MEDS)
- Current address/place of residence
- Date and time of admission
- Working (provisional) diagnosis
- Date and time of admission
- Name and contact information of admitting, qualified and licensed practitioner
- Utilization review staff contact information

If, upon admission, a beneficiary is in a psychiatric emergency medical condition, as defined in Health & Safety Code section 1317.1(k), the time period for the

hospital to request authorization shall begin when the beneficiary's condition is stabilized, as defined in Health & Safety Code section 1317. l G). For emergency care, no prior authorization is required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

B. Review of initial authorization request

BHD or its designee will decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in I.A. above. BHD or its designee will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.

II. Continued Stay Authorization

A. Continued Stay Authorization Request

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF must submit a continued-stay- authorization request for a specified number of days to BHD or its designee.

B. Exchange of information between hospital or PHF and BHD or its designee

The treating provider at the hospital or PHF may request information and records from BHD or its designee needed to determine the appropriate length of stay for the beneficiary. BHD or its designee may request only information from the hospital and treating provider that is reasonably necessary to decide whether to grant, modify or deny the request. The exchange of information is intended to occur flexibly, with MHPs and hospitals exchanging relevant client and clinical information as needed to complete concurrent review procedures and for discharge planning and aftercare support.

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self- harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after the BHD or its designee admission notice.
- Known treatment history as it relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.

- BHD information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use disorder (SUD) information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.
- Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested.

C. Review of Continued Stay Authorization Request

BHD or its designee will issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.

BHD remains responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph 1 or 2 have been met:

1. The existing treatment authorization expires and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by BHD or its designee and the beneficiary's treating provider; or,
2. BHD or its designee denies a hospital's continued stay authorization request and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by BHD or its designee and the beneficiary's treating provider.

III. Adverse Decision, Clinical Consultation, Plan of Care, and Appeal

A. While Licensed Mental Health Practitioners (LMHPs) I Licensed Practitioners of the Healing Arts (LPHAs) may review authorization requests and issue approvals within their scope of practice, all BHD's or its designee's decisions to modify or deny a treatment request must be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs. A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for

authorization for treatment consistent within the psychologist's scope of practice.

B. A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for BHD's or designee's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.

C. If BHD or its designee modifies or denies an authorization request, BHD or its designee will notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.

D. If BHD or its designee denies a hospital's authorization request, BHD or its designee will work with the treating provider to develop a plan of care. Services and payment for services may not be discontinued until the beneficiary's treating provider(s) has been notified of BHD's or its designee's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health needs of the beneficiary. If BHD or its designee and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to BHD or its designee, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from BHD or its designee.

E. The BHD or its designee's denial of an authorization request and consultation between the treating provider and BHD or its designee may result in one of the following outcomes:
   - BHD or its designee and the hospital treating provider agree that the beneficiary shall continue inpatient treatment at the acute level of care, and the denial is reversed.
   - BHD or its designee and the hospital treating provider agree to discharge the beneficiary from the acute level of care and a plan of care is established prior to the beneficiary transitioning services to another level of care.
   - BHD or its designee and the hospital treating provider agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down facility bed is not available and the beneficiary remains in the hospital on administrative day level of care.
   - BHD or its designee and the treating hospital provider do not agree on a plan of care and the beneficiary, or the treating provider on behalf of the beneficiary, appeals the decision to BHD or its designee.

Authorizing Administrative Days

Hospitals/PHFs may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services, but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for administrative day services, BHD or its designee shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (excepting weekends and holidays). Once five contacts have been made and documented, any remaining days within a seven-consecutive- day period from the day the beneficiary is placed on administrative status may be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

BHD or its designee may waive the five contacts per week requirement if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options. The lack of available treatment facilities and the contacts made to appropriate facilities shall be documented and include:

- Status of placement
- Date of contact
- Signature of person making contact

Examples of appropriate placement status options include, but may not be limited to:

- The beneficiary's information packet is under review;
- An interview with the beneficiary has been scheduled for (date);
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a wait list;
- The beneficiary has been accepted and will be discharged to a facility on (date);
- The beneficiary has been rejected from a facility due to (reason); and/or,
- A conservator deems the facility to be inappropriate for placement.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services

BHD does not require prior authorization for Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Authorization for CRTS and ARTS must be by referral and/or concurrent review.

If BHD refers a beneficiary to a facility for CRTS or ARTS, the referring LPHA will complete the CR/AR Services Form and specify the number of days authorized. The referral will serve as the initial authorization. BHD or its designee shall then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

If BHD does not initiate the referral for CRTS or ARTS, BHD or its designee shall conduct concurrent review of treatment authorizations following the first day of admission to the

facility through discharge. BHD or its designee may elect to authorize multiple days as long as the services are medically necessary.

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries will be communicated to the beneficiary's treating provider within 24 hours of the decision and care will not be discontinued until the beneficiary's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. If BHD or its designee denies or modifies the request for authorization, BHD will notify the beneficiary, in writing, of the adverse benefit determination. In cases where BHD determines that care should be terminated (no longer authorized) or reduced, BHD must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Prior Authorization or BHD Referral for Outpatient SMHS

BHD will not require prior authorization for the following services/service activities:

- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services, including initial assessment;
- Targeted Case Management;
- Intensive Care Coordination;
- Peer Support Service; and,
- Medication Support Services.

As a regular practice, assessments are conducted by BHD's clinical staff. BHD will not require prior authorization in the event that an organizational provider conducts an assessment; however, prior to the commencement of services, BHD's Quality Assurance Manager (QAM) or designee will review and approve the beneficiaries' completed assessment and Problem List. Assessments and Problem Lists completed by organizational providers may be faxed to 530-841-4799.

BHD requires prior authorization or referral for the following services:

- Intensive Home-Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

For purposes of prior authorization, referral by BHD to a contracted provider is considered to serve the same function as approving a request for authorization submitted by a provider or beneficiary.

Initial authorization for these services will be provided by referral on the Service Authorization Request (SAR) form and shall specify the amount, scope and duration of the treatment BHD has authorized. All authorizations will be completed by an LPHA. Prior to the expiration of the initial referral, BHD requires organizational providers to request payment authorization for the continuation of services at the following intervals:

- Every month

    - Day Treatment Intensive
    - Therapeutic Behavioral Services
    - Therapeutic Foster Care
- Every six months
    - Intensive Home-Based Services
    - Day Rehabilitation

BHD shall document all authorization determinations on the SAR Log.

If BHD denies or modifies an authorization request, notification will be given to the beneficiary, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow guidelines outlined in BHD Policy and Procedure ADMIN 15-01.

Outpatient Authorization Timeframe

BHD shall review and make authorization determinations regarding provider request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the receipt of the information reasonably necessary and requested by BHD to make the determination. In cases where BHD or the provider determine that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receipt of the request for service.

BHD may extend the timeframe for making an authorization decision for up to 14 additional calendar days if the following conditions are met:

- The beneficiary, or the provider, request an extension; or
- BHD justifies (to DHCS upon request), and documents a need for additional information and how the extension is in the beneficiary's best interest.

The BHD referral or prior authorization will specify the amount, scope, and duration of treatment that BHD has authorized. BHD will document its determinations of whether a service requires BHD referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If BHD or its designee denies or modifies the request for authorization, BHD or its designee will notify the beneficiary, in writing, of the adverse benefit determination. In cases where BHD terminates, reduces, or suspends a previously authorized service, BHD will notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services. The beneficiary's notice will meet the requirements to notify beneficiaries of an adverse benefit determination.

Retrospective Authorization Requirements

BHD's QAM or designee conducts retrospective authorization of inpatient and outpatient SMHS under the following circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;

- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries, and/or,
- Beneficiary's failure to identify payer.

BHD communicates retrospective authorizations decisions to the individual who received the services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination in a manner consistent with state requirements.

Utilization Review

BHD conducts utilization review and/or auditing activities in accordance with state and federal requirements, and may disallow claims and/or recoup funds, as appropriate, in accordance with BHD's obligations to DHCS.

Ongoing Monitoring Requirements

MHPs are responsible for demonstrating ongoing compliance with the Parity Rule and Behavioral Health Information Notices (BHINs) 22-016 and 22-017. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements upon request by DHCS and during compliance reviews and/or External Quality Review Organization reviews of each MHP.

If, at any time, DHCS determines BHD to be out of compliance with requirements outlined in BHINs 22-016 and 22-017, BHD will be required to submit a Plan of Correction, as well as evidence of correction, to DHCS.

Out of County Services for Children and Youth

Regarding the provision of and the authorization of services for Foster Care children, KinGAP youth or Aid to Adoptive Parents (AAP) adoptees residing outside his or her county of origin, it is the policy of BHD to follow and adhere to the rules and processes defined in the Department of Health Care Services (DHCS) Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices 17-032 and 18-027, Senate Bill (SB) 785 and Department of Mental Health (DMH) Information Letter 09-06, as follows.

I. Medi-Cal Eligible Children in a Foster Care Aid Code - Presumptive Transfer

Presumptive transfer means a prompt transfer of the responsibility for providing or arranging and paying for SMHS from the county of original jurisdiction to the county in which the foster child or youth resides. Presumptive transfer is intended to provide children and youth in foster care who are placed outside their counties of original jurisdiction timely access to SMHS, consistent with their individual strengths and needs, and Medicaid EPSDT requirements.

BHD shall provide Medi-Cal SMHS to foster children upon presumptive transfer to BHD from the MHP in the county of original jurisdiction without any delay in timeliness. Upon presumptive transfer, BHD shall assume responsibility for the authorization and provision of SMHS, and the payment for services, within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction unless a waiver based on an exception to presumptive transfer exists, based on DHCS MHSUDS Information Notices No. 17-032 and 18-027.

For any foster child who is placed by a placing agency out of the county of original, the responsibility to provide or arrange for the provision of and payment for SMHS will transfer to the county of residence.

A. Expedited Transfers
    1. In situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, BHD will provide SMHS immediately, and without prior authorization.
    2. There may be instances when a child or youth must be moved to a new placement outside of the county of original jurisdiction for his or her safety and a Child and Family Team (CFT) meeting is unable to be convened prior to placement. In these instances, the county placing agency must immediately contact the MHP in the county of residence to notify the MHP of the placement and the need to provide or arrange and pay for SMHS to meet the needs of the child or youth. Counties may use the presumptive transfer county points of contact list on this webpage: http://www.cdss.ca.gov/County-Offices to assist with the expedited transfer of SMHS.

B. Presumptive Transfer and the Child and Family Team Process
    1. Presumptive transfer must be discussed by the CFT in situations in which a child or youth is to be placed outside the county of original jurisdiction. The use of an effective CFT process is especially important when an out of county placement is being considered, and is the primary vehicle for coordinating care. The CFT process can help families develop and maintain respectful, trusting relationships that can, over time, lead to greater stability and improved outcomes. In the context of presumptive transfer, the CFT process informs placement decisions, as well as the child or youth's foster care case plan, and mental health treatment plan. If an out of county placement occurs and SMHS are presumptively transferred to the county of residence, the SMHS provider(s) from the county of residence MHP becomes part of the child or youth's CFT.
    2. An effective CFT process allows the child or youth and families to actively participate in case planning, and may over time lead to an increase in positive outcomes, including improvements in placement stability. The CFT process represents an opportunity to mitigate the negative impacts a change in placement can have on a foster child or youth and his or her family. The CFT strives for permanency with the foster child or youth's own family or other resource families. As such, the CFT will develop a plan for the foster child or youth to return to his or her community with clear milestones, goals, and timelines, when appropriate. The plan will consider the desired outcomes for the foster child or youth, including keeping the foster child or youth connected to relationships in the county of original jurisdiction if and when appropriate.

II. Exceptions to Presumptive Transfer

A. The foster child, the person or agency responsible for making the mental health care decisions on behalf of the foster child, the county probation agency or the child welfare services agency with responsibility for the care and placement of the child, or the child or youth's attorney may request that the placing agency consider a waiver of presumptive transfer. The placing agency may decide to waive

presumptive transfer on an individual, case-by-case basis only if one or more of the four exceptions listed below exists. The waiver decision must be documented in the child's case plan, and communicated to all other members of the CFT through a CFT coordinator if one exists, or the placing agency's case carrying social worker or deputy probation officer, and the MHP in the county of jurisdiction.

1. The transfer would negatively impact mental health services being provided to the child or youth or delay access to services provided to the foster child;
2. The transfer would interfere with the family reunification efforts documented in the individual case plan;
3. The foster child's placement in a county other than the county of original jurisdiction is expected to last less than six months; or
4. The foster child's residence is within 30 minutes of travel time to his or her established SMHS care provider in the county of original jurisdiction.

B. On a case-by-case basis, presumptive transfer may be waived. The responsibility for providing SMHS remains with the county of original jurisdiction when it is determined an exception exists and that the presumptive transfer waiver is appropriate pursuant to the established conditions of and exceptions to presumptive transfer. When an exception to presumptive transfer exists, waiver determinations are made by the placing agency of the county of original jurisdiction, in consultation with the CFT members.

C. A waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract with a SMHS provider within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. Such information may be obtained by the placing agency verbally or in writing from the MHP in the county of original jurisdiction. That information shall be documented in the child's case plan.

D. A waiver request places a hold on the transfer of responsibility for SMHS until such time that the placing agency in the county of original jurisdiction has made a determination that the waiver meets the required conditions and is in the best interest of the child or youth. In this situation, the county of original jurisdiction is responsible for continuing to provide, or arrange for the provision of, and pay for SMHS to the child or youth without interruption until the placing agency makes a determination regarding the waiver.

E. The placing agency is responsible for informing the child, his or her parent, the CFT coordinator if one exists, or the placing agency's case carrying social worker or deputy probation officer, the MHP in the county of original jurisdiction and the county of residence, and the child's attorney of a waiver request.

III. Medi-Cal Eligible Children in a Foster Care Aid Code - Exception to Presumptive Transfer Exists

A. The MHP in the child's county of origin is responsible for providing or arranging for medically necessary specialty mental health services for children in a foster care aid code residing outside their county of origin.

B. A public or private provider may submit a Service Authorization Request (SAR) to the MHP in the child's county of origin.

C. The MHP in the child's county of origin must make an authorization decision (approve or deny services) within 3 working days following the date of receipt of the request for services from the public or private provider.

D. The MHP in the child's county of origin must notify the MHP in the child's county of residence and the requesting provider of the decision to approve or deny services within 3 working days following the date of receipt of the request for services.

E. If the MHP in the child's county of origin needs additional information not submitted with the initial request the authorization decision must be made within 3 working days from the date the additional information is received, or 14 calendar days from the receipt of the original authorization request, whichever is less.

F. The MHP in the child's county of origin must make payment arrangements with the host county MHP or with the requesting provider within 30 days of the date that the MHP in the child's county of origin authorized services.

G. If the MHP in the child's county of origin requires the use of a contract as a payment mechanism, the MHP must use the standard contract (e.g., Organizational Provider Agreement). The standard contract must be completed within 30 days of authorizing services for the child.

H. The MHP submitting the claim for services will receive the State and Federal funds.

I. MHPs in a child's county of origin must accept the following standard documents:
    1. Client Assessment
    2. Client Plan (if applicable, depending on service type)
    3. Problem List
    4. Service Authorization Request
    5. Client Assessment Update
    6. Progress Notes - Day Treatment Intensive Services
    7. Progress Notes - Day Rehabilitation Services

J. For foster children placed outside their county of origin, the county of residence MHP must provide the child welfare agency in the child's county of origin with information regarding the services being provided if the information is available and requested. The county of residence MHP must meet the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements in the communications with the child welfare agency in the child's county of origin.

IV. Medi-Cal Eligible Children in an Adoptive Assistance Program (AAP) Aid Code

A. The MHP in the child's adoptive parents' county of residence must provide medically necessary specialty mental health services to a child in an AAP aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS). When an MHP

receives a request for specialty mental health services for a child in an AAP aid code, the MHP must determine if the child's adoptive parents reside in the county that the MHP serves. If the child's adoptive parents are residents of the county that the MHP serves, the MHP must provide services to that child as it would provide services for any other Medi-Cal eligible child.

B. The MHP in the child's adoptive parents' county of residence shall submit a Service Authorization Request (whether for an initial assessment, initial treatment or ongoing services), prepared by the provider, to the MHP in the child's county of origin. The MHP in the child's adoptive parents' county of residence must complete the authorization process (including authorization by the MHP in the county of origin) within the DHCS established authorization timelines for in county beneficiaries.

C. The MHP in the child's county of origin must make an authorization decision (approve or deny services) within 3 working days following the date of receipt of the request for services.

D. The MHP in the child's county of origin must notify the MHP in the child's adoptive parents' county of residence and the requesting provider of the decision to approve or deny services within 3 working days following the date of receipt of the request for services.

E. If the MHP in the child's county of origin needs additional information not submitted with the initial request, the authorization decision must be made within 3 working days from the date the additional information is received, or 14 calendar days from the receipt of the original authorization request, whichever is less.

F. The MHP in the child's county of origin does not need to make payment arrangements with the MHP in the child's adoptive parents' county of residence because funds for claims submitted for children in an AAP aid code will be sent to the MHP submitting the claim.
   1. The MHP in the child's county of origin may make payment arrangements with the requesting provider within 30 days of the date that the MHP authorized services.
   2. To avoid situations where a child in an AAP aid code living outside his or her county of origin is denied services solely on the basis that the child has out of county Medi-Cal, MCBH shall ensure their providers are aware that a child in an AAP aid code living outside his or her county of origin shall be served in the same way as a child living in his or her county of origin.

V. Medi-Cal Eligible Children in a KinGAP Aid Code

A. The MHP in the child's legal guardians' county of residence must provide medically necessary specialty mental health services to a child in a KinGAP aid code residing outside his or her county of origin <u>in the same way</u> that it would provide services to any other child for whom the MHP is listed as the county of responsibility on MEDS. When an MHP receives a request for specialty mental health services for a child in a KinGAP aid code, the MHP must determine if the child's legal guardians reside in the county that the MHP serves. If the child's legal guardians are

residents of the county that the MHP serves, the MHP must provide services to that child as it would provide services for any other Medi-Cal eligible child.

B. The MHP in the child's legal guardians' county of residence shall submit an authorization request (whether for an-initial assessment, initial or ongoing treatment), prepared by the provider, to the MHP in the child's county of origin. The MHP in the child's legal guardians' county of residence must complete the authorization process (including authorization by the MHP in the county of origin) within the MHP's established authorization timelines for in county beneficiaries.
C. The MHP in the child's county of origin must make an authorization decision (approve or deny services) within 3 working days following the date of receipt of the request for services.
D. The MHP in the child's county of origin must notify the MHP in the child's legal guardians' county of residence and the requesting provider of the decision to approve or deny services within 3 working days following the date of receipt of the request for services.
E. If the MHP in the child's county of origin needs additional information not submitted with the initial request, the authorization decision must be made within 3 working days from the date the additional information is received, or 14 calendar days from the receipt of the original authorization request, whichever is less.
F. The MHP in the child's county of origin must make payment arrangements with the MHP in the child's legal guardians' county of residence or with the requesting provider within 30 days of the date that the MHP authorized services.
G. The MHP submitting the claim for services will receive the State and Federal funds.
H. To avoid situations where a child in a KinGAP aid code living outside his or her county of origin is denied services solely on the basis that the child has out of county Medi-Cal, MHPs shall ensure their providers are aware that a child in a KinGAP aid code living outside his or her county of origin shall be served in the same way as a child living in his or her county of origin.

VI. Forms for AAP, KinGap and Foster Care Youth with Exception to Presumptive Transfer

A. When BHD is the "County of Origin", all procedures as described above will be followed. The state- provided forms for Service Authorization Request (SAR) will be used, and before MCBH can authorize services requested by the "Host" county, MCBH will review and approved the state-provided Client Assessment, Client Plan, and other forms as indicated.

B. When BHD is the "Host" county, MCBH will perform a complete assessment and provide the County of Origin with all required forms, as described above.

VII. Timeframes for AAP, KinGap and Foster Care Youth with Exception to Presumptive Transfer

A. When BHD receives a request for authorization of services for a foster child (when an exception to presumptive transfer exists), KinGAP youth, or adoptee who is residing in another California county, MCBH will approve or deny the request within 3 working days after receipt of the SAR. To ensure this timeframe, Front Office staff will time-stamp the received SAR and bring to the Director's attention. The Director may, in her absence, assign another staff person with authorizing

authority. If additional information is needed from the requesting (Host) county, BHD will specify the needed information within the 3-day timeframe. Once BHD has sufficient information to approve or deny the Service Request, BHD will respond to the requesting county within 3 working days, or 14 days from original request, whichever is shorter.

B. When BHD is hosting a foster child, KinGAP youth, or adoptee from another County, BHD will request appropriate services after a thorough assessment and determination of treatment needs. The SAR will be faxed to the County of Origin and logged in the Authorization Log. Any requests for additional information by the authorizing county will be responded to as appropriate and as quickly as possible. Client Plan updates will be submitted for re-authorization every 6 months.

C. Authorization files and Logs are maintained by BHD Director. Utilization Review activities occur per the Quality Improvement Work Plan and the Utilization Review Plan.

(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.

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

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-Specialty Mental Health Services (NSMHS) or SMHS access criteria are met;
2. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

NSMHS are delivered by Medi-Cal Fee-for-Service (FFS) providers and Managed Care Plans (MCPs) and include the following:

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

<u>Health Care Services</u>

Partnership HealthPlan (PHP) is the MCP that serve the physical health care needs of Medi-Cal clients in Siskiyou County. PHP also provide the mental health benefit for clients with “mild or moderate” mental health issues, including the NSMHS listed above.

If the assessment determines that there is a need for health care services, MHP staff refer the beneficiary to Partnership HealthPlan (PHP) for medical care. PHP also provides the

mental health benefits for clients with “mild or moderate” mental health issues. Care coordination and effective communication between MHP and PHP including procedures for exchanges of medical information are included in the Memorandum of Understanding (MOU) between MHP and PHP. The MOU is available upon request. If a client is assessed by the MHP as not meeting access criteria for specialty mental health services due to having a mild to moderate impairment, or having a condition that would be more responsive to appropriate physical health care, a referral is made to PHP and a NOABD is issued. If a PHP member is screened by PHP as potentially requiring specialty mental health services, they will be referred to the MHP for an assessment to determine SMHS access criteria. In order to coordinate care across plans, BHD and PHP are implementing the California Advancing and Innovating Medi-Cal (CalAIM) No Wrong Door policy and Standardized Screening and Transition Tools policies.

MHP staff also coordinates care with hospitals and rural and tribal health clinics.

Concurrent NSMHS and SMHS

Beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary on the basis of the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary on the basis of the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a patient-centered shared decision-making process.

- Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).
- Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from a FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

Substance Use Disorder Services

If the assessment determines that there is a substance abuse issue, mental health staff refer the beneficiary to SUD services. As an integrated department, all clinicians are trained in mental health and substance use disorder diagnoses.

Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria on the basis of the beneficiary having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition.

Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the beneficiary has a co-occurring SUD. Similarly, clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

Educational Services

If the assessment determines that the beneficiary could benefit from coordinated care with an educational facility (e.g., schools, community college), MHP staff refer/link the beneficiary with the appropriate education professional. MHP staff work closely with the school system to provide specialty mental health services.

Housing

If the assessment determines that the beneficiary requires assistance in obtaining or changing housing, the MHP staff refers the beneficiary to local housing programs, and/or assists the beneficiary and/or family to secure housing through Mental Health Services Act (MHSA) support activities or other supported housing programs.

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

Social Services

If the assessment determines that the beneficiary requires assistance in obtaining the services of Public Assistance, Child Welfare Services (CWS), or Adult Protective Services, the MHP staff help the beneficiary to access these services.

Probation

If the assessment determines that the beneficiary requires assistance with Probation services, the MHP staff collaborate as appropriate. The MHP has embedded staff in the Probation Day Reporting Center that provides individual and group services for beneficiaries that are criminally involved.

Vocational Services/Employment

If the assessment determines the beneficiary is interested in obtaining or changing employment, the MHP staff refer the client to an appropriate agency. Referrals are made to the Siskiyou County CalWORKs program and Siskiyou Works.

(2) A description of the process for:

(B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.

Beneficiary Handbook

BHD provides a Guide to Medi-Cal Mental Health Services (beneficiary handbook) and provider directory to clients upon request and when first receiving specialty mental health services. The handbook and directory are available in English and Spanish at the BHD county service locations and on the BHD website. The content and format are consistent with BHIN 22-060, CCR Title 9, §1810.360 and the CFR, Title 42, § 438.10. The beneficiary handbooks will be updated to be consistent with BHIN 23-048 as required by January 1, 2024 to align with DHCS policies released between December 2022 through August 2023.

Outreach and Engagement

BHD offers outreach and engagement opportunities through MHSA Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) programs that provide information to beneficiaries and potential clients who may need SMHS about access to services under the MHP. The following are a few examples of outreach and engagement programs.

Homeless Outreach

Siskiyou County is in the sixth year of its 10-Year Plan to End Homelessness. This plan addresses community identified housing needs and resources and emphasizes outreach and engagement efforts for chronically homeless individuals. BHD facilitates a multi-disciplinary team (MDT) of service providers that meet on an ad-hock basis with individuals experiencing homelessness to identify and address barriers to accessing housing and conducts weekly Coordinated Entry meetings to review the by-name list of individuals with unmet housing needs.

BHD will continue to leverage state, federal, and local funding in conjunction with MHSA Outreach and Engagement to expand homeless street outreach to members of the community who are experiencing homelessness. In Fiscal Year 2022-23, in response to ongoing concerns expressed through the MHSA Community Program Planning process and by the Siskiyou County Advisory Board regarding individuals experiencing

homelessness, BHD partnered with the Yreka Police Department (YPD) to provide outreach and crisis services to community members who were experiencing homelessness. This year, BHD will grow the homeless outreach team through the addition of one Behavioral Health Specialist who will work directly with the YPD Homeless Outreach Liaison, and others including Public Health to deliver outreach services to the unhoused community.

Healthy Siskiyou Mobile Unit

In collaboration with the Public Health Division of Siskiyou County Health and Human Services Agency, MHSA supports staff to conduct outreach, screenings and linkage to behavioral health and substance use disorder services to un- and underserved populations in communities throughout Siskiyou County. Screenings and referrals are conducted by Public Health staff, and referrals and linkages are to existing health care providers including mild to moderate behavioral health providers, BHD, Social Services and other supportive service providers. Staff are bilingual and targeted outreach includes underserved Latino communities, and the unhoused as well as the general population.

Promotoras/Latinx Outreach

Under guidance from the Tulelake Family Resource Center, a bilingual outreach worker provides outreach, education, linkage and referral, translation, and supportive services to Spanish speaking clients and their families. Services target communities in eastern Siskiyou County where the largest concentration of Latinx persons reside. This program is staffed by Promotoras who provide culturally appropriate physical and behavioral health education and information, assist people in accessing the care they need, offer interpretation and translation services, and advocate for individual and community health needs. Staff provide psych-education groups that educate community members about mental health issues to decrease stigma about mental health care and treatment. The Promotoras/Latinx program serves primarily older adults.

PEI Outreach for Increasing Recognition of Early Signs of Mental Illness

Outreach for Increasing Recognition of Early Signs of Mental Illness programs engage, encourage, educate, and train potential responders to recognize and respond effectively to early signs of potentially severe and disabling mental illness. These include the following programs targeting different populations:

- Mental Health First Aid: Mental Health First Aid is a skills-based training course that teaches participants how to identify, understand and respond to signs of mental illness and substance use disorders.
- Challenge Day/Yreka High School: Challenge Day events are experimental social and emotional learning programs for grades 7-12 that offer schools an opportunity to ignite a shift toward greater school connectedness, empathy, and inclusivity.
- Rural Youth Media Outreach Program: The Rural Youth Media Program engages middle and/or high school students in a video production project that focuses on mental health and substance use issues.

(2) A description of the process for:

(C) Assuring continuity of care for clients receiving specialty mental health services prior to the date the entity begins operation as the MHP.

The MHP is fully operational and provides a range of specialty mental health services to Medi-Cal beneficiaries to assure continuity of care for all persons who meet access criteria for specialty mental health services.

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

For more information, see policy CLIN 307, Continuity of Care.

(2) A description of the process for:

(D) Providing clinical consultation and training to clients' primary care physicians and other physical health care providers.

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

During non-business hours, urgent psychiatric issues are evaluated by the Psychiatric Emergency Team (PET) in conjunction with medical providers at the two local emergency departments. PET workers are also stationed at Fairchild Hospital to improve response time and increase support for hospital staff.

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

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

The MHP also provides intensive services to clients that have both Severe Mental Illness (SMI) and co-occurring physical health conditions. The client’s physical health problems include conditions such as diabetes, chronic pain, stroke, lung disease, liver disease, traumatic brain injuries, and memory care issues. These medical conditions require the care of multiple specialists, such as cardiologists, neurologists, pulmonologists, urologists, nephrologists, and others to ensure their medical needs are addressed properly. The MHP offers these clients case management and peer services to assist them in navigating through complex coordination of the medical and mental health care systems. The MHP also advocates for clients to access services as needed that support their medical and mental health treatment goals.

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

Beneficiary Problem Resolution Process

Grievance Process

BHD will strive to provide resolution of a client's grievance as quickly and simply as possible.

1. Clients may file a grievance verbally or in writing.
2. A client may authorize another person, including his/her attorney, to act on his/her behalf.
3. When a BHD staff member receives a grievance, he/she shall submit the grievance to the BHD designee.
    a. If the grievance is written, the receiving BHD designee shall date stamp the written document.
4. The BHD designee shall record the grievance (verbal or written) in the grievance and appeals log within one (1) working day of the date of receipt. See "Resolution Procedures" above for the content requirements of the grievance and appeals log.
5. The BHD designee shall provide to the client written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the BHD representative who the client may contact about the grievance. The written acknowledgement to the client must be postmarked within five calendar days of receipt of the grievance.
6. The BHD designee will then forward the grievance to the Quality Assurance Manager or designee.
7. A decision regarding the grievance must be made within ninety (90) calendar days of receipt of the grievance. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if BHD determines that there is a need for additional information and the delay is necessary, and is in the best interest of the client.
    b. The timeframe for resolving grievances related to disputes of a BHD decision to extend the timeframe for making an authorization decision may not exceed 30 calendar days.
    c. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, BHD will provide the client with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.
    d. If BHD extends the timeframe, not at the request of the client, it must complete all of the following: (1) give the client prompt oral notice of the delay, (2) within two calendar days of making the decision, give the client written notice of the reason for the decision to extend the timeframe and inform the client of the right to file a grievance if he/she disagrees with that decision, and (3) resolve the grievance no later than the date the extension expires.
8. BHD will notify the client (or his/her representative) of the grievance decision in writing utilizing the DHCS Notice of Grievance Resolution (NGR) form to notify beneficiaries of the result of the grievance resolution. The NGR shall contain a clear and concise explanation of BHD's decision, and shall be provided in a format and language that meets applicable notification standards.
    a. If a client cannot be reached (i.e., returned mail), BHD will document the notification effort in the grievance and appeals log.

b. Grievances received over the telephone or in-person by BHD, or a network provider of BHD, that are resolved to the client's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.
c. Grievances received via mail by BHD, or a network provider of BHD, are not exempt from the requirement to send an acknowledgment and disposition letter in writing.

9. BHD will also notify any provider(s) or staff persons cited in the grievance of the final decision verbally.
10. If BHD fails to notify the client or other affected parties of its grievance decision within the allowable timeframe, the client will be given a NOABD (Grievance/Appeal Resolution) advising that he/she has a right to request an appeal and/or a state fair hearing.
    a. The NOABD will be given on the date that the timeframe expires.

NOTE: Clients may not request a state fair hearing before, during, or after the grievance process, unless BHD has failed to act within the timeframe required by the grievance process and the client has exhausted the BHD appeal process.

Discrimination Grievances

1. "Discrimination Grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
2. BHD will provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:
    a. BHD and DHCS if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
    b. The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.
    c. The BHD beneficiary handbook will include information on filing a Discrimination Grievance with the BHD, the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights, and shall specifically include information stating that BHD complies with all state and federal civil rights laws. If a beneficiary believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with BHD, the DHCS Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights.
3. The BHD Compliance Officer is designated as the Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
4. BHD will adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. BHD will not require a beneficiary to file a Discrimination Grievance with BHD before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil

Rights.

5. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, BHD will submit the following information regarding the complaint to the DHCS Office of Civil Rights:
    a. The original complaint.
    b. The provider's or other accused party's response to the complaint.
    c. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of BHD.
    d. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
    e. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
    f. The results of the BHD investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

Standard Appeals

1. Clients may file an appeal (as defined above) verbally or in writing. The appeal must be made in response to an adverse benefit determination.
    a. The appeal must be filed within sixty (60) calendar days from the date on the NOABD.
    b. A client must follow up a verbal appeal with a signed, written appeal.
2. BHD shall provide only one level of appeal for beneficiaries.
    a. A client may authorize another person, including his/her attorney, to act on his/her behalf.
3. In the appeal process, the client may also select a provider as his/her representative.
4. When a BHD staff member receives an appeal, he/she shall submit the appeal to the BHD designee who shall date stamp a written appeal.
5. The BHD designee shall record the appeal (verbal or written) in the grievance and appeals log within one (1) working day of the date of receipt. See "Resolution Procedures" above for the content requirements of the grievance and appeals log.
6. The BHD designee shall provide to the client written acknowledgement of receipt of the appeal. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the BHD representative who the client may contact about the appeal. The written acknowledgement to the client must be postmarked within five calendar days of receipt of the appeal.
7. The BHD designee shall then forward the appeal to the BHD Quality Assurance Manager or designee.
8. The client will begiven the opportunity to present evidence and allegations of fact or law.
    a. This component may be done in person or in writing.
9. BHD will ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the client or his/her authorized representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.
10. Before and during the appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart including medical records, other documents and records, and any new or additional evidence considered,

relied upon, or generated by BHD in connection with any standard or expedited appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeals.

11. BHD will provide the client or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony. BHD will inform the client or authorized representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals, as specified, and in the case of expedited resolution.
12. BHD will allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.
13. A decision regarding the appeal must be made within thirty (30) calendar days of receipt of the appeal.
    a. If request for an appeal was first given verbally, the timeline requirements begin on that day, not the day when the written follow-up is received from the client.
    b. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    c. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if BHD determines that there is a need for additional information and the delay is necessary and is in the best interest of the client.
    d. For any extension not requested by the client, BHD will provide the client with written notice of the reason for the delay.
        - BHD will make reasonable efforts to provide the client with prompt oral notice of the extension;
        - BHD will provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the client of the right to file a grievance if the client disagrees with the extension;
        - BHD will resolve the appeal as expeditiously as the client's health condition requires and in no event extend resolution beyond the 14 calendar day extension; and
        - In the event that BHD fails to adhere to the notice and timing requirements, the client is deemed to have exhausted BHD's appeal process and may initiate a State hearing.
14. The BHD Quality Assurance Manager or designee will notify the client or his/her representative in writing of the appeal decision using a DHCS Notice of Appeal Resolution (NAR) template or the electronic equivalent of that template generated from BHD's Electronic Health Record System.
    a. If an Adverse Benefit Determination is upheld or not wholly resolved in favor of the client, the NAR will be comprised of two components: 1) Notice of Appeal Resolution, and 2) "Your Rights" attachments. These documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR.
    b. The NAR will include the following:
        - The results of the appeal resolution and the date it was completed;
        - The reasons for BHD's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
        - For appeals not resolved wholly in the favor of the client, the right to request a State hearing and how to request it;

- For appeals not resolved wholly in the favor of the client, the right to request and receive benefits while the hearing is pending and how to make the request; and,
- Notification that the client may be held liable for the cost of those benefits if the hearing decision upholds BHD's Adverse Benefit Determination.

c. The NAR "Your Rights" attachment provides clients with the following required information pertaining to NAR:
   - The client's right to request a State hearing no later than 120 calendar days from the date of BHD's written appeal resolution and instructions on how to request a State hearing; and
   - The client's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten (10) days from the date the letter was post-marked or delivered to the client).

d. For appeals resolved wholly in favor of the client, written notice to the client will include the results of the resolution and the date it was completed. BHD will also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. BHD will utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

e. BHD will authorize or provide the services promptly and as expeditiously as the client's condition requires if the BHD reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. BHD will authorize or provide services no later than 72 hours from the date and time it reverses the determination.

15. BHD will also notify any provider(s) or staff persons cited in the appeal of the final decision verbally.
16. If BHD fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a NOABD (Grievance/Appeal Resolution) by the BHD Quality Assurance Manager or designee, advising that the client has a right to request a state fair hearing.
    a. The NOABD will be given on the date that the timeframe expires.

Continuation of Services

NOTE: BHD will provide aid paid pending (APP) to beneficiaries who want continued services and have filed a timely request for an appeal or State Fair Hearing.

- A timely request is 10 days from the date the notice of action (NOABD) was mailed, or 10 days from the date the NOABD was personally given to the beneficiary, or before the intended effective date of the Adverse Benefit Determination, whichever is later.
- BHD will authorize or provide the disputed services promptly, and as expeditiously as the client's health condition requires, but no later than 72 hours from the date BHD receives notice reversing the determination if the services were not furnished while the appeal was pending and if BHD or state fair hearing officer reverses a decision to deny, limit, or delay services.
- The beneficiary must either have an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by the

MHP; or, the beneficiary must have been receiving specialty mental health services under an exempt pattern of care.

- An exempt pattern of care is the denial of a provider's request to continue a pattern of care that has been exempt from authorization by the MHP and would require an NOABD. An exempt pattern of care may exist in a situation when a county has a policy that permits a predetermined amount of services to be provided without prior authorization. (For example, a county allows providers 3 visits without prior authorization. A provider subsequently requests authorization for an additional 3 visits.)
- This action will permit a beneficiary to continue to receive their existing services until the client withdraws the appeal or request for State Fair Hearing, the client does not request a State Fair Hearing and continuation of benefits within 10 calendar days from the date BHD sends the notice of an adverse appeal resolution, or a State Fair Hearing decision adverse to the client is issued.
- If the decision of an appeal reverses a decision to deny the authorization of services, and the client received the disputed services while the appeal was pending, BHD shall cover the cost of such services.
- BHD will notify the requesting provider and give the client written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Expedited Appeals

1. Clients may file an expedited appeal verbally or in writing. The expedited appeal must be made in response to an action.
    a. The expedited appeal process may only be used when the standard appeal process could jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.
    b. NOTE: A client does NOT need to follow up a verbal expedited appeal with a signed, written appeal.
2. A client may authorize another person, including his/her attorney, to act on his/her behalf. In the appeal process, the client may also select a provider as his/her representative.
3. BHD shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.
4. When a BHD staff member receives an appeal, he/she shall submit the appeal to the BHD designee. The BHD designee shall date/time stamp a written expedited appeal.
5. The BHD designee shall record the appeal (verbal or written) in the grievance and appeals log within one (1) working day of the date of receipt, and acknowledge receipt of the appeal to the client in writing, following the requirements stated above for a standard appeal.
6. BHD informs beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. Beneficiaries must be informed of this sufficiently in advance of the resolution timeframe for an expedited appeal.
7. The BHD shall forward the request for an expedited appeal to the BHD Director.
8. The BHD Director will review the request for an expedited appeal.
    a. If the request for an expedited appeal is denied, the appeal will be transferred to the standard appeal process and resolved within the timeframe specified in that process.

    b. BHD will make reasonable efforts to give the client prompt verbal notice of the denial of the expedited appeal process and follow up with a written notice within two (2) calendar days.
    c. If the request for an expedited appeal is granted, the client will be given the opportunity to present evidence and allegations of fact or law. This component may be done in person or in writing.
9. Before and during the expedited appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart and any other documents relevant to the appeal.
10. BHD must resolve the appeal, and provide notice, as expeditiously as the client's health condition requires, no longer than 72 hours after BHD receives the expedited appeal request. All affected parties (including client, providers, staff members, etc.) must be notified verbally, as well as in writing, of the decision within this timeframe.
    a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if BHD determines that there is a need for additional information and that the delay is necessary and is in the best interest of the client.
11. BHD will notify the client or his/her representative of the expedited appeal decision in writing using a DHCS NAR template or the electronic equivalent of that template generated from BHD's Electronic Health Record System. The same notification requirements stated in the procedures above for Standard Appeals will also apply to Expedited Appeals.
12. In addition to the written NAR, BHD will make reasonable efforts to provide prompt oral notice to the client of the resolution
13. BHD will also notify any provider(s) or staff persons cited in the expedited appeal of the final decision verbally.
14. If BHD fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a NOABD (Grievance/Appeal Delay) advising that he/she has a right to request a state fair hearing.
    a. The NOABD will be given on the date that the timeframe expires.
15. If BHD denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. In addition, BHD must complete all of the following actions:
    a. BHD will make reasonable efforts to provide the client with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
    b. BHD will provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the client of the right to file a grievance if the client disagrees with the extension; and
    c. BHD will resolve the appeal as expeditiously as the client's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within 30 days of receipt of the appeal).

State Hearings

- Clients have the right to request a State hearing only after receiving notice that BHD is upholding an adverse benefit determination.
- Clients must exhaust the county appeal process before filing for a state fair hearing.
- If BHD fails to adhere to the notice and timing requirements in 42 CFR §438.408

(also stated in the appeal procedures listed below), the client is deemed to have exhausted BHD's appeals process and may then initiate a State hearing.

- Clients may request a State hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the client that the Adverse Benefit Decision has been upheld by BHD. Please refer to BHD Policy No. 15-01 for further information about NARs.
- BHD will notify clients that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing.
- In the case of an Expedited State Hearing, BHD will notify beneficiaries that the State must reach its' decision on the state fair hearing within three working days of the date of the request for the hearing. "Expedited State Hearing" means a State hearing, used when BHD determines, or the client or the client's provider certifies that following the 90-day timeframe for a State hearing as established would seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.
- BHD will authorize or provide the disputed services promptly and as expeditiously as the client's health condition requires, but no later than 72 hours from the date it receives notice reversing BHD's adverse benefits determination.

Quality Management

The Quality Assurance Manager and the Quality Improvement Committee (QIC) shall conduct, at minimum, an annual evaluation of grievances, standard appeals, or expedited appeals. Overall trend issues shall be analyzed as part of the quality improvement monitoring process. The quality improvement recommendations and findings shall be documented in the QIC minutes and the annual QI work plan evaluation, and regularly communicated with the BHD Director.

The written record of grievances and appeals shall be submitted at least bi-annually to the QIC for systematic aggregation and analysis for quality improvement. Quality Assurance Manager shall review grievances and appeals quarterly and as needed. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

Provider Problem Resolution Process

A provider may appeal a denied or modified request for the MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal must be submitted to the MHP within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the regulatory time frames.

The MHP will have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP will utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

If the appeal is not granted in full, the provider will be notified of any right to submit an

appeal to DHCS pursuant to Section 1850.320.

If applicable, the provider shall submit a revised request for the MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

If applicable, the MHP will have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the documentation to the Medi-Cal fiscal intermediary that is required to process the MHP payment authorization.

(4) A description of the provider selection process, including provider selection criteria consistent with §§ 1810.425 and 1810.435. The entity designated to be the MHP will include a Request for Exemption from Contracting in accordance with § 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH.

Provider Credentialing and Recredentialing

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

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

- The appropriate license and/or board certification or registration, as required for the particular provider type;
- Evidence of graduation or completion of any required education, as required for the particular provider type;
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

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

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

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

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

The MHP routinely verifies provider information through:

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

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

For more information, see policies: Provider Selection & Certification ADMIN 16-05; Agency Certification- Medi-Cal ADMIN 16-04.

PAVE Enrollment

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

Hospital Selection Criteria

The MHP requires that each hospital complies with federal Medicaid laws, regulations, guidelines, State statutes, regulations, and not violate the terms of the MHP contract between the MHP and DHCS. The Hospitals must sign a provider agreement with DHCS,

provide psychiatric inpatient hospital services (within its scope of licensure) to all clients who are referred by the MHP (unless compelling clinical circumstances exist that contraindicate admission, or the MHP negotiates a different arrangement with the hospital), refer clients for other services when necessary, and not refuse an admission solely based on age, sex, race, religion, physical or mental disability, or national origin.

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

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

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

(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 clients 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 clients that will be served by the MHP.

In the following section, we will address 5(A) and (B) by providing information about the range of specialty mental health services offered through BHD, followed by data and information about how the network of providers meets the needs of the anticipated number and location of clients.

Range of Specialty Mental Health Services

BHD provides the following range of Medi-Cal reimbursable specialty mental health services, either through BHD staff or contract providers:

Mental Health Services - Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day

rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:

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

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

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

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

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

Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.

Crisis Intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.

Targeted Case Management – Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be

face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

Intensive Care Coordination (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 to access SMHS. 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 is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child.
- Supports the parent/caregiver in meeting their child's needs.
- Helps establish the Client and Family Team and provide ongoing support.
- Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the child 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 IHBS. Service activities may include, but are not limited to assessment, treatment plan, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for this service.

Therapeutic Behavioral Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.

Peer Support Services - Provision of Peer Support Services shall conform to the requirements of Supplement 3 to Attachment 3.1-A and Supplement 3 to Attachment 3.1-B of the California Medicaid State Plan. BHD's provision of Peer Support Services and implementation of a Medi-Cal Peer Support Specialist Certification Program shall further conform to the applicable requirements of BHIN 21-041 and to the requirements in any

subsequent BHINs issued by DHCS pursuant to Welfare & Institutions Code section § 14045.21.

Depending on the individual client's needs, SCBH will arrange for the following services out of county:

Day Treatment Intensive are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Day Rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Crisis Stabilization Services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy.

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

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

Children's Crisis Residential Programs - Children's Crisis Residential Programs (CCRP) are licensed by the California Department of Social Services as a Short-Term Residential Therapeutic Program and have a mental health program approved by the Department of Health Care Services. CCRPs serve children experiencing an acute mental health crisis as an alternative to psychiatric hospitalization.

Therapeutic Foster Care (TFC) - The TFC service model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS activities (plan development, rehabilitation and collateral) to children up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and

supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. The TFC parent will provide trauma informed interventions that are medically necessary for the child. TFC is intended for children who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

Psychiatric Health Facility (PHF) - A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. “Psychiatric Health Facility Services” are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”.

Psychiatric Inpatient Hospital Services – Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary’s stay at the hospital must be continued beyond the beneficiary’s need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

Service Provided by Geographic Distribution

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

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

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

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

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

The following map shows the beneficiary population density of the county by zip code in September 2018. This representation of the density remains stable from year to year; a majority of the beneficiaries reside along the I-5 corridor that runs north/south through the center of the county. For beneficiaries living in the west and east regions, the MHP ensures timely access by offering transportation into the Yreka or Mount Shasta clinics and by sending clinicians and behavioral health specialists into the rural communities to provide direct services.

The MHP is approved for a time and distance waiver through DHCS for the areas of Happy Camp, Forks of Salmon, Somes Bar, and Tulelake. The MHP provides evidence to DHCS annually to demonstrate that the MHP is the closest specialty mental health provider to these areas and that the MHP is able to provide telehealth services to these areas, when appropriate.

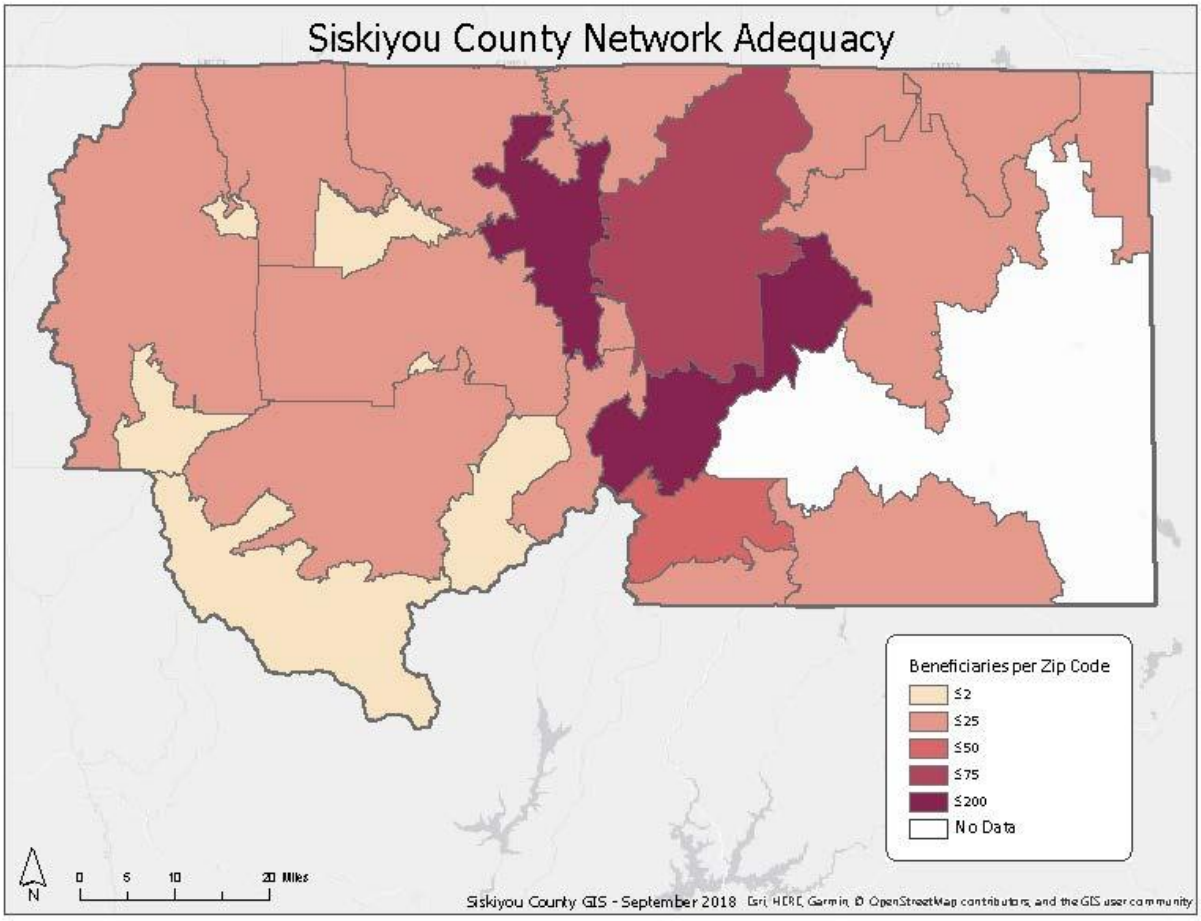

Figure 1 Siskiyou County Network Adequacy Heat Map 2019

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

All beneficiaries under the age of 21 will receive equal access to mental health services as outlined by Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements and other state regulations.

Those with full scope Medi-Cal who are under the age of 21, by definition, are also EPSDT eligible. Under EPSDT they are eligible for Medi-Cal services to correct or ameliorate medical conditions (including mental health conditions). These needs are being met at the current time. BHD will provide SMHS services for all beneficiaries under the age of 21 who meet specialty mental health access criteria as required by EPSDT.

<u>Katie A/Pathways to Wellbeing Process and Services</u>

As a result of the Settlement Agreement in Katie A. v. 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.

BHD has implemented the Pathways to Wellbeing (Katie A Settlement Agreement) to serve children and youth who are eligible for ICC, IHBS and TFC services, including those who have been identified as Katie A subclass members. BHD provides ICC and IHBS under the Core Practice Model (CPM) for clients under the age of 21 who are eligible for full scope Medi-Cal, and meet SMHS access criteria.

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, IHBS and TFC, BHD utilizes the principles of the CPM, in which the services are provided in conjunction with a CFT.

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

Intensive Care Coordination

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

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

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

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

Intensive Care Coordination provides:

- A single point of accountability for ensuring that needed services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, culturally, and linguistically relevant manner;
- Services and supports that are guided by the needs of the youth;
- Facilitation of a collaborative relationship among a youth, his/her family and those involved in child- serving systems;
- Support the parent/caregiver in meeting their youth's needs;
- A care planning process that ensures a care coordinator organizes and matches care across providers and the serving systems to allow the youth to be served in their home community; and

- Facilitated development of the CFT. The CFT includes, as appropriate, both formal supports such as the care coordinator, providers, case managers from child-serving agencies, and natural supports such as family members, neighbors, friends, and clergy.

ICC service components consist of:

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

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

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

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

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

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

Intensive Home-Based Services

IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning. Interventions are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community. IHBS is available to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and meet access criteria for Specialty Mental Health Services (SMHS). BHD makes an individualized determination of each child's/'youth's need for IHBS,

based on the child's/youth's strengths and needs.

IHBS are delivered according to an individualized treatment plan developed by the CFT. The CFT develops goals and objectives for all life domains in which the child's mental health condition produces impaired functioning (including family life, community life, education, vocation, and independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives should seek to maximize the child's ability to live and participate in the community and to function independently (including through building social, communication, behavioral, and basic living skills).

Providers of IHBS should engage the child in community activities where the child has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

The difference between IHBS and more traditional outpatient SMHS is that IHBS is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the child's or youth's client plan, and will be predominantly delivered outside an office setting, and in the home, school, or community.

IHBS include, but are not limited to:

- Educating the child's family about, and training the family in managing, the child's disorder;
- Skill-based remediation of behaviors, including development and implementation of a behavioral plan with positive behavioral supports and modeling for the child's family and others how to implement behavioral strategies;
- Improving self-care, including addressing behaviors and social skills deficits that interfere with daily living tasks and with avoiding exploitation by others;
- Improving self-management of symptoms, including assisting with self-administration of medications;
- Improving social decorum, including addressing social skills deficits and anger management;
- Supporting the development and maintenance of social support networks and the use of community resources;
- Supporting employment objectives, by identifying and addressing behaviors that interfere with seeking and maintaining a job;
- Supporting educational objectives, through identifying and addressing behaviors that interfere with succeeding in an academic program in the community; and
- Supporting independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

IHBS are highly effective in preventing a child being removed from home (biological, foster, or adoptive) for admission to an inpatient hospital, residential treatment facility or other residential treatment setting.

Settings: IHBS may be provided in any setting where the child is naturally located, including the home (biological, foster, or adoptive), school, recreational settings, child care centers, and other community settings. IHBS may not be provided to children/youth in group home settings, except in specific situations.

Availability: IHBS are available wherever and whenever needed, including in evenings and on weekends.

Providers: IHBS are typically provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS. More complex cases may require service delivery by a clinician rather than a paraprofessional.

Therapeutic Foster Care

TFC may be provided under the EPSDT benefit to all children and youth who:

- Are under the age of 21;
- Are eligible for the full scope of Medi-Cal services; and
- Meet access criteria for SMHS.

Membership in the Katie A. subclass is not a prerequisite to receiving TFC. It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC.

BHD will make individualized determinations of need for TFC based on each child's/youth's strengths and needs. TFC is appropriate for children and youth with more intensive needs, or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community. TFC must be provided by TFC parents who are approved by a TFC Agency that meets licensure and accreditation requirements established by the California Department of Social Services (CDSS).

Child welfare departments have an affirmative responsibility to identify, screen, and refer children and youth who are in the child welfare system, and may be in need of TFC. The MHP has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC.

Other entities, such as juvenile probation, have an affirmative responsibility to identify, screen, and refer children and youth who may be in need of TFC.

Adults and Older Adults

With MHSA Community Services and Supports funding, BHD provides *Adult/Older Adult Full-Service Partnerships*.

Target Population

Adults and older adults who are seriously mentally ill and whose service needs are unmet or minimally met and are at-risk of homelessness, involvement in the criminal justice system, institutionalization, frequently use local hospital emergency departments and/or psychiatric hospital services as their primary treatment resource for mental health treatment or involuntary care.

Adult FSP programs provide support for housing, employment, and education, in addition to providing mental health services and integrated treatment for individuals who have a co-occurring mental health and substance use disorder. Services may be provided to individuals in their homes, in the community, or in other settings.

Adults:

Adults ages 26-59 who meet ALL of the following criteria:

1. The mental disorder results in substantial functional impairments or symptoms, or

there is a psychiatric history that indicates that without treatment there is an imminent risk of decompensation with substantial impairments or symptoms.

AND

2. Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services or entitlements.

AND

3. They are in ONE (1) of the following situations:
   a. They are unserved and one of the following:
      - Homeless or at risk of becoming homeless.
      - Involved in the criminal justice system.
      - Frequent utilizers of hospital emergency room services as the primary resource for mental health treatment.
   b. They are underserved and at risk of one of the following:
      - Homeless.
      - Involvement in the criminal justice system.
      - Institutionalization.

Older Adults:

Adults 60 or older who meet ALL of the following criteria:

1. The mental disorder results in substantial functional impairments or symptoms or they have a psychiatric history that suggests that without treatment there is an imminent risk of decompensation with substantial impairments or symptoms.

AND

2. Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services or entitlements.

AND

3. They are in at least ONE (1) of the following situations:
   a. They are unserved and ONE (1) of the following:
      - Experiencing a reduction in personal and/or community functioning.
      - Homeless.
      - At risk of becoming homeless.
      - At risk of becoming institutionalized.
      - At risk of requiring out- of-home care.
      - At risk of becoming frequent utilizers of hospital and/or emergency room services as the primary resource for mental health treatment.
   b. They are undeserved and at risk of ONE (1) of the following:
      - Homelessness.
      - Institutionalization.
      - Nursing home or out-of-home care.
      - Frequently using hospital and/or emergency room services as their primary resource for mental health treatment.
      - Involvement in the criminal justice system.

(7) The proposed Cultural Competence Plan as described in § 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 § 1810.410(c).

The BHD Cultural Competence Plan is updated annually in accordance with the terms of the MHP Contract and DMH Information Notice No. 10-02 and Title 9 § 1810.410. The Cultural Competence Plan was updated in December 2022 and is available on the BHD website.

(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.

Planned admissions to non-contract hospitals occur very rarely, but if they do, they will be arranged by contacting the BHD 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.

Pre-authorization is required if a planned admission does occur in both contract and non-contract hospitals. Pre-authorization is not required for emergency admissions. Authorization for planned admissions will be approved or denied based on current state requirements.

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

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

Quality Assessment and Performance Improvement

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

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

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

The MHP conducts performance monitoring activities throughout the MHPs' operations.

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

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

1. Surveying beneficiary/family satisfaction with the MHP's services at least annually;
2. Evaluating beneficiary grievances, appeals, and fair hearings at least annually;
3. Evaluating requests to change persons providing services at least annually; and
4. The MHP informs providers of the results of beneficiary/family satisfaction activities.

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

The MHP has implemented mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

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

The MHP's QAPI Program includes Performance Improvement Projects.

QI Committee and Program

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

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

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

QI activities will include:

1. Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified;
2. Identifying opportunities for improvement and deciding which opportunities to pursue;
3. Identifying relevant committees internal or external to the MHP to ensure appropriate exchange of information with the QI Committee;
4. Obtaining input from providers, beneficiaries, and family members in identifying barriers to the delivery of clinical care and administrative services;
5. Designing and implementing interventions to improve performance (including required performance improvement projects);
6. Measuring the effectiveness of the interventions;

7. Incorporating successful interventions in the system, as appropriate; and
8. Reviewing client grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required.

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

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

QI Work Plan

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

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

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

The Quality Improvement Work Plan (QIWP) and QIWP Evaluation are revised annually and are available online at https://www.co.siskiyou.ca.us/behavioralhealth.

Utilization Review

The quality assurance department is responsible for all utilization management (UM) activities. Assessments will be provided to children and adults to determine medical necessity, level of care, and appropriateness of services by either the MHP or contracted

providers. Additionally, utilization review activities are conducted retrospectively by the quality assurance and health information departments. Any problems or issues identified throughout the quality management system will be reviewed in the QIC. Charts may also be referred to the QA department by the QIC and by any other staff when there are concerns about the quality of care; specifically the authorization, provision, or documentation of specialty mental health services to a particular client.

Utilization Management Program

The MHP performs documentation reviews to monitor the utilization of services and timely and appropriate documentation for 100% of Service Authorization Requests, 100% of Treatment Authorization Requests, 10% of organizational and contractor documentation (non-hospital), and 10% of the active caseload for utilization and peer reviews combined.

The Quality Assurance Manager (QAM) provides new clinical staff documentation training and documentation review. Documentation training is also provided to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.

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

(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.

Policies and Procedures Regarding Confidentiality

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

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

All MHP staff are required upon hire, and annually thereafter to complete a compliance training of which confidentiality standards are a major component. Each MHP staff member must pass an exam on the compliance program and must sign an agreement to adhere to compliance and ethical standards while maintaining employment with the MHP.

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

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

For more information, refer to MHP's Compliance Plan and policies: Compliance Program ADMIN 13-05; Implementation of Compliance Program COMP 14-01; Compliance Trainings COMP 14-03; and the MHP Code of Conduct policy, Code of Conduct and Ethics ADMIN 14-05; HIPAA policies; Breach Notification and Mandatory Reporting ADMIN 14-01; Confidentiality of Client Records ADMIN 14-04; Confidentiality Agreement and Acknowledgement ADMIN 17-01; and Confidentiality Agreement and Acknowledgement ADMIN 17-01; Exhibit A.

(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.

No other policies and procedures have been specifically identified by BHD as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in Title 9, Chapter 11. Since BHD is an existing MHP, we do not believe there are any policies and procedures that are relevant to determining readiness to provide specialty mental health services to Siskiyou County beneficiaries.