Inyo County Health and Human Services Behavioral Health

Implementation Plan Update

JULY 2023

Kimball C. Pier, Ph.D., LMFT

Health and Human Services Deputy Director

Behavioral Health Division

The Implementation Plan is required by CCR Title 9, Chapter 11, § 1810.310. In accordance with § 1810.310(c)(1), an MHP shall submit proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan prior to implementing the proposed changes.

INTRODUCTION AND OVERVIEW

INYO COUNTY HEALTH AND HUMAN SERVICES - BEHAVIORAL HEALTH

County Demographics and Description

Inyo County is the second largest county in California encompassing 10,192 square miles and is the second most sparsely populated after Alpine County, one of California's smallest rural counties. According to the 2020 census, the population of Inyo County was 19,016 citizens. The population is concentrated in Bishop, (population 3,879) West Bishop (population 2,607), Lone Pine, (population 2,035), Big Pine (population 1,756) and The Bishop Paiute Tribal Community (population 1,588). All of these communities are located along the Owens Valley beneath the Eastern crest of the Sierra Nevada. Inyo County has the highest point in the contiguous United States; Tumanguya (Mt. Whitney) at 14,505 ft., and the lowest point in the contiguous United States at Badwater in Death Valley at 282 feet below sea level.

Bishop and the smaller communities in Inyo County have suffered as a result of the pandemic, causing the closures of numerous small businesses as well as some of the larger businesses. The pandemic also brought with it a significant increase in substance use, and concurrent spikes in symptoms for individuals with existing mental health disorders, and emergence of depression, anxiety, and trauma-related symptoms especially for our adolescent and elder populations.

In addition, during summers of 2020 and 2021, California experienced some of its worst wildfires the outcomes of which were even more restricted activity and isolation for those experiencing medical problems and mental health problems associated with isolation, loss of employment, lack of financial resources, and families struggling to work while having children home from school.

At this time, Inyo County Behavioral Health Services is developing new approaches and building out existing approaches that match the intentions and goals of CSC (Coordinated Specialty Care) and CalAIM, an acronym for "advancing and innovating Medi-Cal). We are implementing a "whole person" approach to treatment and being innovative in ways we can meet the needs of our community members. In particular, staff have participated in TIC (Trauma Informed Care) training, and we are also participating in JEDI (justice, equity, diversity, and inclusion) training and we are focused on being a trauma-informed county by incorporating the principles of TIC and JEDI in all our work.

The majority of Inyo County's population identify as Euro-American, with next largest segment identifying as LatinX or Mexican, and the next largest, indigenous tribal members. Based on the 2020 census, 66% identify as white; 19% identify as Hispanic or of Latino origin. Given the LatinX population which has grown 3.7% since the last census, Spanish is a threshold language for Inyo County, and we are challenged to find ways to meet our Spanish-Speaking client's needs in behavioral health and substance use disorders services. service.

The federally- recognized "Native American" (indigenous) nations in Inyo County are the Bishop Paiute Tribe, Big Pine Paiute Tribe of the Owens Valley, Fort Independence Reservation, Lone Pine Paiute Shoshone Reservation, and Timbisha Shoshone Tribe. The Timbisha Shoshone Tribe, located in Death Valley National Park, is the only tribe located inside a national park in the US.

Settlement within Inyo County by Euro-Americans within the past one hundred fifty years has had significant consequences for the indigenous tribes of Inyo County. Most significant of these are the impact on the physical, spiritual, and mental health,[1] and for whom historical trauma is strongly correlated with higher incidences of addiction-related health problems, mental health problems related to trauma, and disproportionate numbers of justice-involved individuals. [2]The combination of multi-generational trauma compounded by substance use disorders is often stigmatized in ways that prevent people from feeling welcome or safe in seeking recovery or healing services. Seeking culturally relevant healing services is particularly challenging when our State and County governed behavioral health systems are grounded in a Western medical paradigm and allow no room for practices and methods that fall outside of the Western medical model.

The health issues experienced by people of color and particularly indigenous people include diabetes, hypertension, heart disease, obesity, increased rates of and colon cancer, which are related to diets high in salt, sugar, and fat. Immune-related disorders and inflammatory conditions are also related to acute and chronic trauma. The effects on mental and spiritual health are correlated with transgenerational and historical trauma, the symptoms of which manifest in substance use and dependence, depression, anxiety, bipolar disorders, and post-

[1] Spillane, N. S., Schick, M. R., Kirk-Provencher, K. T., Nalven, T., Goldstein, S. C., Crawford, M. C., & Weiss, N. H. (2022). Trauma and Substance Use among Indigenous Peoples of the United States and Canada: A Scoping Review. Trauma, Violence, & Abuse, 0(0). https://doi.org/10.1177/15248380221126184
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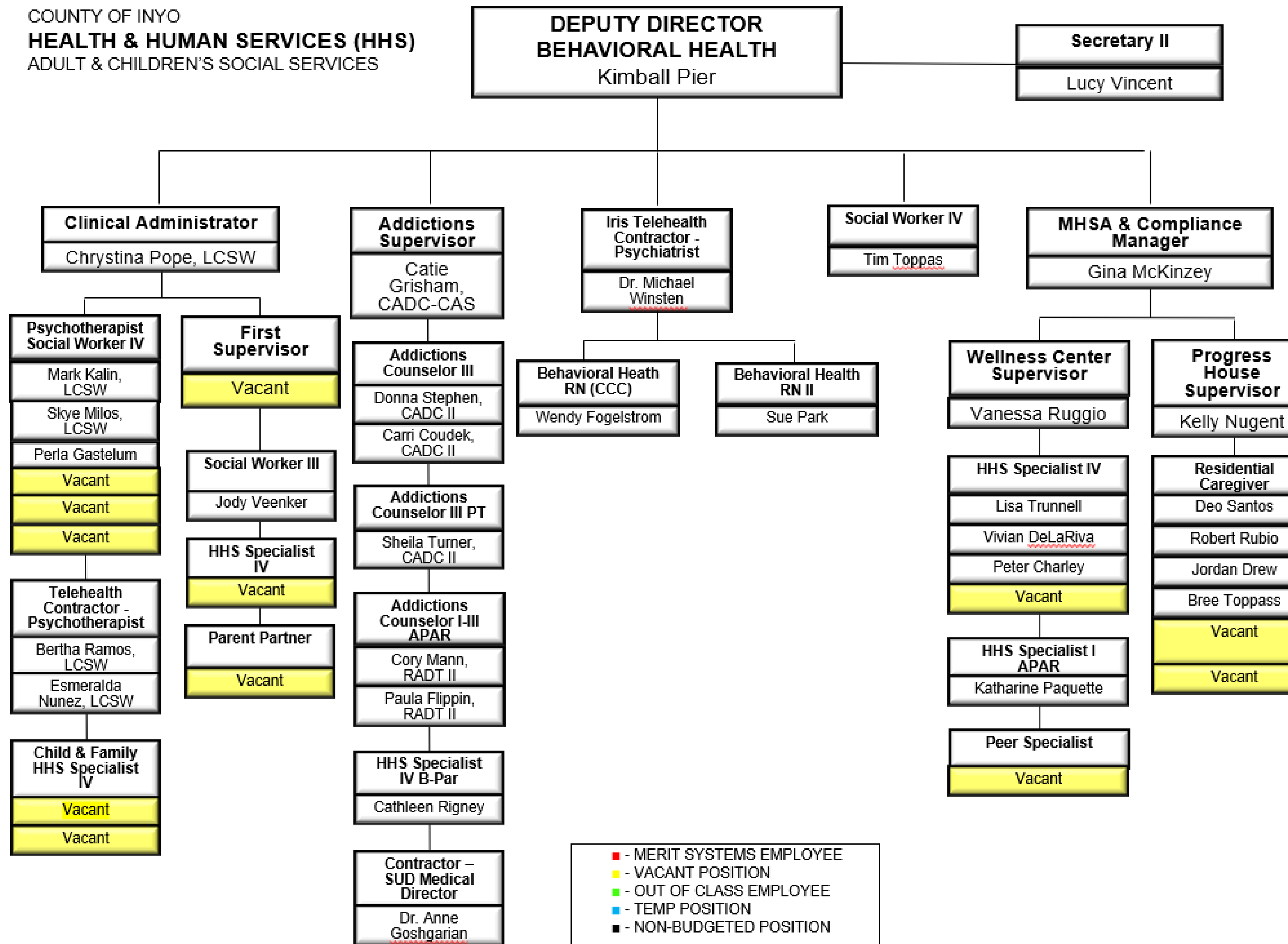
traumatic stress disorder among other illnesses that occur disproportionately among Indigenous People and people of color.

Finally, we have a disproportionate number of indigenous people and people of color in jail who need rehabilitative and recovery services. As it is, Inyo County, like most other rural counties, lack the infrastructure to provide safe, secure housing for justice-involved clients who require a higher level of care. The jail serves as the “de facto” psychiatric hospital which is true for many rural counties where resources are few for individual who are substance-involved, mentally ill, and experience chronic homelessness. We are striving to build out services in the jail and to make our re-entry services more robust.


COUNTY OF INYO
HEALTH & HUMAN SERVICES (HHS)
ADULT & CHILDREN'S SOCIAL SERVICES
DEPUTY DIRECTOR BEHAVIORAL HEALTH
Kimball Pier
Secretary II
Lucy Vincent
Clinical Administrator
Chrystina Pope, LCSW
Addictions Supervisor
Catie Grisham, CADC-CAS
Iris Telehealth Contractor - Psychiatrist
Dr. Michael Winsten
Social Worker IV
Tim Toppas
MHSA & Compliance Manager
Gina McKinzey
Psychotherapist Social Worker IV
Mark Kalin, LCSW
Skye Milos, LCSW
Perla Gastelum
Vacant
Vacant
Vacant
First Supervisor
Vacant
Social Worker III
Jody Veenker
HHS Specialist IV
Vacant
Parent Partner
Vacant
Telehealth Contractor - Psychotherapist
Bertha Ramos, LCSW
Esmeralda Nunez, LCSW
Child & Family HHS Specialist IV
Vacant
Vacant
Addictions Counselor III
Donna Stephen, CADC II
Carri Coudek, CADC II
Addictions Counselor III PT
Sheila Turner, CADC II
Addictions Counselor I-III APAR
Cory Mann, RADT II
Paula Flippin, RADT II
HHS Specialist IV B-Par
Cathleen Rigney
Contractor – SUD Medical Director
Dr. Anne Goshgarian
Behavioral Heath RN (CCC)
Wendy Fogelstrom
Behavioral Health RN II
Sue Park
Wellness Center Supervisor
Vanessa Ruggio
HHS Specialist IV
Lisa Trunnell
Vivian DeLaRiva
Peter Charley
Vacant
HHS Specialist I APAR
Katharine Paquette
Peer Specialist
Vacant
Progress House Supervisor
Kelly Nugent
Residential Caregiver
Deo Santos
Robert Rubio
Jordan Drew
Bree Toppass
Vacant
Vacant
- MERIT SYSTEMS EMPLOYEE
- VACANT POSITION
- OUT OF CLASS EMPLOYEE
- TEMP POSITION
- NON-BUDGETED POSITION

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 Sections 1810.425 and 1810.435. The entity designated to be the MHP will include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH [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 Section 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to Section 1810.410(c).

(8) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.
(9) A description of the MHP's Quality Improvement and Utilization Management Programs.
(10) A description of policies and procedures that assure 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 Inyo County Health and Human Services - Behavioral Health Implementation Plan Update addresses all the required elements outlined in the California Code of Regulations (CCR), Title 9, §1810.310. Care was taken to follow the structure established in the regulation, to ensure all the necessary descriptions of policies, procedures and processes, are included. Elements that were required in the original Implementation Plan but are not applicable to the update are so noted.

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

(3) If the changes are consistent with this Chapter, the changes 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.

<u>Payment Authorization for Psychiatric Inpatient Hospital Services</u>

Policy

1. In accordance with Title 9, § 1820.220, Inyo County Health and Human Services - Behavioral Health (ICHHS-BH) has designated a Point of Authorization (POA) where psychiatric inpatient hospitals submit written requests for MHP payment authorizations for Medi-Cal psychiatric inpatient hospital services provided to Inyo County clients. The contact information for the ICHHS-BH POA is:

   Inyo County HHS Behavioral Health Division
   1360 North Main Street
   Bishop, CA 93514
   Phone: (760) 873-6533
   Fax: (760) 873-3277

2. ICHHS-BH will receive and process all TARs for Medi-Cal or potential Medi-Cal patients with inpatient psychiatric stays. All TARs will be reviewed according to the current state TAR instructions by licensed/waivered mental health professionals.
3. ICHHS-BH will approve or deny TARs within fourteen (14) calendar days of receipt of the request. All inpatient provider appeals ruled in favor of the provider shall adhere to regulations regarding payment and authorized for payment within fourteen (14) calendar days of receipt of the revised TAR.
4. ICHHS-BH will be financially responsible for the costs associated with medically necessary inpatient hospitalization for Medi-Cal beneficiaries and individuals with no health insurance residing in Inyo County.

Procedures

1. ICHHS-BH Managed Care Analyst/Administrative Secretary or designee will receive the TAR and medical records via the mail and date stamp the TAR. The verification of the date stamp will be reviewed by Behavioral Health Director or Designee on the log before signing approval. Any corrections made to a TAR by the MHP will be crossed through and initialed by the altering staff. Staff will forward the TAR to designated licensed/waivered mental health professionals for review.

2. The licensed/waivered mental health staff will review the TAR to make sure the form is completed correctly according to current State Department of Health Services and Department of Mental Health "Treatment Authorization Request (TAR) Instructions" and hospital agreement with ICHHS-BH, e.g.:
   a. All necessary blanks completed
   b. Medical records attached

3. The licensed/waivered mental health staff will closely review the following:
   a. Boxes 6-20 of the TAR for completion and accuracy,
   b. Boxes 21-22E for evaluation of medical necessity, and

    c. Compare the client's chart to the TAR for supporting documentation criteria, if available.

4. After reviewing the TAR, the licensed/waivered mental health staff will:
    a. Approve the TAR as written (with signature), or
    b. Request more information from the provider, or
    c. Deny the TAR (with signature).

5. All adverse decisions by the licensed/waivered mental health staff regarding inpatient TARs (payment denial) are subject to final review by an ICHHS-BH psychiatrist, MD

<u>Authorization for Outpatient Specialty Mental Health Services</u>

1. Authorization – Overview
    a. Urgent requests receive authorization for treatment within one (1) hour through on-call staff. Designated staff are assigned on-call responsibility. Unlicensed designated staff are required to consult with licensed or waivered staff by phone to obtain approval or denial of urgent requests for network providers of outpatient specialty mental health services.
    b. All routine requests are scheduled through the front office for a cross-cultural clinical assessment with the intake clinician. The Authorization/Treatment Team determines planned services authorizations.
    c. Evaluation referrals for mental health services as related to the IEP process (formerly referred to as 3632 evaluations) are managed through the ICHHS-BH Child and Family Services Program Chief. If a school should deviate from the referral process as outlined in the ICHHS-BH /County Office of Education Memorandum of Understanding (MOU), staff will inform the Child and Family Services Program Chief for follow up.

2. Service Authorization Procedures – Authorization/Treatment Team
    The ICHHS-BH Authorization/Treatment Team consists of the intake clinician, the Adult Services Program Chief and/or Child and Family Services Program Chief, and other treatment provider staff, as assigned.
    a. Utilization Review (UR) responsibilities include review of 1) clinical assessments and other relevant information to determine medical necessity, 2) authorization of appropriate services, and 3) the duration of the authorization period (i.e., 6 months).
    b. The Authorization/Treatment Team reviews all the assessments for completeness and evaluates clinical assessments for the purpose of referrals and coordination with other relevant services, including substance abuse treatment services, education, housing resources, regional center services, physical health care, vocational rehabilitation, etc.
    c. The Authorization/Treatment Team is also responsible for review and authorization of private network providers, planned hospital admissions, TBS, and contract mental health provider requests to deliver services. This process includes authorization of services for new clients, as well as re-authorization of on-going services.
    d. The Authorization/Treatment Team shall complete the following activities during Authorization/Treatment Team meetings:
        i. Review charts and authorize services per utilization review standards
        ii. Assign a clinician, MD, case manager, or social worker, as appropriate and necessary
        iii. Forward the intake packet to the front desk staff for processing

e. The Authorization/Treatment Team reviews initial and annual service plans to assure clinical and documentation standards are met. All plans are to be signed by the client and approved staff member prior to authorization. The client plan will be signed or co-signed by a Physician, licensed/waivered Psychologist, Licensed /registered/waivered Social Worker, licensed/registered/waivered/marriage and family therapist, licensed/registered/waivered professional clinical counselor or a Registered Nurse. All service plan renewals are also reviewed and evaluated for appropriateness of re-authorization for continued services. Add-on service requests are reviewed also for appropriateness of service authorization and provider assignment. This process assures that only services on the care plan are claimed. Further, the care plan is to contain information that indicated the client received a copy of the plan or declined a copy.
f. The Authorization/Treatment Team will initially authorize services for the following standard increments of time unless medical necessity warrants a different period of time or further assessment is needed:
   i. Mental Health Services – 1 year
   ii. Case Management – 1 Year
   iii. Medication Support – 1 Year
   iv. Day Rehabilitation Services – 6 months
   v. Intensive Day Treatment – 3 months
g. When the Authorization/Treatment Team has reviewed an initial clinical assessment and has determined that medical necessity exists, service delivery is authorized. The Authorization/Treatment Team will determine which services are appropriate to meet the client's needs and assign specific service providers (clinician, case manager, and/or psychiatrist, etc.).

Out of County Services for Children and Youth

ICHHS-BH will assure delivery of medically necessary specialty mental health services for children in foster care, KinGAP or Aid to Adoptive Parents (AAP) aid codes placed outside their county of origin. The staff person coordinating the intake process shall make appropriate administrative staff and clinical staff aware to follow processes to authorize, document, and provide or reimburse services per DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 17-017 and Department of Mental Health (DMH) Information Notice No. 09-06:

1. Medi-Cal Eligible Children in a Foster Care Aid Code

   ICHHS-BH shall provide specialty mental health services to foster children upon presumptive transfer to ICHHS-BH from the MHP in the county of original jurisdiction without any delay in timeliness. Upon presumptive transfer, the MHP in the county in which the foster child resides shall assume responsibility for the authorization and provision of Medi-Cal Specialty Mental Health Services, and the payment for services, unless a waiver based on an exception to presumptive transfer exists, based on DHCS MHSUDS Information Notice No. 17-017.

2. Medi-Cal Eligible Children in an Aid to Adoptive Parents 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 a 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 an 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 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 72 hours 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 72 hours 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 72 hours 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.
    i. 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.
    ii. 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, MHPs 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.

3. 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 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 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 72 hours 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 72 hours 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 72 hours 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 Short-Doyle/Medi-Cal 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.

(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.

<u>Access Triage and Screening</u>

1. Toll Free Number
   The MHP maintains a statewide toll-free number (1-800-841-5011) available 24 hours per day and 7 days a week.

2. Client contact is made via walk-in, call-in, referral, or crisis on-call. Notification of a potential managed care client may also come internally through Administrative Secretary who receives requests from Child Protective Services and/or Probation placements.

3. If the clinical intake staff member is available, the clinical intake will be conducted at that time. If the clinical intake staff is not available, then an appointment will be made. Clinical Intake appointments are made within seven days of initial contact. An appointment reminder card will be provided for clients who are scheduled. Once completed, the packet is given to the appropriate staff member responsible for the clinical intake.

4. When a client arrives for his or her scheduled clinical intake appointment and contact clinical intake staff member to inform that client has arrived.

5. The clinician will escort client to private office and conduct the clinical assessment.

6. Upon completion of clinical intake, arrangements are to be made in writing between the clinical intake staff and potential client as to how and when the next contact will be made. Either the potential client will contact the office or the clinician will contact the potential client following the Authorization/Treatment Team meeting.
7. Clinical intake staff is to escort client to lobby and complete any unfinished clinical intake paperwork including assessment and progress note.
8. If another session is required to complete the clinical intake, the clinician will schedule another appointment and give client a reminder card.
9. Once the clinical assessment is completed, it will be reviewed by the Authorization/Treatment Team based on UR standards. UR and Service Authorization is made within seven days of Clinical Intake date.
10. The authorization documentation will be completed on the minutes.
11. If services are authorized, clinical staff gives the documentation packet to the Office Assistant and discusses the urgency of any appointments authorized with the Psychiatrist and creates a file/chart. There is a sample file/chart to be used as a model.
12. If based on the assessment the client needs other services including substance use disorder services, educational services, health care services or housing services, the client is referred to the appropriate service provider and ICHHS-BH staff ensure the service provider and client are aware of the referral.
13. If the client is determined to not meet medical necessity criteria for Medi-Cal specialty mental health services or services are denied for any reason, a Notice of Adverse Benefit Determination (NOABD) will be issued in accordance with state and federal requirements. The NOABD process is described in the ICHHS-BH Beneficiary Problem Resolution Process policy and procedure.

<u>Substance Use Disorder Services</u>

ICHHS-BH has an integrated Mental Health and Substance Use Disorders Services Division with shared leadership that provides mental health and substance use disorders services. ICHHS-BH provides both specialty mental health services and substance use disorder services to Medi-Cal adult clients with serious and persistent mental illness and to children and youth with severe emotional disturbances, or substance use disorders, based on the client’s assessed needs.

<u>Educational Services</u>

If the access, triage and screening process determines that the client could benefit from coordinated care with an educational facility, ICHHS-BH staff refer and link the client with the appropriate educational professional staff. School based services are provided by ICHHS-BH when indicated by the client plan or Individual Education Plan.

<u>Health Care Services</u>

Anthem Blue Cross Partnership Plan (ABC) and California Health and Wellness (CHW) are the Managed Care Plans (MCPs) that serve the physical health care needs of Medi-Cal clients in

Inyo County. The MCPs also provide the mental health benefit for clients with "mild or moderate" mental health issues. Care coordination and effective communication between ICHHS-BH and the MCPs including procedures for exchanges of medical information are included in the Memorandum of Understanding (MOU) between ICHHS-BH and the MCPs. The MOUs are available upon request. If a client is assessed by ICHHS-BH as not meeting medical necessity criteria for specialty mental health services due to having a mild to moderate impairment, or having a condition that would be more responsive to appropriate physical health care, a referral is made to the MCP and a Notice of Adverse Benefit Determination (NOABD) is issued. If a MCP member is screened by the MCP as potentially requiring specialty mental health services, they will be referred to ICHHS-BH for an assessment to determine medical necessity.

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

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

<u>Housing Services</u>

If the access, triage and screening process determines the client is in need of housing support, ICHHS-BH may refer the client the Mental Health Services Act (MHSA) Community Services and Supports (CSS) program where linkages to housing supports are available. One important component of the CSS plan is in the provision of respite and transitional housing for Full Service Partners (FSPs) as needed. We continue to purchase four beds at Progress House, an Adult Residential Facility. We have used these beds for persons with severe mental illness who are transitioning out of acute care, incarceration or who are homeless. We have provided transition services for four transition age youth/young adults with severe mental illness who had spent time incarcerated in our local jail and have spent time in homelessness. In addition, we have served persons who are living within the community who are in need of a respite due to a mental health crisis. We have been able to keep persons within our community and to assist them to successfully transition back into the community through this strategy.

<u>Vocational/Employment Resources</u>

If the access, triage and screening process indicates that the client needs and wants vocational services, ICHHS-BH may refer the client to the MHSA program or the employment and eligibility office. The MHSA CSS program includes employment support at the Wellness Centers for clients who are assessed as needing these services. ICHHS-BH has a social worker who works at of the employment and eligibility office to help coordinate services to our clients.

(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.

ICHHS-BH provides a Guide to Medi-Cal Mental Health Services (client 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 ICHHS-BH county service locations. The content and format are consistent with CCR, Title 9, §1810.360 and the Title 42, Code of Federal Regulations (42 CFR), § 438.10.

Regarding community outreach, the MHSA funded CSS Program includes anti-stigma events. Our Adult and Older Adult Wellness Centers (located in Bishop and Lone Pine) provide adults and older adults with necessary services and supports in a welcoming environment. Often persons who are homeless will be guided by partners or even community members to come to the wellness centers for support. Several persons have reported that they had been steered to the wellness centers by the local church, law enforcement, social services, or the hospital. We have also received calls from these partners letting us know about persons they have referred to the wellness center or persons for whom they have concerns. During times of more extreme hot or cold or otherwise inclement weather, persons are especially engaged at the wellness centers. We have provided more intensive outreach to persons during times of inclement weather, either extreme heat in the summer or cold during the winter. We have also successfully provided targeted outreach to several persons and have engaged with them in the community, even if they are initially unwilling to come even to the wellness centers. Wellness center workers have patiently and persistently provided outreach over time to build trust with persons who have been very distrustful and distressed in their illness. We have also become aware of persons with mental illness who have ended up incarcerated often due to a combination of mental illness and substance abuse. We have used the Wellness Centers as a place to connect as they re-enter the community. At times, persons also need transitional living as they re-enter the community and are able to benefit from a combination of supports to meet their needs.

We have also continued to offer Latino Outreach through both the wellness center sites and within the community. A contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist is able to treat anxiety and depression related to trauma issue as well as the provision of family support. A bilingual Latina employee at the wellness center also provides outreach to the underserved population and is able to serve as an advocate for Spanish-speaking persons with mental illness struggling to navigate the systems of support. Approximately 22 youth were served through this CSS strategy along with outreach to at least 55 additional persons.

A specific strategy has been needed to address the needs of our isolated southeastern area of the County, the Death Valley area, closer to Nevada population centers than to Inyo towns. While there is a contract with a mental health provider in Pahrump, few persons are willing or able to engage in this service. A small amount of telemedicine is also available for persons engaged in services. A strategy of using a Mental Health Nurse to outreach and engage with persons with mental illness in this part of the county has been most useful. The Nurse has provided services to several isolated older adults who live in this community as well as checking in with adults or youth and family who have been identified with mental illness. Persons often evidence co-occurring addiction issues as well as related health conditions. The Nurse also

participates in a bi-monthly community potluck that serves to connect with residents effectively. The Nurse has further been trained as a certified Mental Health First Aid trainer and has scheduled to provide this training for interested persons in the community.

(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.

This element is not applicable to the Implementation Plan Update. ICHHS-BH is fully operational and provides a range of specialty mental health services to Medi-Cal clients to assure continuity of care for all persons needing medically-necessary mental health services. ICHHS-BH has been the MHP in Inyo County since 1997, providing specialty mental health services to the county's Medi-Cal clients.

(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 ICHHS-BH psychiatrist is available to physical health care providers for consultation, training, or distribution of educational materials related to medications or other mental health care issues. Our psychiatrist may be contacted at our central clinic in Bishop during business hours Monday through Wednesday and is available in Lone Pine in the South County on the second Wednesday of each month.

As discussed above in response to (2)(A), ABC and CHW are the MCPs that serve the physical health care needs of Medi-Cal clients in Inyo County. As required by Title 9 § 1810.370(a), ICHHS-BH and both MCPs have entered into MOUs. The MOUs address referral protocols between ICHHS-BH and the MCPs. In accordance with § 1810.370(a)(2), ICHHS-BH provides the availability of clinical consultation, including consultation on medications, to the MCPs for clients whose mental health conditions are being treated by the MCPs.

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

<u>Beneficiary Problem Resolution Process</u>

ICHHS-BH is committed to finding solutions to the issues clients may encounter when receiving services from ICHHS-BH. Clients will not be subjected to discrimination or treated unfairly for filing a grievance, appeal or expedited appeal. ICHHS-BH follows procedures and timelines for the Grievance and Appeal process consistent with 42 CFR § 438.400 – 438.424.

<u>Definitions</u>:

Adverse benefit determination
An Adverse Benefit Determination occurs when the MHP does at least one of the following:

1. Denies or limits a requested service through the authorization process (this includes the type of service or the level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit);
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;

4. Fails to provide services in a timely manner, as determined by the State Department of Health Care Services;
5. Fails to act within the timeframes provided in 42 CFR Section 438.408 (b)(1), (2) and (3) for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals; and/or
6. The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

An Appeal is a request for review of an adverse benefit determination.

An Expedited Appeal is used when the ICHHS-BH determines or (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

A Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Any problem that a client may have which does not involve an adverse benefit determination must be filed as a grievance.

- Possible grievances include, but are not limited to, access to services, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or staff member, or failure to respect the client's rights.

State Fair Hearings

Clients have a right to request a State Fair Hearing after completing the ICHHS-BH Problem Resolution Process. Clients must exhaust the county Problem Resolution Process before filing for a State Fair Hearing.

<u>Procedures</u>

1. Beneficiary Notification
    a. Beneficiaries will be notified of grievance and appeal procedures through a brochure (available in both Spanish and English) that explains their rights and the grievance and appeal process, along with a self-addressed mailing envelope.
    b. These brochures will be provided to beneficiaries at the following times and/or locations:
        i. Upon entry into the MHP system
        ii. By clinic providers upon admission to their program or service
        iii. Be posted in plain view at each provider location
        iv. Upon receiving a NOABD
        v. By calling the 24-hour Toll Free Access line for information about the grievance and appeal procedures
    c. Staff will provide clients with the Beneficiary Brochure and Client Problem Resolution Guide at admission and again at the time of the annual assessment.
    d. Clerical staff shall ensure that a Beneficiary Brochure and Client Problem Resolution Guide is attached to each Annual Assessment Form.
    e. The Beneficiary Brochure and Client Problem Resolution Guide and forms are visibly posted and accessible in public waiting areas and other clinic areas at all certified

provider sites for use by clients without making verbal or written request. Self-addressed envelopes are available in the public waiting area for use by clients who prefer to communicate by mail.

f. Problem Resolution materials will be available in English and in Inyo County's threshold language, Spanish. Clients who are visually impaired shall be able to access the information via audiotape. Bilingual and interpreter services are available to assist with the process.
g. Information regarding the ICHHS-BH problem resolution process is also available through the toll-free 24-hour phone system.
h. Changes to the problem resolution process and/or client's rights shall be posted in a prominent location at all ICHHS-BH sites.
i. Brochures and other informing materials except for provider directories shall be updated as soon as possible, but at least within 90 days, to reflect any new regulations. Provider directories will be updated at least monthly and electronic provider directories will be updated no later than 30 days after ICHHS-BH receives updated provider information.

2. Written Notice of Adverse Benefit Determination

Beneficiaries must receive a written NOABD when the ICHHS-BH takes any of the actions described above. ICHHS-BH must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR Section 438.10. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

a. The adverse benefit determination the Plan has made or intends to make;
b. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The NOABD will explicitly state why the beneficiary's condition does not meet specialty mental health services medical necessity criteria;
c. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
d. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

ICHHS-BH will mail the NOABD to the beneficiary within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Medi-Cal covered services, at least 10 days before the date of action. ICHHS-BH will mail the NOABD in as few as 5 days prior to the date of action if ICHHS-BH has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
b. For denial of payment, at the time of any action affecting the claim.
c. For standard service authorizations that deny or limit services, as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following the receipt for request for services.
d. The Contractor shall deposit the NOABD with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

3. Confidentiality
   All information pertaining to grievances and appeals will be treated as confidential information.

4. Other Related Beneficiary Rights
   Other related beneficiary rights that will be honored, include:
   a. A beneficiary may authorize another person, including a Provider, to act on his/her behalf regarding a grievance or appeal procedure:
      i. The authorized person will need a release of information signed by the beneficiary in order to receive confidential clinical information.
      ii. Minors may be represented by their parents or guardians, except when prohibited by law or when they consent to substance use disorder treatment.
   b. Beneficiaries will not be subjected to discrimination or any other penalty or punitive action for filing a grievance, appeal or expedited appeal.
   c. Beneficiaries may present their grievance or appeal orally or in writing, though oral appeals must be followed up in writing.
   d. Beneficiaries may request records or other documents generated by either Plan in connection with the appeal.
   e. Beneficiaries must exhaust the MHP Appeal process prior to applying for a State Fair Hearing.

5. Grievance and Appeal Logs
   a. When an ICHHS-BH staff member receives a grievance or appeal, he/she shall submit the it to the Managed Care Analyst/Administrative Secretary. If the grievance or appeal is written, the receiving staff member shall date/time stamp the written document.
   b. The ICHHS-BH Managed Care Analyst/Administrative Secretary shall record the grievance (verbal or written) in the confidential Grievance and Appeals Log within one (1) working day of the date of receipt.
   c. The log shall include, but is not limited to:
      i. Name of the client;
      ii. Date of receipt of the grievance;
      iii. Nature of the problem;
      iv. The date of each review or, if applicable, meeting; and
      v. Final disposition, including:
         - Date of final decision
         - Final resolution or explanation of reasons if there was not a disposition
         - Date the decision or explanation is sent to the client

6. Grievance Process
   a. Beneficiary Filing:
      A beneficiary may file any expression of dissatisfaction about any matter other than an adverse benefit determination orally, using the 24-hour Toll Free Access line, in writing, or by mail by completing the ICHHS-BH grievance form.
   b. ICHHS-BH Response:
      i. Upon receipt of any grievance, service providers must report the grievance within one (1) working day to the Managed Care Analyst/Administrative Secretary (or designated staff) where it will be date stamped and entered immediately into the Grievance and Appeal Log.

ii. The Managed Care Analyst/Administrative Secretary shall promptly acknowledge receipt of a verbal or written grievance to the client in writing.
iii. The Quality Improvement Manager will assign the grievance to a staff member to assist in the resolution of the grievance.
iv. ICHHS-BH will ensure that individuals making decisions on the grievances have the appropriate clinical expertise in treating the beneficiary's condition, if the decision involves a grievance regarding denial of a request for an expedited appeal, or if the grievance involves clinical issues.
v. The staff assigned to assist in the resolution of the grievance will not have been involved in any previous level of review or decision-making.
vi. ICHHS-BH will strive to provide resolution of a client's grievance as quickly and simply as possible.

c. Assigned Staff Responsibilities:
The assigned staff will be responsible for:
i. Assisting the beneficiary in completing the grievance and appeal form, if necessary.
ii. Responding to the beneficiary in writing to confirm receipt of the grievance.
iii. Assisting the beneficiary in resolving the grievance.

d. Resolution:
i. The beneficiary will be notified in writing by the MHP regarding the final resolution of the grievance within thirty (30) days from the date the grievance is filed.
ii. The timeframe may be extended by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests more time to gather information).
iii. The final resolution of each grievance, including the date of the decision, will be documented in the Grievance Log.

7. Standard Appeal Process
a. Beneficiary filing:
i. A beneficiary may file an appeal orally, using the 24-hour Toll Free Access line, in writing, or by mail by completing the ICHHS-BH appeal form, within 60 calendar days of an adverse benefit determination taken by ICHHS-BH.
ii. If the appeal is oral, the beneficiary must follow up with a signed, written appeal within 60 days of Notice of Adverse Benefit Determination.
iii. The date of the oral appeal starts the response time clock.

b. ICHHS-BH Response:
i. Upon receipt of any appeal, service providers must report the appeal within one (1) working day to the Managed Care Analyst/Administrative Secretary (or designated staff) where it will be date stamped and entered immediately into the Grievance and Appeal Log.
ii. The Managed Care Analyst/Administrative Secretary shall promptly acknowledge receipt of a verbal or written appeal to the client in writing.
iii. The Quality Improvement Manager will assign the appeal to a staff member to assist in the resolution of the appeal.
iv. ICHHS-BH will ensure that individuals making decisions on an appeal of adverse benefit determinations have the appropriate clinical expertise in treating the beneficiary's condition, if the decision involves an appeal based on a denial of medical necessity, or if the appeal involves clinical issues.

v. The staff assigned to assist in the resolution of the grievance will not have been involved in any previous level of review or decision-making.
vi. ICHHS-BH will strive to provide resolution of a client's appeal as quickly and simply as possible.

c. Beneficiary Participation in Appeal:
Beneficiaries may:
i. Present evidence in person or in writing; and
ii. Examine his/her medical record and any other records pertaining to the appeal before and during the appeal process.
iii. Be provided with their medical records, other documents & records, and any new or additional evidence considered, relied upon, or generated by ICHHS-BH in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the resolution timeframes for appeals.

d. Notification of Appeal Resolution:
i. The beneficiary (or his/her representative) will be notified in writing by ICHHS-BH (including the decision date) regarding the final resolution of the appeal within thirty (30) calendar days from the date the appeal is filed. If a client cannot be reached (i.e., returned mail), ICHHS-BH will document the notification effort in the Grievance and Appeals Log.
ii. If the decision made was not wholly in favor of the client, the notice shall also contain information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.
iii. The timeframe may be extended by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests more time to gather information or ICHHS-BH determines there is need for additional information and the delay is in the beneficiary's interest.
iv. The final resolution of each appeal, including the date of the decision, will be documented in the Appeal Log.
v. ICHHS-BH will also notify any provider(s) or staff persons cited in the appeal of the final decision, in writing.
vi. If ICHHS-BH fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a NOABD, advising that the client has a right to request a State Fair Hearing.
    - The NOABD will be given on the date that the timeframe expires.
    - NOTE: Clients cannot request a State Fair Hearing before or during the appeal process, unless ICHHS-BH has failed to act within the timeframe required by the grievance process.

8. Expedited Appeal Process

a. Criteria:
Beneficiaries have the right to an Expedited Appeal if using the Standard Appeal resolution process could jeopardize their life, health or ability to attain, maintain or regain maximum function.

b. Notification:
i. Beneficiaries will be notified of their right to an Expedited Appeal and the necessary criteria in the grievance and appeal brochure.

ii. ICHHS-BH will inform 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, sufficiently in advance of the resolution timeframe for the expedited appeal.

c. Differences from Standard Appeal

All procedures related to Standard Appeal apply for an Expedited Appeal, except for the following differences:

i. ICHHS-BH will determine whether or not the beneficiary meets the criteria for an Expedited Appeal before proceeding on an expedited timeframe.

ii. ICHHS-BH will reach a decision regarding the Expedited Appeal and notify (orally and in writing) the beneficiary of the resolution within 72 hours of receipt of the Expedited Appeal.

iii. ICHHS-BH may extend this timeframe by up to 14 calendar days if the beneficiary requests an extension, or ICHHS-BH determines that there is need for additional information and that the delay is in the beneficiary's interest. If ICHHS-BH extends the timeline for processing an expedited appeal not at the request of the beneficiary, ICHHS-BH shall make reasonable efforts to give the beneficiary prompt oral notice of the delay, and notify the beneficiary of the extension and the reasons for the extension, in writing, within 2 calendar days of the determination to extend the timeline.

iv. The beneficiary may make the request orally, without written follow-up. No punitive action will be taken against a beneficiary or provider because they request an expedited appeal or support a beneficiary's request for an Expedited Appeal.

d. Denial of the Expedited Appeal Process

If ICHHS-BH determines that the criteria for an Expedited Appeal are not met and deny an Expedited Appeal process:

i. ICHHS-BH will notify the beneficiary and/or his/her representative orally and will notify him/her in writing within 72 hours from the date of the denial; and

ii. The Standard Appeal process will apply.

9. State Fair Hearing

a. If ICHHS-BH fails to adhere to the notice and timing requirements of the appeal process, or if an appeal is denied, the beneficiary has the right to file for a State Fair Hearing (SFH) and be informed about filing instructions.

b. The written notice informing a beneficiary that their appeal has been denied will include information regarding their right to:

i. File for a State Fair Hearing and instructions on how to file a SFH or call the toll free number on the form. A beneficiary must request a SFH no later than 120 calendar days from the date of the appeal resolution.

ii. Request services while the hearing is pending and how to make that request.

10. Clients' Rights regarding Aid Paid Pending

In certain instances, ICHHS-BH will provide aid paid pending (APP) to beneficiaries who request continued services and have filed a timely request for an **appeal or state fair hearing**.

a. A beneficiary receiving specialty mental health services shall have a right to file for continuation of specialty mental health services pending the outcome of a fair hearing.
b. ICHHS-BH will continue the beneficiary's benefits while an appeal is in process if all of the following occur:
   i. The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice;
   ii. The appeal involves the termination, suspension, or reduction of a previously authorized service;
   iii. The beneficiary's services were ordered by an authorized provider;
   iv. The period covered by the original authorization has not expired; and,
   v. The request for continuation of benefits is filed on or before the later of the following:
      - Within 10 calendar days of the Contractor sending the notice of adverse benefit determination;
      - The intended effective date of the adverse benefit determination.
c. If, at the beneficiary's request, ICHHS-BH continues the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits must be continued until the beneficiary withdraws the appeal or request for state fair hearing, the beneficiary does not request a state fair hearing and continuation of benefits within 10 calendar days from the date ICHHS-BH sends the notice of an adverse appeal resolution, or a state fair hearing decision adverse to the beneficiary is issued

Please note: A beneficiary may file an appeal or a state fair hearing request about an action whether or not a NOABD has been issued. However, clients must first exhaust the ICHHS-BH Problem Resolution Process before filing for a state fair hearing.

11. Quality Management

All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings will be reviewed by the Behavioral Health Director if appropriate and may include Inyo County Risk Management. Monitoring shall be accomplished by ongoing review of the complaint/grievance log for adherence to timelines for response. In addition, the nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review will include an analysis of any trends in cultural issues or disparity in care addressed by our consumers. A summary of trends will be presented to the Community Quality Improvement Committee (CQIC) meetings as appropriate for feedback on policy changes. A summary of these findings will be recorded in the CQIC meeting minutes.

Provider Problem Resolution and Appeal Processes

Providers have the right to access the provider appeal process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

Provider Appeal Process

ICHHS-BH will work cooperatively to resolve any problems identified by providers in a sensitive and timely manner, utilizing both a Provider Problem Resolution Process and a Provider Appeal

Process. These processes may be accessed by ICHHS-BH providers to address payment authorization issues and other complaints and concerns.

Providers shall be informed of the Provider Problem Resolution Process and the Provider Appeal Process through the ICHHS-BH Provider Manual.

1. A provider may appeal a denied or modified request for ICHHS-BH payment authorization or a dispute with ICHHS-BH concerning the processing or payment of a provider's claim to ICHHS-BH.

   Appeals are sent to:
   Inyo County HHS - Behavioral Health
   162 J Grove Street
   Bishop, CA 93514-2696

2. A provider may initiate the appeal process orally, but will need to follow up with a signed written appeal or through a written request submitted to the ICHHS-BH Managed Care Analyst/Administrative Secretary or designee.
   a. The Managed Care Analyst/Administrative Secretary will document the date of receipt of the appeal in the ICHHS-BH Provider Grievance and Appeal Log. The resolution and date of response to the appeal are also recorded in the log.
   b. The appeal should clearly identify the provider's concerns and may include any supporting documentation that will assist in the problem resolution.
   c. The written appeal shall be submitted to ICHHS-BH within ninety (90) calendar days of the date of receipt of the non-approval of payment, or within ninety (90) calendar days of the ICHHS-BH failure to act on the request for payment.

3. The ICHHS-BH Director or designee shall review the written appeal and any associated documentation.
   a. If the appeal concerns the denial or modification of ICHHS-BH payment authorization request, ICHHS-BH shall utilize staff who were not involved in the initial denial or modification decision.

4. ICHHS-BH shall respond to the provider's appeal with a decision in writing within sixty (60) calendar days from the receipt of the provider's appeal request.
   a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider, and any action required by the provider to implement the decision.
   b. If the appeal is denied or not granted in full, the provider shall be notified of any right to submit an appeal to the California Department of Mental Health (see below).

5. If applicable, ICHHS-BH may request a provider to submit a revised request for ICHHS-BH payment authorization.
   a. The provider shall submit a revised request within thirty (30) calendar days from receipt of the ICHHS-BH decision to approve the ICHHS-BH payment authorization request.
   b. ICHHS-BH shall process the provider's revised request for payment within fourteen (14) calendar days from the date of receipt of the provider's revised request for payment authorization.

6. If ICHHS-BH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied by ICHHS-BH.

Provider Appeals to the California Department of Health Care Services

1. Hospitals and inpatient services providers may appeal directly to DHCS when a ICHHS-BH payment authorization request for emergency services has been denied or modified via the provider resolution process. Such denials or modifications are eligible for DHCS appeals if the ICHHS-BH decision was based on the following issues:
   a. The provider did not comply with the required timelines for notification or submission of the ICHHS-BH payment request, or
   b. The medical necessity criteria were not met.

2. If a provider chooses to appeal to DHCS, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days from the date of the ICHHS-BH written decision of denial.
   a. The provider may appeal to DHCS within thirty (30) calendar days after sixty (60) calendar days from submission to ICHHS-BH, if ICHHS-BH fails to respond.
   b. Supporting documentation shall include, but not be limited to:
      i. Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.
      ii. Clinical records supporting the existence of medical necessity if at issue.
      iii. A summary of reasons why ICHHS-BH should have approved the ICHHS-BH payment authorization.
      iv. A contact person(s) name, address and phone number.

3. DHCS shall notify ICHHS-BH and the provider of its receipt of a request for appeal within seven (7) calendar days.
   a. The notice to ICHHS-BH shall include a request for specific documentation supporting denial of the ICHHS-BH payment authorization and for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal.
      i. ICHHS-BH shall submit the requested documentation within twenty-one (21) calendar days or DHCS shall decide the appeal based solely on the documentation filed by the provider.

4. DHCS shall have sixty (60) calendar days from the receipt of the ICHHS-BH documentation, or from the twenty-first (21st) calendar day after the request for documentation (whichever is earlier), to notify the provider and ICHHS-BH of its decision, in writing.
   a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider and the ICHHS-BH, and any actions required by the provider and ICHHS-BH to implement the decision.
   b. At the election of the provider, if DHCS fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by DHCS.
   c. DMH may allow both a provider representative(s) and the ICHHS-BH representative(s) an opportunity to present oral argument to DHCS.

5. If the appeal is upheld, the provider shall submit a revised request for ICHHS-BH payment authorization within thirty (30) calendar days from receipt of the DHCS decision to uphold the appeal.
    a. If applicable, ICHHS-BH shall have fourteen (14) calendar days from the receipt of the provider's revised ICHHS-BH payment authorization request to approve the ICHHS-BH payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the ICHHS-BH payment authorization.

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

Individual and Group Provider Selection and Retention

Overview

In order to ensure delivery of the highest quality mental health services, ICHHS-BH is committed to selecting and retaining qualified providers who meet strict standards and regulations surrounding client care, availability of services, cultural competence, and client rights.

During the initial application process, ICHHS-BH shall review potential providers for acceptable credentialing and compliance with state and federal regulations. In addition, contract providers shall be reviewed at least annually and credentialing and compliance shall be completed once every three years.

Individual Providers Eligible to Provide Services through ICHHS-BH

The following categories of providers are eligible to provide mental health services through ICHHS-BH:

1. Psychiatrists who are licensed as Medical Doctors (MDs) or Doctors of Doctors of Osteopathic Medicine (DOs) by the State of California AND have successfully completed a psychiatric residency.
2. Individuals with doctoral degrees who are clinical psychologists licensed by the State of California
3. Individuals with masters' degrees who are licensed as Licensed Clinical Social Workers (LCSWs) or Marriage and Family Therapists (MFTs) or Licensed Professional Clinical Counselors (LPCCs) by the State of California
4. Individuals with masters' degrees in nursing who are licensed by the State of California to practice independently.

In addition to possessing the necessary licenses or certifications described above, ICHHS-BH providers shall:

1. Maintain a safe facility;
2. Store and dispense medications in compliance with all applicable state and federal laws and regulations;
3. Maintain client records in a manner that meets state and federal standards;
4. Meet the standards and requirements of the ICHHS-BH Quality Management Program; and

5. Meet any additional requirements that are established by the ICHHS-BH as part of a credentialing or evaluation process.

Credential Verification

At the time of credentialing, ICHHS-BH may verify the following information from primary sources:

1. A current valid license to practice as an independent mental health practitioner.
2. When applicable, clinical privileges in good standing at the institution designated by the mental health practitioner as the primary admitting facility.
3. A valid Drug Enforcement Administration (DEA) Permit or Controlled Dangerous Substances (CDS) certificate for physicians (primary source not required).
4. Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, and licensure of the mental health practitioner.
5. Board certification if the practitioner states that he/she is board certified on the application.
6. Work history (primary source not required).
7. Current, adequate malpractice insurance, according to the Behavioral Health policy.
8. History of professional liability claims, which resulted in settlements or judgments paid by or on behalf of the practitioner.
9. Information from recognized monitoring organizations regarding the applicant's sanctions or limitations on licensure from:
   - State Board of Licensure of Certification and/or the National Practitioner Data Bank and,
   - State Board of Medical Examiners, the Federation of State Medical Boards of appropriate state agency and,
   - Regional Medicare and Medi-Cal offices.

<u>Organizational Provider Selection and Retention</u>

Organizational providers which offer mental health services through ICHHS-BH are required to:

1. Possess the necessary license to operate;
2. Provide for appropriate supervision of staff;
3. Have as Head of Service a licensed mental health professional or other appropriate individual as described in state regulations;
4. Possess appropriate liability insurance;
5. Maintain a safe facility with required fire clearances;
6. Store and dispense medications in compliance with all applicable state and federal laws and regulations;
7. Maintain client records in a manner that meets state and federal standards;
8. Meet the standards and requirements of the ICHHS-BH Quality Management Program;
9. Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to California Code; and
10. Meet any additional requirements that are established by ICHHS-BH as part of a credentialing or evaluation process.

ICHHS-BH and/or DHCS will verify through an on-site review that:

1. The organizational provider possesses the necessary license to operate, if applicable, and any required certification.
2. The space owned, leased or operated by the provider and used for services or staff meets local fire codes.
3. The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary, and in good repair.
4. The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of beneficiaries and staff.
5. The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required state or federal notices, and procedures for reporting unusual occurrences relating to health and safety issues.
6. The organizational provider maintains client records in a manner that meets the requirements of ICHHS-BH, the requirements of the MHP contract between ICHHS-BH and DHCS; and applicable state and federal standards.
7. The organizational provider has sufficient staff to allow ICHHS-BH to claim federal financial participation (FFP) for the services that the organizational provider delivers to beneficiaries, as described in CCR, Title 9, Sections 1840.344 through 1840.358, as appropriate and applicable.
8. The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
9. The organizational provider's head of service, as defined in CCR, Title 9, Sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.
10. For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
    a. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
    b. Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
    c. All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
    d. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
    e. Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
    f. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.
    g. Policies and procedures are in place for dispensing, administering and storing medications.

<u>Monitoring and Verification of Provider Eligibilty</u>

1. Upon offering employment to staff, ICHHS-BH will check to ensure that a) a licensee is in good standing with his/her licensing board, and/or that any individual (licensed or otherwise) is not on an exclusion list. The following lists will be checked for exclusions:

   a. The Office of Inspector General's List for Excluded Individuals and Entities (LEIE)
   b. The Medi-Cal List of Suspended or Ineligible Providers
   c. The Social Security Death Master File
   d. The Excluded Parties List System/System Award Management (EPLS/SAM) database

2. The National Plan and Provider Enumeration System (NPPES) will also be checked to determine if an individual has a current National Provider Identifier (NPI) number.

3. On a monthly basis, all current ICHHS-BH employees and individual contracted providers (if applicable in the future) will be checked for a valid license (if applicable), and will be checked against the Medi-Cal List of Suspended of Ineligible Providers, LEIE, and EPLS/SAM by ICHHS-BH staff.

4. If it is discovered that ICHHS-BH staff do not have valid licenses or are found to be on an exclusion list, or if any non-licensed staff are found to be on an exclusion list, the following actions will occur:
   a. All billings requiring a license will be backed out or voided during the period that the license was not valid.
   b. If a license is invalid due to administrative reasons (i.e. lapsed license), but the licensee otherwise remains in good standing with his/her licensing board, the licensed staff member may be directed to only engage in services that do not require a license.
   c. If a license is invalid due to legal, ethical or other violations, ICHHS-BH will consult with Inyo County Personnel Services to determine a course of action.
   d. If an individual is found to be on an exclusion list, ICHHS-BH will consult with Inyo County Personnel Services to determine a course of action. If the individual on the exclusion list is in a position where services are billed, all services rendered while the individual was on the exclusion list will be backed out or voided.

5. If it is discovered that an individual contracted provider does not have a valid license or is found to be on an exclusion list, the following actions will occur:
   a. All billings requiring a license will be backed out or voided by ICHHS-BH during the period that the license was not valid.
   b. The individual contracted provider may not be reimbursed for services rendered without a license. If any payments have been made to such a provider, the provider must refund those payments to ICHHS-BH in accordance with the terms of their contract.
   c. If a license is invalid due to legal, ethical or other violations, the provider's contract will be terminated.

6. Contractors
   The County's contracted organizational providers will be responsible for verifying the credentials of licensed clinicians who provide mental health services within their agency.

<u>Hospital Selection Requirements</u>

ICHHS-BH's hospital selection process requires that each hospital (not including Psychiatric Health Facilities):

1. Comply with federal Medicaid laws, regulations and guidelines and State statutes and regulations and not violate the terms of the MHP contract between ICHHS-BH and DHCS.
2. Sign a provider agreement with DHCS.

3. Provide psychiatric inpatient hospital services, within its scope of licensure, to all clients who are referred by ICHHS-BH, unless compelling clinical circumstances exist that contraindicate admission, or ICHHS-BH negotiates a different arrangement with the hospital.
4. Refer clients for other services when necessary.
5. Not refuse an admission solely on the basis of age, sex, race, religion, physical or mental disability, or national origin.

ICHHS-BH may also consider but is not limited to any or all of the following in selecting hospitals:

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

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

Non-Discrimination Policy

ICHHS-BH does not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

A provider shall not be excluded from eligibility solely based on the type of license or certification that the provider possesses.

(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 ICHHS-BH, 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

<u>ICHHS-BH offers the following range of Medi-Cal reimbursable specialty mental health services</u>:

Assessment - A service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

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 includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the client in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the client; and family counseling with the significant support person(s) to improve the functioning of the client. The client may or may not be present for this service activity.

Individual Therapy – A service activity that is a therapeutic intervention provided to an individual client that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may include family therapy directed at improving the client's functioning and at which the client is present.

Group Therapy – A service activity that is a therapeutic intervention provided in a group setting that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may include family therapy directed at improving the client's functioning and at which the client is present.

Individual Rehabilitation - A recovery or resiliency focused service activity provided to an individual client identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. Rehabilitation also includes support resources, and/or medication education.

Group Rehabilitation - A recovery or resiliency focused service activity provided in a group setting identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social,

communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. Rehabilitation also includes support resources, and/or 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 – A service that includes one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

Therapeutic Behavioral Services (TBS) – TBS is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental service for children/youth with serious emotional problems who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a high level group home or a locked facility for the treatment of mental health needs, including acute care; or to enable a transition from any of those levels to a lower level of residential care. TBS intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a lower level of placement. The purpose of providing therapeutic behavioral services is to further the child/youth's overall treatment goals by providing additional therapeutic services during a short-term period.

Targeted Case Management – Targeted Case Management is a service to assist clients access 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 client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

Intensive Care Coordination - Intensive care coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for children and youth who are assessed to be in need of ICC. An ICC coordinator serves as the single point of accountability to:

- Ensure 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/youth.
- Facilitate a collaborative relationship among the child/youth, his/her family and involved child-serving systems.
- Support the parent/caregiver in meeting their child/youth’s needs.
- Help establish the Client and Family Team and provide ongoing support.
- Organize and match care across providers and child serving systems to allow the child/youth to be served in his/her home community.

Intensive Home-Based Services - Intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to children and youth who are assessed to be in

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

Crisis Intervention - An unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Adult Residential Treatment Services - Recovery focused rehabilitative services, provided in a non-institutional, residential setting, for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

<u>Depending on the individual client's needs, ICHHS-BH will arrange for the following services out of county</u>:

Crisis Stabilization Services - An unplanned, expedited service provided to both youth and adults lasting less than 24 hours, to or on behalf of a client to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the client or others, or substantially increase the risk of the client becoming gravely disabled.

Crisis Residential Treatment Services - Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term - 3 months or less) as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care.

Short Term Residential Treatment Program (STRTP) services - A residential facility licensed by the State Department of Social Services Community Care Licensing Division and operated by a public agency or private organization that provides short-term, specialized, and intensive therapeutic and 24-hour care and supervision to children. The care and supervision provided by an STRTP shall be non-medical, except as otherwise permitted by law. There are two STRTPs in Inyo County that are DHCS approved but not yet certified by MHP as of the time this Implementation Plan was written.

Psychiatric Health Facility (PHF) - Therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitation services provided in a psychiatric health facility licensed by the Department of Social Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. The PHF is accredited by the Joint Commission and Medicare, and only provides services to adults.

Day Treatment Intensive - A structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals.

Day Rehabilitation - A structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals.

Therapeutic Foster Care (TFC) - The TFC service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised, and supported TFC parents. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.

Psychiatric Inpatient Hospital Services – 24-hour inpatient services provided by a hospital to clients for whom the facilities, services and equipment described in CCR Title 9 §1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with CCR Title 9 § 1820.205. Inpatient services are only available for adults in county, at the PHF. Children and youth are referred out of county for inpatient services. Any adults needing psychiatric inpatient hospital services rather than services provided by the PHF are admitted to an out-of-county hospital.

Service Provided by Geographic Distribution

The following provider and beneficiary service maps show about the location of clients and services provided, in comparison with the time and distance standards for Inyo County specialty mental health services (60 miles or 90 minutes travel time from clients to provider locations):

County of Inyo Adult Beneficiaries of Psychiatry and Mental Health Services

6

Bishop Office

168

Lone Pine Office

190

136

127

Pahrump Valley Counseling

178

127

395

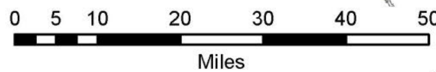
178

Tecopa HHS

Key

- Mental Health Service Providers
- Adult Beneficiaries
- Within 90 minutes

100% of beneficiaries are within 90 minutes of health service providers



County of Inyo Youth Beneficiaries of Psychiatry and Mental Health Services

6
168
Bishop Office
Lone Pine Office
136
190
127
395
178
Pahrump Valley Counseling
Tecopa HHS

Key

- Mental Health Service Providers
- Youth Beneficiaries
- Within 90 minutes

100% of beneficiaries are within 90 minutes of health service providers

0 5 10 20 30 40 50
Miles

Analysis of Provider Network Adequacy in Relation to Anticipated Client Service Needs

Inyo County is a small rural county with a population of 18,546, as reported by the 2010 US census. The racial makeup of Inyo County is 64.8% White, 20.6% Hispanic, and 10.2% Native. 15.2% of the people in Inyo County, CA speak a non-English language, and 94.1% are U.S. citizens. Inyo County has a total of 10,227 square miles, of which 10,181 square miles is land and 46 square miles is water. It is the second largest geographic county in California. ICHHS-BH has mental health service providers located in Bishop, Lone Pine and Tecopa, and a contract provider in Pahrump, Nevada. Routine appointments and services are provided in the Bishop and Lone Pine clinics, and ICHHS-BH staff provide school-based services in schools throughout the county. ICHHS-BH employs 24 staff and one contractor who provide services. Alternative services are also available at Toiyabe Indian Health Project in Bishop. Crisis staff have the capability to respond by going offsite to any location a client may need crisis intervention services. Based on the location of provider sites and beneficiaries within Inyo County, ICHHS-BH is able to meet the distance and time standards for Inyo County identified in DHCS MHSUDS Information Notice No 18-011 of 90 miles or 60 minutes from beneficiaries to providers, as shown in the service area maps above.

According to the most recent published report from the California External Quality Review Organization (EQRO) from their review in April 2017, in Calendar Year (CY) 2015 there were 5,274 total Medi-Cal eligibles, including those added under the Affordable Care Act, resulting in 29% of the population being Medi-Cal eligible. In CY 15, ICHHS-BH served 319 Medi-Cal beneficiaries. Of the total clients served, 67 (21%) of the clients were Hispanic and 34 (10.7%) were Native American. According to the EQRO, between CY 2013 and CY 2015, the Inyo County penetration rate was higher than the statewide average and similar to the average for small rural MHPs during the same period. In CY 2015, the Hispanic penetration rate was also similar to small rural MHPs and higher than statewide, showing an increase from previous years. Based on this data and the travel times and distances, we believe the service capacity of ICHHS-BH is sufficient to meet the needs of the clients in Inyo County, both currently and ongoing.

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

The service array for children and families, as well as for adults and older adults is addressed in response to content areas 5(A) and (B) above. ICHHS-BH has 23 staff and one contractor total who are able provide services to children and youth. Five staff focus almost exclusively on services to youth under 18. Alternative services are also available for children at Toiyabe Indian Health Project.

Katie A/Pathways to Wellbeing Process and Services

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.

ICHHS-BH 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. ICHHS-BH 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, when medically necessary. Thus far, none of our children and youth have been assessed as requiring TFC, nor have any TFC providers in or near our county been identified.

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

It is the policy of ICHHS-BH 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.

Implementation of Pathways to Wellbeing by ICHHS-BH

Katie A. subclass members shall be identified through collaborative meetings that are held between ICHHS-BH staff and agencies that may be placing children or youth in Inyo County. There will be regularly scheduled collaborative meetings with both Inyo County Child Protective Services (ICCPS) and Inyo County Juvenile Probation (ICJP) to early identify potential Katie A. subclass members.

1. Child Protective Services Clients

   In order to identify Katie A. subclass members that come through the Child Protective Services system, there will be a collaborative meeting called the Child and Family Staffing Meeting, held weekly. The meeting will serve multiple purposes including identifying, with appropriate releases in place, youth newly involved in the Child Protective Services system. Foster youth who are being placed in Inyo County, with ICCPS oversight, are also identified. With appropriate releases between ICHHS-BH and ICCPS, youth and families are identified who may need Specialty Mental Health Services and appropriate referrals made.

   ICCPS has a referral form for Katie A. subclass identification that is to be completed on every child removed from parental care or that is pending foster placement. (See Katie A. Screening Form). These referral forms are brought to the Child and Family Team meeting for review by a licensed mental health professional (usually the ICHHS-BH Program Chief for Children's Services). If indicated, based on criteria on the form, plans are made for referral to intake within ICHHS-BH. All initial reviews of children, youth and families are noted on the Child and Family Team minutes sheet. In some cases, referrals to Provider Contracts or other providers are recommended.

2. Juvenile Probation Clients

   For Juvenile Probation initiated referrals, there will be a monthly collaborative meeting called the Inyo County Interagency Placement Review Team (ICIPRT) meeting, to review any youth subject to placement. ICIPRT includes representation from ICHHS-BH, ICCPS, ICJP, school district of student, Inyo County Office of Education, CASA child advocates, and outside providers (such as Toiyabe Family Services), as appropriate. It is at this meeting that youth are screened for subclass membership in Katie A. and referred for Specialty

Mental Health Services assessment as appropriate. Additionally, Probation staff will contact the ICHHS-BH Children's Services Program Chief with any youth they feel require Specialty Mental Health Services in order to prevent future placement or treat identified needs.

3. Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)

   Following a clinical assessment through ICHHS-BH and following a determination of medical necessity for Specialty Mental Health Services, children and youth will be assessed for ICC and IHBS Services at the Child and Family Staffing and then at a CFT meeting that includes ICHHS-BH representative (usually the Children's Services Program Chief), the child/youth, family members, ICCPS Social Worker, and other pertinent representatives for the youth. If the youth does not meet medical necessity, a Notice of Adverse Benefit Determination is sent to both the youth and their appropriate representative(s) and parent(s).

4. Child and Family Team (CFT)

   CFT meetings will be held as soon as possible after assessment to develop a plan for the youth and family, to coordinate services between all providers and advocates, and to include family, foster family, and extended supports as possible. Arrangement, coordination, and facilitation of CFT meetings is up to the lead referral or placing agency, be it CPS, Juvenile Probation, or ICHHS-BH. It is expected that inclusion of the youth and family be made at **all** CFT meetings unless there is a valid reason why the youth and / or family cannot attend, in person or by electronic means. If the youth and/or family members cannot attend, a notation as to specific reasons will be made in the CFT minutes.

5. Therapeutic Foster Care (TFC)

   Should TFC be indicated following review in a CFT meeting, referrals will be made to TFC in an area outside of Inyo County. The agency which will place the youth will make every effort to find a TFC that is culturally appropriate, in an area that the family can access most easily, and that will meet the client's mental health needs in the most appropriate manner.

<u>Key Service Programs for Children, Youth and Families</u>

The following are a few examples of some key innovative programs provided by ICHHS-BH for children, youth and families using MHSA Prevention and Early Intervention (PEI) funding:

Families Intensive Response Strengthening Team (FIRST)

In the last two years we expanded our collaborative services using a wraparound model to additional families beyond those with youth at risk of placement in a high level of out of home placement. This allowed us to include an early intervention strategy for our work with "at risk" families and we are able to strengthen these families using a child/family team model. We additionally hired a supervisor who had worked extensively in a drug court program who could lead the team encouraging home-based support. We additionally were able to pull in resources from the First Five program and Substance Use Prevention programs, as well as other agencies to intensively support the families. As the result of this expansion, we are able to serve families with younger children. We are also looking for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Continuum of Care Reform. In 2015/2016, we served nine families for a total of 30 family members served.

Parent-Child Interaction Therapy (PCIT) Community Collaboration

Several of our staff have been trained and one has been certified to offer Parent-Child Interaction Therapy (PCIT), an evidence-based intensive parent-training program which has been found to be effective for families with aggressive, defiant, and non-compliant children; families with parents who have limited parenting skills; and families who have experienced domestic violence and/or child abuse. PCIT focuses on promoting positive parent-child relationships and interactions, while teaching parents effective parenting skills. PCIT has been shown to be an effective treatment program for children ages 2-7 years. This program has been adapted as an intervention for many different types of families (child welfare population, at-risk families, adoptive families, foster families, and other languages including Spanish).

PCIT teaches families individualized parenting skills that are developed through a process in which parents directly receive instruction through an earpiece that is linked to a therapist. The therapist, behind a one-way mirror and/or via a live camera feed, observes interactions between the parent and child, coaches the development of relationship enhancing techniques, and gives behavioral interventions for responding to difficult parent-child situations. Sessions last about one hour, occur over 18-20 weekly visits, and show very strong outcomes for both parents and children.

PCIT is a highly effective program and the families show improved outcomes because of this intensive parenting program. In addition, the children and their siblings show improved behavior (positive social interactions, following directions, reduction in acting out behavior) as a result of the program. We have served seven additional families with this intervention. Of the four court-referred families involved in PCIT, three were reunified satisfactorily.

<u>Other Age Appropriate Services</u>

The MHSA CSS System Transformation program provides services to all ages [children (ages 0-17); transition age youth (ages 16-25); adults (ages 18-59); older adults (ages 60+)]; all genders; and all races/ethnicities. The strategies are part of the larger system/continuum of care. We offer a "whatever it takes" service approach in helping individuals achieve their goals. This has allowed us the transformative flexibility to meet the person "where they are." Services for all populations help reduce ethnic disparities, offer peer support, and promote values-driven, evidence-based practices to address each individual's unique needs and mental health. These services emphasize the principles of empowerment, self-determination, wellness, recovery, and resiliency and offer integrated services for clients of all ages and their families. Services are delivered in a timely manner and are sensitive to the cultural needs of each individual. The wellness centers are often the first "accepted door" into the System of Care by persons who do not recognize that they have a mental illness. It is critical that the wellness centers are centrally located within the community in a comfortable setting. Our bilingual workers provide targeted outreach to the Latino population both within the schools and the community settings to build trust and to offer support in the wellness center.

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

The ICHHS-BH Cultural Competence Plan has been updated for 2018 in accordance with the terms of the MHP Contract and DMH Information Notice No. 10-02 and Title 9 § 1810.410. The 2018 Cultural Competence Plan is available upon request and will be submitted to DHCS with the MHP triennial review documents within 30 days prior to the FY 2017/18 DHCS triennial review.

(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.

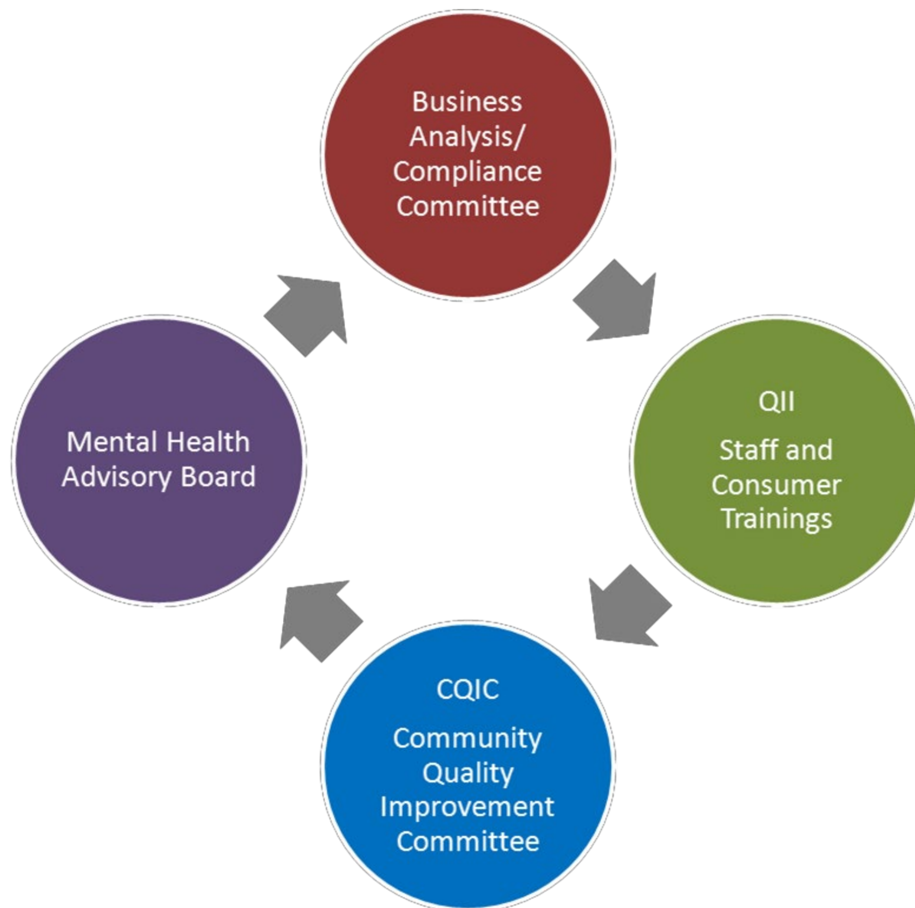
Planned admissions to non-contract hospitals occur very rarely or not at all, but if they do, they will be arranged by contacting the ICHHS-BH Point of Authorization described under "Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the 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.

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

Quality Improvement

Four committees comprise the QIC, the Business Analysis/Compliance Committee, QII Staff Trainings, Community Quality Improvement Committee (CQIC) and the Mental Health Advisory Board. These forums are responsible for the key functions of the ICHHS-BH Quality Improvement Program.

The following flow chart illustrate the interaction between these four committees.



These committees are involved in the following functions:

1. The Business Analysis/Compliance Committee is responsible for addressing programs policy and procedural changes and compliance adherence. The committee includes the Behavioral Health Director, HHS Compliance Officer, Fiscal staff, Clinical and line staff. This committee meets at least quarterly and addresses:

   - Fiscal coding and procedural needs.
   - Eligibility clarification.
   - Operations and workflow needs.
   - Policy and Procedural changes
   - Electronic Health Record (EHR) implementation.
   - Monitoring and updating the Compliance Plan annually
   - Use of outcome data to inform program planning decisions
   - Capacity needs

   Information from this meeting is documented and forwarded to the QII Staff Trainings to assure consistency and quality of services.

2. QII Staff Trainings is a quality assurance/improvement meeting conducted at least monthly. The QII provides an opportunity for program staff to review information from the Business

Analysis/Compliance committee and items from the work plan. This forum reviews confidential, critical incident reports to ensure the quality of services for our consumers. Program staff attend this meeting and evaluate both consumer-focused issues (e.g. cultural diversity; clinical case review; clinical training issues, performance outcome measurement; clinical record audit results; consumer satisfaction results; denial of service; etc.) as well as system-focused (e.g. improvement of the QI format, employee suggestions/recommendations, partner concerns, clinic/site audit results, etc.) topics. QII's are identified for consumer participation (i.e.; Confidentiality Policies and Procedures). The function of the QII meeting also reviews and recommends action regarding issues such as:

- Specific case histories for high risk and high utilizing beneficiaries
- Clarification and feedback for Policies and Procedures
- Clinical quality improvement topics for integrated treatment of consumers
- Medication Monitoring issues specific to a consumer
- Legal and ethical issues such as potential boundary violations
- Denials of service
- Improved recovery focused treatment
- Treatment that is inappropriate or inadequate for an individual's needs
- Possible system level issues that relate to client care and access
- Review and identification of QI items/ and summary issues to be sent to CQIC

All proceedings and findings of the QII are documented and provided to the CQIC in summary format to ensure that we maintain a client's confidentiality in this small, rural community.

3. The Community Quality Improvement Committee (CQIC) is charged with implementing the specific and detailed review and evaluation activities of the agency. On a quarterly basis, the CQIC:
   - Collects, reviews, evaluates, analyzes information and implements actions that frequently involve the handling of information that is of a sensitive and confidential nature.
   - Provides oversight to Quality Improvement (QI) activities, including the development and implementation of the Performance Improvement Projects.
   - Recommends policy decisions, reviews and evaluates the results of QI activities, and monitors the progress of the Performance Improvement Projects.
   - Institutes needed QI actions and ensures follow-up of QI processes.
   - Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by all four QIC meetings.

The CQIC provides oversight and is involved in QI activities. The CQIC conducts an annual evaluation of the overall effectiveness of the QI program. This helps to demonstrate that QI activities, including Performance Improvement Projects, contribute to meaningful improvement in clinical care and consumer services.

The CQIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the Performance Improvement Projects. 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.

Each quarterly meeting of the QIC shall include a verbal summary of significant QIC meeting findings, decisions, actions, and recommendations. In addition, written information may also include data summaries, as available.

The composition has included the clinical managers, HHS Quality Improvement data analysts, an adult Native American consumer, an adult Hispanic consumer, a family member, Patient's Rights Advocate, community members affiliated with religious organizations, providers (including a contract provider), a social services employee, MHSA coordinator and Public Health Division representative. Invitations also have been made to include representation from Toiyabe Indian Family Services, Inyo County Superintendent of Schools, and the Rural Health Clinic.

Due to the diverse membership of the CQIC, information sharing will be provided in summary form only to ensure compliance with regulations pertinent to the limitations on the sharing of confidential information.

The CQIC presents information to the Mental Health Advisory Board to ensure that quality issues are discussed.

4. The Behavioral Health Advisory Board meets at least 10 times annually. The members of the Behavioral Health Advisory Board include appointed consumers, representative from the Inyo County Board of Supervisors, Behavioral Health Director and consumers. The Board receives information from the CQIC and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the Business Analysis /Compliance Committee to finalize and policy changes.

Utilization Review

In an effort to maintain the quality of clinic services, Inyo County Health and Human Services Behavioral Health (ICHHS-BH) implemented the Utilization Review process as a Quality Management component of the ongoing monitoring of service delivery, adherence to documentation standards, and quality of clinic services.

Utilization Review (UR) is a key component in the overall Quality Management process with chart review checklists and tracking/monitoring through a comprehensive feedback loop that is submitted for review to the Quality Improvement Committee (QIC) as needed.

Utilization Review is performed by Authorization/Treatment Team members and other designated staff as appropriate. Data from utilization review activities are reviewed for training needs and opportunities.

The procedures for implementing the UR process are as follows:

1. The Authorization/Treatment Team members select clinical cases for review. A minimum of six charts will be reviewed annually.
2. An effort will be made to select at least one chart for each provider
3. Chart selection includes child/youth, adult, and older adult cases.
4. It is anticipated that a maximum of one (1) hour is required to complete a thorough, focused review of a chart that has involved numerous visits.

5. The Reviewer shall distribute the UR Chart Review Checklist results to the provider and will be available to discuss findings and suggested ways to improve documentation.
6. Further training needs will be identified based on trends and scheduled for Q2 meetings on a quarterly or “as needed” basis.
7. Results of chart reviews and trainings are tracked and a summary is presented to the Quality Improvement Committee for feedback.

(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.

ICHHS-BH/SUD employees will follow 45 CFR 96.132 (e) in regards to the confidentiality of Client Treatment Records which states that a system be in effect to protect and prevent any inappropriate disclosure of patient/client records. This system will include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosures.

<u>Procedure</u>

1. All client records are to be stored in the locked file in the Bishop clinic. During office hours when clients are being seen, records will be turned or covered on desks to prevent recognition of client name.
2. ICHHS-BH/SUD staff shall recognize that some personal information is particularly sensitive, such as HIV/AIDS information and alcohol and drug abuse information. Such information shall be treated with additional confidentiality protections and required by law, professional ethics and accreditation requirements.
3. Records shall not be taken outside the physical boundary of ICHHS-BH except with the authorization of the Mental Health Director.
4. All ICHHS-BH/SUD employees shall receive education on the confidentiality requirements and sign an oath of confidentiality. All employees will be advised of disciplinary action that may occur upon inappropriate disclosures.

(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 as relevant by ICHHS-BH as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in Title 9, Chapter 11. Since ICHHS-BH 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 Inyo County beneficiaries.