D. Providing Specialty Mental Health Services

Documentation Standards

CalMHSA has collaborated with DHCS on the integration of CalAIM requirements and documentation standards. Staff are required to complete online trainings through the CalMHSA LMS dependent on their user roles in SmartCare. Detailed instructions on how to register with CalMHSA LMS in order to register for the CalAIM trainings may be found HERE.

Clinical staff are required to complete the following CalMHSA trainings:

01-Foundations of Documentation and Service Delivery
02-Access to Services
03-Assessments
04-Diagnosis, Problem Lists, and Care Planning
05-Progress Notes
06-Care Coordination
07-Screening Tools for SMHS
08-Transition of Care Tool
09-Discharge Planning
10-Effective Administration of Screening Tools
Coding for DMC and DMC-ODS - Non-CE
Coding for SMHS - Non-CE

For guidance regarding required CalMHSA Documentation trainings for direct service staff please refer to OPOH *Section O: Training*. All direct service staff are required to complete the required documentation trainings and review the documentation guides relevant to their credential level to ensure compliance with DHCS BHIN 23-068 which clarifies documentation standards and requirements for all SMHS, DMC and DMC-ODS services.

Assessment Standards

To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. Assessments shall be updated **as clinically appropriate,** such as when the member's condition changes.

Care Plan Standards

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal Specialty Mental Health Services. The intent of this change is to affirm that care planning is an ongoing interactive component of service delivery rather than a one-time event. Required care plan elements may be notated within the assessment record, problem list, or service notes, or the provider may use a dedicated care plan template within the Electronic Health Record. The provider shall be able to produce and communicate content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws if requested.

Federal or state laws continue to require the following services to have care plans and/or specific care planning activities in place. All required elements of the Care Plan must be addressed as indicated in Enclosure 1a of BHIN 23-068: TCM, ICC, Peer Support Services, TBS, STRTPs, Crisis Houses FSPs and Medicare recipients.

For more information on specific requirements please refer to the *Care Plan Explanation Sheet* on the Optum Website > UCRM tab.

Problem List Standards

All clients receiving services after July 1, 2022, are required to have a Problem List documented within the EHR. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. Updates to the Problem List are to be completed on an on-going basis within the EHR on the "Client Clinical Problem Details" page as well as service notes to reflect the current presentation of the client, with problems being added or removed when there is a relevant change to the client's condition.

Service Note Standards

Providers shall create service notes for the provision of all services. Each service note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. Notes are to be completed and signed within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

Please be advised certain service lines have requirements which remain in effect due to applicable federal regulations or guidance, regulations which supersede these

indicated timelines above. In these cases, regulations must be followed as indicated by DHCS.

Peer Support Role

Interventions Rendered by Certified Peer Support Specialists

Beginning July 1, 2022, per BHIN 22-019, peer support services provided by a Certified Peer Support Specialists must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the Client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

Peer-led interventions provide an additional tool to assist clients in developing self-awareness and self-mastery skills. Those providing this service can be peer specialist, individuals with "lived experience" or family members of consumers. Examples of peer led interventions include but are not limited to Wellness Recovery Action Plan® and Whole Health Action Plan (WHAM). These services are designed to assist clients in managing day to day activities in at home and in the community. Designated staff with an understanding of the peer experience may also facilitate the structured interventions.

Adult/Older Adult Specialty Mental Health Services

Coordination of Care: Creating a Seamless System of Care

Coordination of care between service providers is essential for a client's continuity of care and a mental health system to work efficiently. As a client may move between different levels of care, it is vital that service providers complete a **warm hand off** with each other to provide continuity of care for the client.

This is accomplished in the following manner: *Providers shall develop discharge planning to support individuals transitioning between the same or a different level of care, including those outside the BHS system of care.*

This includes but is not limited to the referring provider contacting and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage.

This includes completion of the Transition of Care Tool for Medi-Cal Mental Health Services when transitioning members between SMHS services with the BHP to a lower

level of care for Non-SMHS with the MCP (*Section C*). This tool is located on the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> *Forms* tab. See also: Transition of Care Tool Explanation Sheet

This also supports the clients' efforts to return to, achieve and maintain the highest possible level of stability and independence. The BHP Systems of Care stipulates that the provider shall assign each client a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, through service and resource coordination. The BHP monitors coordination of care.

To this end, the BHP defines a long-term client as any individual that receives behavioral health services beyond 60 days of his/her/their admission to a behavioral health program. Long-term clients would be expected to have a completed behavioral health assessment, problem list and client plan (as applicable).

Clients diagnosed with a primary or co-occurring opioid and/or alcohol use disorder should be offered a referral for an assessment for Medication Assisted Treatment (MAT). Although it is outside the scope of practice for a non-prescribing staff to make specific medication recommendations, staff can recommend a referral for MAT at the intake appointment and at other points in the treatment process, as clinically indicated.

Staff are encouraged to use motivational interviewing to help clients who would benefit from medication treatment to consider this option. Clients with an opioid and/or stimulant use disorder should be referred or linked to naloxone treatment to prevent overdose risk.

Program Policy and Procedures should address clinical training and supervision on providing appropriate MAT referrals as clinically indicated at any time during treatment or following an overdose. This training and supervision should also address access to Naloxone, especially for clients who refuse a MAT referral and have an opioid use disorder.

Post Discharge Coordination of Care

New or current clients discharged from a 24-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within 72 hours. If the referral is deemed urgent, client shall be seen within 48 hours of contact with program. A need for urgent services is defined in 8 HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21) health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.

The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. Compliance to this standard is monitored through the Quality Assurance Program Review process.

Outpatient, Case Management and Assertive Community Treatment Services

The BHP defines adult clients as those between the ages of 18-59 years. Older adults are age 60 and above. Clients may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

When the provider conducts an assessment of a client who has called or walked into the program, providers will follow the "*SmartCare Walk-in Workflow*" located at the Optum Website> BHS Provider Resources> > SMH & DMC-ODS Health Plans > *SmartCare* tab.

If the Access and Crisis Line refers a client to an organizational provider or to a County-operated facility, the ACL completes an inquiry for each client. The provider's program staff is then responsible for recording all ongoing activity for that client into the EHR.

Specific Procedures and Criteria for Case Management and Assertive Community Treatment Services

Brief Description of Services Available

San Diego County Adult/Older Adult Behavioral Health Services are as follows:

- Transitional Case Management provides short-term case management services (up to 90 days) for unconnected clients who suffer from severe mental illness (SMI) and are discharged from Acute Care (ex: Behavioral Health unit (BHU). The goal is to connect clients to outpatient case management and/or Assertive Community Services as clinically indicated.

- Institutional Case Management services are provided to clients who reside in a State Hospital or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating, and monitoring functions and have a staff-to-client ratio of up to 1:60. Clients are contacted face to face at a minimum of once a quarter.

- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, coordination of care, and occasional crisis intervention services. SBCM services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:25. Clients are typically evaluated in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.

    - Note that the evaluation completed when a client enters a case management program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation only if it is done by an SBCM program run by the County of San Diego. Case Management evaluations done by contractors should be coded as an Assessment.

The following are specific procedures and criteria for each level of care:

Strength-Based Case Management

Overview: Strengths-Based Case Management services are delivered through BHS contracted service. Programs assist clients with severe mental illness who may have a co-occurring disorder and may be justice-involved to access needed mental health, medical, educational, social, prevocational, vocational, housing supports and rehabilitative or other community services. The service activities may include, but are not limited to case management, care coordination, referral, and linkage to needed services; monitoring services delivery to ensure member access to services and the services delivery system, monitoring of the client's progress, and plan development. The SBCM model emphasis is on the structure of the program, supervision, and clinical services. The staff ratio is approximately 1:25.

Services provided include, but are not limited to:

- Medication management which is coordinated outside the SBCM program in the FFS sector
- Strength Based Case Management

- Rehabilitation and recovery services
- Care Coordination to needed services
- Co-occurring services linkages
- Access and linkage to Supportive Housing
- Access to Supportive employment/vocational and educational services

Assessment/ Eligibility Criteria: Client must meet two or more of the criteria below:

1. A face-to-face meeting is necessary to determine the presence of a severe psychiatric disability and need for Strength Based Case Management (SBCM) services per LOCUS (Level 3 – High Intensity Community Based Services)

2. Has current LPS Conservatorship (may be a designated County Conservator or family member (Private Conservator)

3. Client is not homeless but may be at-risk of homelessness

4. Minimum one hospitalization in the past year, OR multiple ER utilizations, PERT interventions, jail mental health service and/or long-term care hospitalization.

5. Have major impairments in life functioning

6. Person is not connected to outpatient treatment

7. Person is experiencing an acute psychiatric episode that might require SBCM level services

8. Is at high risk of admission to an inpatient mental health facility

9. Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies

10. Does not have a case manager from another program who is able to address mental health needs.

Discharge Criteria*:* The goal of SBCM is to help improve the clients' mental health and quality of life to support clients to live in the least restrictive environment. A LOCUS is completed every 6 months to assist in determining if client is ready for lower level of care. Clients receiving Strength-Based Case Management services are reviewed by the

program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the level of case management.

Assertive Community Treatment (ACT) Services

Overview: ACT Services are provided in a multi-disciplinary team-based model of service that uses a comprehensive team approach and provides treatment 24 hours a day, 7 days a week, 365-days a year. The services are targeted for homele**ss** persons with a severe mental illness who may have a co-occurring disorder, are unconnected to outpatient services, may be referred by the justice system, have multiple major areas of impairment, have more than one long term care episode, and multiple ER and acute care hospitalizations and justice related episodes.

The ACT programs provide **integrated** mental health and medication services, rehabilitation and recovery services, intensive case management and has a staff-to-client ratio of approximately 1:10. Clients are typically provided services in person at a minimum of four (4) times per week to meet ACT fidelity rating and the appropriate clinic need of the client Services may be provided on a much more frequent basis, depending on client need.

Services provided include, but are not limited to:

- Integrated Mental Health Services and Medication Management
- Rehabilitation and recovery services
- Intensive case management
- Co-occurring services
- Access and linkage to Supportive housing
- Access to Supportive employment/vocational and educational services
- Care Coordination to needed providers

Assessment/ Eligibility Criteria*:*

Eligibility criteria are the same as the criteria for SBCM with the following additional factors: Homelessness or at risk of homelessness and a level of acuity and need for intensive ACT services per LOCUS assessment (Level 4 Medically Monitored Non-Residential Services)

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets criteria for access to specialty mental health services and the services must be medically necessary. According to service mix outlined above, the clinician shall complete the appropriate assessment form in the

Electronic Health Record (EHR) and ensure that all relevant clinical information is obtained and documented. Upon program assignment, an Assessment, Problem List and Client Plan (as applicable) shall be completed for clients in community setting within a clinically appropriate timeframe.

Evaluation: Clients are typically evaluated in person at a minimum of four (4) times per week to meet the client's clinical needs and meet a high ACT fidelity rating. ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy. Clinical Assessment for Criteria to Access Specialty Mental Health Services Delivery System

Discharge Criteria: Same as SBCM

Housing Quality Checklist

The purpose of the Housing Checklist is to ensure participants, who are receiving ACT and SBCM services and housing are referred and connected to safe and quality housing placements. The checklist is an evaluation tool that ensures all housing is equally assessed using the same standards. Service providers are required to confirm that the housing under consideration meets all required elements of providing safe, decent, and sanitary housing for the initial and ongoing occupancy of enrolled participants. If the placement process indicates the presence of any health and safety issues, the home/unit should be removed from consideration and clients should not be placed in the home/unit.

Documentation in MSR or QSRs shall report any of the housing sites that have been removed. Permanent Housing funded by a local or Federal Housing Authority are exempt and not required to be inspected. The Housing Quality Checklist is located on the Optum San Diego Website MHP Provider Documents and References Tab. https://www.optumsandiego.com/

Crisis Stabilization Services

Overview: "Crisis Stabilization" means a service lasting less than 24 hours (23.59 hours), to or on behalf of a member for a condition that required more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: Assessment, coordination of care, and therapy. Crisis Stabilization is distinguished from crisis intervention by being delivered by providers who meet the Crisis Stabilization contract, site, and staffing requirements described in Sections 1840.338 and 1840.348 of CCR, Title 9.

Crisis Stabilization is a package program, and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management. Crisis Stabilization shall be provided on site at a licensed 24 hour health care facility or hospital-based outpatient program or a provider site certified by the Department or a Behavioral Health Plan (BHP) to perform crisis stabilization. CCR, Title 9 1840.338

Assessment/ Eligibility Criteria: Member must present with a mental health crisis for a condition that requires a timelier response than a regularly scheduled visit and must meet access criteria - services must be medically necessary

Services provided include, but are not limited to:

- Clinical Triage
- Face to Face psychiatric assessment
- Crisis Intervention
- Medication
- Linkage to other services as determined by Triage
- Disposition planning
- Voluntary and WI Code 5150 mental health services lasting less than 24 hours to a person in a psychiatric emergency due to a mental health condition.

Discharge Criteria: Discharge occurs when member no longer meets criteria for danger to others, danger to self and grave disability and crisis stabilization services are no longer medically necessary. It must be ensured that the member can be discharged safely to a lower level of care in addition to being connected to outpatient services and provided with referrals.

Billing: The maximum number of hours for claimable for Crisis Stabilization in a 24-hour period is 23 hours. CCR Title 9 1840.368

Staffing Requirements:

- A physician shall be on call at all times for the provision of those crisis stabilization services that may only be provided by a physician.

- There shall be a minimum of one Registered Nurse, Psychiatric Technician or Licensed Vocational Nurse on site at all times beneficiaries are present.

- At a minimum there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other patients receiving crisis stabilization at any given time.

- If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services.

- Persons included in required crisis stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services. CCR, Title 9 1840.348

- Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed.

Staffing Requirements for a Crisis Stabilization Unit that is a 5150 LPS Designated Facility:

A Crisis Stabilization Unit that is 5150 LPS designated and approved is required to meet California Code of Regulations (CCR) Title 9, Division 1, Article 10, Section 663 inpatient staffing requirements. Inpatient services shall be under an administrative director who qualifies under Section 620 (d), 623, 624, 625 or 627. In addition to the director of the service, the minimum professional staff shall include psychiatrists if the administrative director of the services is not a psychiatrist, who shall assume medical responsibility as defined in Section 522; a psychologist, social worker, registered nurse, and other nursing personnel under supervision of a registered nurse.

Nursing personnel shall be present at all times. Physicians, psychiatrists, registered nurses and other mental health personnel shall be present or available at all times. Psychologists and social workers may be present on a limited-time basis. Rehabilitation therapy, such as occupational therapy, should be available to the patients.

The minimum ratio of the full-time professional personnel to resident patients shall be as follows.

Personnel	Ratio per 100 Patients
Physician	5
Psychologists	2
Social Workersa	2
Registered Nurse	20
Other mental health personnel	25

Overview of Programs

For Contractors and County Case Management who provide clinical SBCM and/or ACT Services to LPS Conservatees on behalf of the Public Conservator, responsibilities include:

1. Ensure active and continuous clinical Strength-Based Case Management and/or Assertive Community Treatment Services responsibility, which includes, but is not limited to, ensuring the Conservatee has appropriate:

    - Medical care and treatment
    - Psychiatric care and treatment
    - Personal care
    - Food/Nutrition
    - Clothing
    - Shelter
    - Education and employment
    - Recreation and socialization

2. Ensure a clear photograph of the conservatee is taken at the initial face-to-face visit and annually thereafter. The photo must be preserved in the case file for the purpose of identifying the conservatee if he or she becomes missing (per Probate Code 2360)

3. Collaborate/Coordinate with medical and psychiatric professionals and hospital treatment teams on behalf of the conservatee.

4. Notify all appropriate parties, including family members and other significant parties, of the assigned Case Manager or Case Management team within 14 calendar days (see item #10 below for notification requirements for the Public Conservator's Office)

5. Respond to routine e-mails and phone calls within 2 business days; for more urgent matters, a Supervisor/Program Manager should be available if parties are unable to reach the Case Manager.

6. Upon request, provide case information to the Public Conservator's Office regarding grave disability, including information on the following:

    - Clinical presentation (psychiatric/medical, functional ability, etc.)
    - High-risk behaviors
    - Activities of daily living
    - Current medications and adherence

- Placement history
- Strengths and goals

7. Maintain documentation regarding visits for viewing by Public Conservator Office staff.

8. Ensure conservatee has both a psychiatrist and a primary care physician who will prepare (by a psychiatrist/psychologist) and concur with (by a primary care physician) the annually required Medical Recommendation and Declaration to Reestablish Conservatorship -Reestablishment Recommendation Form (HHSA LPS PC RE-EST). This form must be prepared/signed by both of the conservatee's physicians and submitted to the Public Conservator's Office at least 45 days prior to the end date of the current conservatorship period, which communicates their recommendation as to either the reestablishment or termination of LPS conservatorship. The case management agency must ensure the conservatee is able to see both the psychiatrist and a primary care physician 2 to 4 months prior to the end date of the current conservatorship period. The names and telephone numbers of these physicians must be provided to the Public Conservator's Office and should be kept current within the EHR.

9. During the course of LPS Conservatorship proceedings, including, but not limited to reestablishments, rehearings, or jury trials, it is possible the Public Conservator's Office may not be available to evaluate and provide testimony on select contested matters. In such situations, the treating Psychiatrist or licensed Psychologist for the Conservatee may be asked to testify as an expert in the contested matter. If the current treating Psychiatrist or licensed Psychologist for the Conservatee is affiliated with the case management program, the Office of the Public Conservator may ask the doctor to provide testimony as an expert at the hearing. In the absence of a testifying expert, the conservatorship may be terminated.

10. Maintain involuntary clinical Strength Based Case Management and/or Assertive Community Treatment Services at all times while a conservatorship is in place. If the conservatee is being transferred to another Case Management Agency, services of the sending agency must be maintained until verification is received that the conservatee has been contacted and is prepared to receive involuntary case management services from the receiving agency. The receiving agency must notify the Public Conservator's Office of the successful transfer and start of services with the receiving agency. Services may only be provided on a voluntary basis (or closed) if the Public Conservator's Office has indicated the conservatorship has been terminated by the court.

11. Notify the Public Conservator's Office within 24 hours when any of the following situations occur for a conservatee:

    - Address changes
    - A new case manager is assigned
    - A new case management agency has been assigned
    - AWOL or in a missing person status
    - Hospitalization (medical and/or psychiatric)
    - In custody
    - Death
    - A Serious Incident Report is submitted to the BHS Quality Improvement Unit
    - Any unusual occurrences that raise risk/safety concerns

12. Notify Public Conservator's Office in writing when it is believed a change in rights or when it is believed the Conservatee is no longer gravely disabled.

13. Refer treatment providers to the Public Conservator's Office for matters requiring the consent of the Court via the Public Conservator's Office, such as surgery, non-routine medical treatment, or end of life decisions.

14. Contact the Public Conservator's Office when questions arise regarding the Conservatee's desire/need to enter into contracts of any kind, obtain a driver's license, vote or participate in a research study.

15. Contact the Public Conservator's Office when there is a need to have documents signed on behalf of the Conservatee, except in cases involving assistance with Social Security and Medi-Cal applications, renewals, redeterminations, appeals, etc.

16. Ensure a report is available via the electronic health record (EHR) for the Public Conservator's Office to view monthly, including completed visits.

Initial Face-to-Face Visits:

Initial Face-to-Face visits with conservatees will be conducted according to the type of case management program provided, as follows:

ACT: within 48 hours of the program formally opening the case, consistent with the OPOH standard for face-to-face visits for those deemed urgent and recently discharged from acute care.

SBCM: 10 business days of the program formally opening the case, unless deemed urgent and recently discharged from acute care which would then require the urgent visit within 48 hours

Institutional-In County: within 30 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis.

Institutional-Out of County: within 90 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis.

Hospital Rotation Cases: The Public Conservator's Office has case management responsibilities during the Temporary LPS Conservatorship. During this time Strength-Based Case Management and/or Assertive Community Treatment programs will not be responsible for face-to-face visits or discharge planning, as this will remain the responsibility of the Public Conservator. Once Permanent Conservatorship is established, as long as patient remains in acute care, the case will be opened to County Institutional Case Management services pending discharge to either long-term care or community placement.

If discharge is imminent (planned in less than 10 business days) when the case is opened to County Institutional Case Management services, no face-to-face contact must be made unless the client is requesting such contact, or it is otherwise clinically indicated. Telephone contacts may be made as needed to facilitate discharge planning or other clinical needs during the time the patient remains in acute care.

If discharge is not imminent at the time the case is opened to County Institutional Case Management services, the case manager must plan to meet with the patient in the acute care setting within 10 business days of case opening, with the exception of patients in jail settings.

For conservatees in jail settings (where discharge is not imminent at the time Permanent Conservatorship is established), face-to-face contact must be made within 30 days of opening case to County Institutional Case Management to accommodate clearances needed and access to incarcerated individuals.

When a **Private Conservator** is appointed and requests the assistance of County operated Case Management Services, initial face-to-face contacts will follow the same periods as when the Public Conservator is appointed.

On-Going Face-to-Face Visits

Frequency of visitation will be conducted according to either Strength-Based Case Management (SBCM) or Assertive Community Treatment (ACT) program as follows:

SBCM: Clients are typically seen in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate. Clients who are **conservatees** are required to be seen, at minimum, within **30 calendar days** from the date of the previous visit.

ACT: Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. It is also expected that the case manager will have contact with significant others as clinically appropriate.

Institutional-In County: routine visits to occur every 90 days. Frequency to increase based on clinical need on a case-by-case basis.

Institutional-Out of County: visits to occur every 90 days. Telehealth contacts to occur monthly in between face-to-face visits. Frequency of visits may be adjusted based on clinical need on a case-by-case basis, as approved by Public Conservator's Office COR or designee.

Dual Track Programs

Dual Track programs are designed to treat both mental health and substance use conditions under the same program, however enrollment in both programs simultaneously is not a requirement. Mental Health treatment will align with Bio-Psychosocial Rehabilitation (BPSR) or Assertive Community Treatment (ACT) Models and Substance Use treatment will align with the American Society of Addiction Medicine (ASAM). Admission and Discharge criteria will align with similar outpatient services. Coordination of service delivery between Dual Track programs and other levels of care to be reviewed by Contracting Officers Representative (COR).

Augmented Services Program

Designated case management providers may refer to Augmented Services Program (ASP). The goal of the Augmented Services Program is to enhance and improve client functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific residential care facilities with which the county has an ASP

contract. Emphasis is on developing client strengths, symptom management, and client self-sufficiency. Priority for ASP services is given to those persons in most need of additional services. Additional information about ASP may be found in the ASP Handbook, which is provided to all designated case management services eligible to refer to ASP.

In order to be eligible for funding from ASP, a client must:

1. Have a primary diagnosis of a serious mental disorder,

2. Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to need ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services,

3. Reside in an ASP contracted facility,

4. Score of sixty (60) and above on the ASP scoring tool – if below a score of 60 will need Behavioral Health Program Coordinator (BHPC) approval; and

5. ASP funds must be available for the month(s) of service

The client's case must remain open to the A/OA MHS program that provides ongoing monitoring, care coordination and case management services in order for the ASP facility to continue receiving ASP funds for the client. The case manager notifies the ASP and the ASP facility prior to the time that the case management program closes a client's case.

Telehealth Services

Each telehealth provider is required to be licensed in California and enrolled as a Medi-Cal provider. If the provider is not located in California, they must be affiliated with an enrolled Medi-Cal provider group (or border community) as indicated in the Medi-Cal Provider Manual. Each telehealth provider must meet the requirements of Behavioral Health Information Notice (BHIN 23-018), BPC Section 2290.5(a)(6), or equivalent requirements under California law in which the provider is licensed.

Existing Medi-Cal covered services may be provided via telehealth modality if all the following criteria are met:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment, and that the member has a

right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit

2. The member has provided verbal or written consent, at least once prior to initiating applicable health care services via telehealth, and it has been documented in the client record

3. An explanation that the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time by the Medi-Cal member without it affecting their ability to access covered Medi-Cal services in the future,

4. The member has been provided with an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted

5. The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site

6. An explanation of the potential limitations and risks related to receiving services through telehealth as compared to an in-person visit to the extent that any limitations or risks are identified by the provider

7. The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and

8. The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Medi-Cal providers have the flexibility to determine if a service is clinically appropriate for telehealth via audio-visual two-way real time communication. No limitations are placed on origination or distant sites. Providers must use the applicable billing indicators for services delivered via telehealth.

Videoconferencing Guidelines for Telehealth

Telehealth services are designed to assure timely access of routine and urgent mental health and psychiatric services to reduce emergency and acute clients' hospital inpatient services Specialty Mental Health Provider; hereafter referred to as "telehealth provider" will perform various specialty mental health services via tele-video linkage when an on-site mental health provider is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged.

The site where the telehealth provider is located who will provide the mental health service will be termed “distant” site and the site where the mental health services are being received by the client will be termed the “originating” site. This practice also extends mental health services to clients in remote areas of the county.

The standards of telehealth practice will be the same as for on-site mental health services as described in the California “Telehealth Law of 2012”. County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telehealth services.

1. Use a secure, trusted platform for videoconferencing.

2. Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.

3. Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any patient data locally, but if it must, it should be encrypted.

4. Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

5. Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in which you practice. Just because software says its HIPAA-compliant is not enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, “all technologies” perspective.

6. It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

7. When reviewing software options, you will notice that many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.

8. County operated programs shall connect to the County's secure network when providing telehealth services as the network meets the above requirements and is a trusted platform for videoconferencing. Hardware shall be installed by the County's IT department.

Peer Support Services

DHCS launched the Medi-Cal Peer Support Services benefit in July 2022, in compliance with Senate Bill (SB) 803 (Beall, Chapter 150, Statutes of 2020) which required DHCS to seek federal approval to establish Medi-Cal Peer Specialists as a provider type and to provide distinct Medi-Cal Peer Support Specialist services under the SMHS and DMC-ODS programs. Following federal approval, DHCS added Medi-Cal Peer Support Specialists (Peers) as a unique provider type within specific reimbursable services.

Peer support services are recovery-oriented and resiliency-focused services for those managing behavioral health challenges as well as the parents, family members, and caregivers that support them. Peer support services are evidence based practices that provide role models to inspire hope, demonstrate a life of recovery and resiliency, and encourage real advocacy. For the purpose of this document, "Peer Support Specialist" refers to certified Peer Support Specialist who is providing services in the behavioral health field using their "lived experience" to establish mutuality and build resiliency and recovery. Peer Support Services may include contact with family members or other collaterals (family members or other identified people supporting the member) and may be delivered and claimed as a standalone service or provided in conjunction with other SMHS services, including inpatient and residential services.

Peer Support services may be provided face-to-face, by telephone or telehealth and may be provided anywhere in the community. Peer Support Services require a care plan and must be recommended by physician or other Licensed Mental Health Professional within their scope of practice and as medically necessary.

Certified Medi-Cal Peer Support Specialists may only submit claims to Short Doyle Medi-Cal (SD/MC) for Medi-Cal Peer Support Services: Self-Help/Peer Services and Behavioral Health Prevention Education Services (H0038 and H0025). Peer Support Specialists are required to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment "What are Peer Recovery Support Services".

Programs shall ensure that Peer Support Services are provided by certified Peer Support Specialists as established in BHIN 21-041 and are provided under the direction of a Behavioral Health Professional that is licensed, waivered or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of SMHS and DMC-ODS. Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through Optum

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the Optum Provider Line, 1-800-798-2254, option # 3, except:

- Emergencies/Urgent Services
- Clients directed by the San Diego County Psychiatric Hospital Emergency Psychiatric Unit (EPU) to the FFS Hospitals
- Intoxicated clients who will be assessed within 24 hours to determine the etiology of their symptomatology
- Medicare clients who convert to Medi-Cal on the Medi-Cal eligible date

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Criteria for Access to Inpatient Services for Adult/Older Adults

Adult/Older Adult inpatient services are reimbursed by the BHP only when the following criteria are met, as outlined in Title 9, Section 1820.205A:

1. The client must have an included Title 9 diagnosis that is reimbursable for inpatient services as described in Title 9, Section 1830.205(1).

   AND BOTH of the following:

   1. The condition cannot be safely treated at a lower level of care,

   2. Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:

      1. The symptoms or behaviors

         i. represent a current danger to self or others, or significant property destruction,
         ii. Prevent the member from providing for, or utilizing, food, clothing, or shelter,
         iii. Present a severe risk to the member's physical health,
         iv. Represent a recent, significant deterioration in ability to function.

         OR

      2. The symptoms or behaviors require <u>one</u> of the following:

         i. Further psychiatric evaluation; or
         ii. Medication treatment; or
         iii. Other treatment that can be reasonably be provided only if the patient is hospitalized.

Hospitals cannot require as a condition of admission or acceptance of a transfer that a patient voluntarily seeking mental health care first be placed on a 5150 hold. Continued stay services in a hospital shall be reimbursed when a member experiences one of the following:

- Continued presence of indications that meet the medical necessity criteria

- Serious adverse reaction to medications, procedures or therapist requiring continued hospitalization

- Presence of new indications that meet medical necessity criteria; and,

- Need for continued medical evaluation or treatment that can only be provided if the member remains in the hospital

Inpatient Services for Non Medi-Cal Eligible Adult/ Older Adult Clients (Non-Insured)

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment-funded services and are referred to the San Diego County Psychiatric Hospital or to the Emergency Psychiatric Unit for screening. Both facilities are located at 3853 Rosecrans Street, San Diego, California 92110. The telephone number is (619) 692-8200. These are County-operated facilities.

Crisis Residential Services

The BHP, through its contracted provider, operates Crisis Residential Services, which are considered a "step down" or diversion from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal clients who meet access criteria and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff but do require initial authorization from Optum. Optum will then reauthorize medically necessary services, as appropriate, concurrently with the client's stay based on the continued need for services. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the contractor's website, Community Research Foundation. The Optum Provider Line for authorization is 1-800-798-2254.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs.

It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:

- Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health Care Services and the County of San Diego.

- Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

- Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.

- Parolees who are Medi-Cal beneficiaries and who meet specialty mental health access criteria, as specified in Welfare and Institutions Code section 14184.402 and BHIN 20-073 will be provided medically necessary Medi-Cal covered mental health services.

- Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health access criteria will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.

- Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health access criteria will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.

- Due to the passage of SB 389, MHSA funds may be used to provide services to persons who meet existing eligibility criteria for MHSA-funded programs and who are participating in a pre-sentencing or post-sentencing diversion program, to provide services to persons who are on parole, probation, PRCS, or mandatory supervision. When included in county plans, and in accordance with all the requirements outlined in W&I § 5349, funds may be used for the provision of mental health services in an Assisted Outpatient Treatment program in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1). Additionally,

MHSA may be used for programs and/or services provided in juvenile halls and/or county jails when the purpose of the service is facilitating discharge (CCR, Title 9, § 3610). MHSA funded services are **not** available for individuals incarcerated in state or federal prisons (W&I § 5813.5(f); CCR, tit. 9, § 3610, subd. (f)).

Correctional Program Checklist (CPC)

As directed by COR, contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for clients who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is located on the Optum Website

Mental Health Services for Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits.

Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC). Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment").

California veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

Referral Process for Providing Mental Health Services to Veterans

Adult/Older Adult Mental Health Services: Staff will ask client if he or she is receiving veterans' services benefits. If the client state he or she is receiving benefits or claims to have serviced in the military, the staff will be responsible for completing the following procedure:

The staff will complete "Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form" that will contain all appropriate demographic information and required client signature. This form is located on the Optum Website. The form shall be faxed to the Veterans Service Office for verification at (858) 505-6961, or other current fax number.

If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the client can be offered mental health services.

If the client meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the client can be offered mental health services until the veterans' services benefit determination is completed.

Veterans Service Office

The Veterans Service Office will receive the "*Request for Verification Eligibility to Counseling and Guidance Services Fax Form*" confirming client's eligibility or ineligibility for veterans' services and mail or fax findings to the County mental health program or contracted program.

The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two to three business days upon receipt of the Fax Request.

The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans' services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.

Utilization Management

The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the access criteria delineated in Welfare and Institutions Code section 14184.402. The BHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations.

Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for children's mental health programs.

The UM process is in addition to Department of Health Care Services (DHCS) Information Notice No. 22-016 dated 04.15.22, which outlines that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. If client is concurrently provided day and outpatient services, then ancillary authorization must occur through day program and Optum as the day services cycle supersedes outpatient UM. In these cases, the outpatient program must also complete a UM in accordance with the procedure described in Children, Youth & Families Outpatient Level of Care.

Medication only clients are not included in the Utilization Management process as they are subject to medication monitoring. Specific information regarding medication only clients is found in *OPOH Section D*, Medication Only Services.

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC), standards for participation in the URC, logs for URC activities, and standards for authorization. Although there are slight variances in the utilization review process conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

- Utilization review is a "never billable activity"
- URC logs are to be maintained at each program that record the results of the UR process
- URC logs are to be made available for review as needed by the BHP
- A clinician cannot participate in the authorization decisions regarding their own client

- Questions pertaining to the UR process should be directed to the QA unit

Utilization Review Committee (URC)

Clients who approach six (6) months of treatment and appear to require additional services shall be evaluated for continuation of care. The Utilization Management Committee operates at the program level and must include at least one (1) licensed clinician and may not include the requesting clinician.

The Utilization Management Committee bases its decisions on whether access criteria is still present and works with the treating clinician to ensure that the proposed services are medically necessary and likely to promote meeting the client's treatment goals or resolving areas noted on the Client Clinical Problem List.

To assist in its determination, the Utilization Management Committee receives a UM Request form and a new Care Plan/Client Clinical Problem List to cover the interval for which authorization is requested. Secondary UM review at six (6) months of treatment is reserved for clients who demonstrate ongoing need and require additional services. Secondary and subsequent UM review is also conducted by the program level Utilization Management Committee.

Programs are required to have an internal URC in place to review records and conduct UM process. URC shall follow the guidelines below:

- Review quarterly a minimum of 5 clients.
- A review of services, treatment plan, and the Utilization Management Form shall be completed in order to support determination and document the results of the Utilization Review Committee.
- Client service review shall be performed through SmartCare. [Note that clients who have not received services for six months or longer should be considered for discharge.]
- Utilization Management Form shall be reviewed by program manager or designee within 5 business days.
- Program manager or designee shall be licensed.
- Program manager or designee may agree with primary provider or may recommend a different level of service.

- Final determination shall be made after agreement by program manager or designee and primary provider.

- The Utilization Management Form shall be kept in the client record.

- At the time of your Quality Assurance Program Review, QA Specialists will review client Utilization Management Forms in addition to programs quarterly URC process.

- Clients who have been approved for ongoing services by the URC shall remain on an UM cycle to be completed annually in order to determine continued eligibility for services.

Utilization Review for Crisis Residential Programs

Each crisis residential program meets the utilization management requirement through the service authorization process conducted by the County's Administrative Services Organization (ASO), Optum. Referrals to crisis residential level of care can be made directly to the intake staff but do require initial authorization from Optum. Crisis residential intake staff shall submit the initial authorization request, documenting access criteria for crisis residential level of care, to Optum for review. Optum will review the initial authorization request form to identify if crisis residential services are medically necessary and respond to the provider with a final determination.

For continued stay services, the crisis residential program shall submit requests for concurrent authorization review based on client's need. Optum will then reauthorize, as appropriate, concurrently with the client's stay based on the continued need for services.

Crisis residential programs invite clients to attend their treatment team meeting when continuation of care is being discussed. Should clients not want to attend the treatment meeting, staff will have input from the client prior to the meeting and will meet with the client again following the meeting to review the request for concurrent authorization determination. The treatment team meeting will be documented and submitted to Optum along with the request for concurrent authorization. The authorization determination shall be maintained in the client's hybrid chart.

If a request for authorization is incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review for Outpatient Programs

Beginning July 1, 2010, the BHP implemented a policy change affecting the Adult/Older Adult Behavioral Health Services utilization review process. The purpose of this new policy is to reinforce a change of the primary focus of current County Mental Health-funded (A/OA MHS) outpatient clinic practices to recovery-oriented brief treatment and establish the requirement for implementing the Utilization Management process.

In connection with this policy, clients who still require services but who are stabilized and able to function safely without formal County Behavioral Health outpatient services will be referred to a primary care setting or other community resources for services. It is the expectation of Adult / Older Adult Behavioral Health Services that most clients shall receive brief treatment services that focus on the most critical issues identified by the clinician and client and that services will conclude when clients are stabilized. For detailed information and requirements regarding Utilization Management for outpatient programs see the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans > *UCRM* tab > MH Only section for the UM forms and Explanation Sheets.

Clients shall meet specific criteria and be reviewed through a Utilization Management (UM) process which shall be conducted internally by a Utilization Review Committee (URC) at all County and county contracted outpatient clinics.

The following clients MUST be reviewed via UM:

Clients with a MORS rating of 6 or higher - Clients with a MORS rating of 6 to 8 will be referred out of the County or County contracted outpatient clinic for ongoing services unless an exception is made (see exception noted below). If a client receives a MORS rating of 6 to 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider may request Utilization Review Committee (URC) to review client's case and justify ongoing services if applicable. [Note that someone with a MORS rating of 8 would probably be better supported at a lower level of care.]

The following clients MAY be reviewed via UM:

- Clients with unchanged MORS rating
- Clients who have been enrolled in program services for 2 years or longer
- Treatment Team recommendation

- URC may review client's that meet the above criterion in order to determine appropriateness for ongoing services or transition to a lower level of care.

For continued authorization of ongoing services, the following criteria must also be met:

1. Continued Access Criteria with demonstrated benefit from services
2. Meet Target Population Criteria

Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for: W&I Code 14148.402 Access Criteria. The Adult/ Older Adult BHS Target Population- Individuals we serve include:

- Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.

- People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational, and educational goals.

This criterion applies to all clients including Medi-Cal and indigent clients.

Eligibility for Ongoing County or Contracted Program Outpatient Services

To continue beyond limited brief sessions clients shall be reviewed through a Utilization Management process and meet the following three criteria:

1. Continued Mental Health Access Criteria, with proposed intervention/s significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.

2. Meet Target Population Criteria

3. MORS- rating guideline of 5 or less

OR

An approved Utilization Management Form documenting justification for on-going services for clients with MORS of 6, 7, or 8 which includes at least one continuing current Risk Factor related to client's primary diagnosis:

1. Client has been in Long-Term Care, had a psychiatric hospitalization, or was in a Crisis Residential facility in the last year.

2. Client has been a danger to self or to others in the last six months.

3. Client's impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless.

4. Client's behavior interferes with client's ability to get care elsewhere.

5. Client's psychiatric medication regimen is very complex

6. Client is actively using substances.

Outpatient Guidelines for Specific Program Types

Brief Solution-Focused Outpatient Services: Outpatient clinic services that shall be targeted as brief or time-limited include brief solution-focused individual and/or group treatment, individual and/or group rehabilitative services, and medication management as appropriate for stable clients who may be referred elsewhere for services.

Services that may be delivered include:

- Clinical triage
- Assessment
- Group therapy
- Case Management
- Medication support as indicated

Outpatient Biopsychosocial Rehabilitation Programs: (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, coordination of care, medication support, case management brokerage and occasional crisis intervention services. OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining access criteria for Specialty Mental Health Services are met to provide medically necessary services, which may include psychotherapy.

The initial Assessment, Problem List and Client Plan (as applicable) shall be completed within a clinically appropriate timeframe upon program assignment. If, after completing the assessment, the clinician determines that access criteria for specialty

mental health services are not met, the client will be issued an NOABD (see more complete description of the process in the Member Rights and Issue Resolution chapter of this Handbook) and his/her/their member rights shall be explained.

Clients will receive appropriate support and services to ensure that transition to other services are successful. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the client does not meet access criteria for services. Clients who are referred elsewhere for medication or psychology services may still access County Mental Health-funded case management, peer support, and clubhouse services.

Utilization Review for ACT/FSP/Case Management Programs

Each ACT, FSP, and case management program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of continuation of medically necessary treatment and level of case management services. These decisions will be based on Welfare and Institutions Code Section 14184.402 for diagnosis, impairment and interventions and Case Management Service Level Criteria. Decisions shall be supported by chart documentation of the client's individual functioning level, symptoms, and needs.

The URC shall consist of a minimum of three (3) staff persons. The chair of the URC shall be a licensed/registered/waivered mental health clinician. Additional members shall be two (2) or more staff who provides direct services or clinical oversight. A clinician shall not participate in the authorization decisions of his or her client. The QA unit may identify cases for review.

Initially, all clients who have been receiving services for more than two (2) years shall be reviewed by the URC. The URC may only authorize up to one year of service at the same level. Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability. Prior to the utilization review of the client, the case manager will complete the *Adult Outpatient Utilization Management Form* verifying that the client meets criteria for access to SMHS and the services must be medically necessary. This will summarize necessary information in order to assist with the URC review.

Case managers will prepare cases for URC review by the first of the month of their annual review when the admission date to the current program was two or more years ago. The Program Manager/Supervisor will develop a list of clients due for review each month and will notify the case manager and the URC of the cases to be reviewed. The URC will notify the program and case managers of the date and time of the URC and have the charts gathered accordingly.

A URC Record shall be created for each client reviewed and filed in the front of the progress notes of the client's chart. This URC record will provide a summary of clinical information that supports the authorization decision. The URC Minutes shall summarize the outcomes of the cases reviewed. These minutes will be maintained in a designated file. The file shall be available for review as needed by the QA unit.

Outcome Measures

The following outcome measures shall be employed in order to inform the Utilization Management process. These measures are completed within thirty (30) days of admission, every 6 months thereafter and at discharge by all County and County contracted outpatient providers. Outcome measures and explanation sheets are located on the Optum Website > BHS Provider Resources> SMH & DMC-ODS Health Plans> *UCRM* tab > MH Only section.

Recovery Markers Questionnaire (RMQ)
Illness Management and Recovery (IMR)
Milestones of Recovery Scale (MORS)

Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the County or Contracted outpatient clinic. The MORS rating shall be kept in the client record. Time spent with the client completing outcome measures may be claimed as part of another direct client service when the information obtained from the outcome measure is used for UM/UR review. Documentation shall demonstrate how the information was used for furthering the clinical assessment or for planning, guiding, or developing treatment.

Missed Appointment and Follow Up Standard

County of San Diego BHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. Missed Appointment policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

For new referrals: When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule (defined as a "No Show"). The client shall be contacted within one (1) business day by clinical staff. If the client has been identified as being at an elevated risk, the client (or caregiver, if applicable) will be

contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

For current clients: When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a "No Show"). The client shall be contacted within one (1) business day by clinical staff. If the client has been identified as being at an elevated risk[1], the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an elevated risk and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the client's emergency contact, or initiating a welfare check.

Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the client's whereabouts and admittance to different levels of care throughout the County (e.g., hospital, PERT or jail admissions).

All providers shall have policies and procedures in place regarding the monitoring of missed appointments for clients (and/or caregivers, if applicable).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed appointment must be documented by the program. "**Elevated risk"** is to be defined by the program and/or referral source.

Children and Youth Speciality Mental Health Services

All authorization requirements in this section must be completed for all treatment clients even if the services will be funded by a source other than Medi-Cal, such as SB 163 and Mental Health Services Act (MHSA). Department of Health Care Services (DHCS) Information Notice No.: 22-016 dated 04.15.22 outlines authorization requirements for Specialty Mental health Services (SMHS). It emphasizes that all medically necessary covered SMHS must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR). The information notice specifies that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. Prior authorization may not be required for Crisis Intervention, Crisis Stabilization, Metal Health Services, Targeted Case Management, Intensive Care Coordination, or Medication Support Services.

Seriously Emotionally Disturbed Clients

The priority population for Children's Mental Health Services, including clients seen under MHSA, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the access criteria for specialty mental health services and further are defined as follows (per California Welfare & Institutions Code Section 5600.3:

For the purposes of this part, seriously emotionally disturbed children or adolescents are those who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.

Members of this target population shall meet one or more of the following criteria:

1. As a result of the mental disorder the child has substantial impairment in at least two (2) of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

2. The child is at risk of removal from home or has already been removed from the home.

3. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

4. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

5. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Outpatient Services

Outpatient Time Based Utilization Management

One of the overarching Health and Human Services Agency (HHSA) principles is efficient and effective access to our target populations. CYFS clients receive treatment services that focus on the primary areas of need identified/confirmed by the client/family and conclude when those are stabilized. The focused model shall be communicated at the onset of treatment so the client/family can maximize use of sessions and be prepared for conclusion of treatment.

Clients who meet the access criteria for specialty mental health services shall be eligible for up to six (6) months of treatment sessions. This will apply to Medi-Cal and MHSA

(indigent) clients. Additional treatment time may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

Authorization for Reimbursement of Services

The San Diego County BHP defines Children, Youth and Families Services (CYFS) clients as children and youth up to 21 years of age. Providers shall evaluate Transitional Age Youth (TAY) clients to determine if child or adult network of care would best serve their needs as well as explore TAY specific resources.

Clients and families may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

A client/family may access services by calling or walking into an organizational provider or county-operated program; the client shall be screened and when applicable assessed by the provider. After completion of an assessment and when additional services are offered, that provider is responsible for entering administrative and clinical information into all the appropriate fields in the Management Information System (MIS). Providers must register clients, record assignment and service activities, and update the CSI information in MIS. (See the Management Information System section of this handbook for a description of how MIS supports these provider activities.)

If, after completing the assessment, the clinician determines that access criteria for specialty mental health services are not met, the Medi-Cal member shall be issued a Delivery System Notice *NOABD* (which must also be documented in the *NOABD Log*) which is submitted to QA on a quarterly basis and their member rights shall be explained.

If a client receives day services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services (Individual, Group, Family, or case management. Etc.), authorization for the Mental Health Service must be determined in accordance with the Day Treatment Ancillary UR process applicable to outpatient providers. Authorization is obtained from Optum through the day treatment provider. (See *Utilization Review*)

Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the client does not meet criteria for specialty mental health services.

If the Access and Crisis Line (ACL) refers a client to an organizational provider or to a county-operated facility, ACL enters the client information in the MIS. The provider is then responsible for ensuring all client information is correct and complete. The provider is also responsible for recording all ongoing activity for that client into the MIS. This information includes, but is not limited to, assignment and service activities, the primary diagnosis, the name of the single accountable individual, and all client assignment closings.

Medication Only Services

The BHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children and youth who are receiving only medication support and have no therapist or case manager involved.

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youths may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server.

Such cases are not subject to utilization management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only client must have rapid access to a resumption of therapy if a need should arise.

Procedure for Medication Only Clients:

Clients who have never had an open assignment in the program receiving the referral should not be opened as medication-only clients without previous approval from the Contracting Officer's Representative (COR). In these cases, a complete and up to date Behavioral Health Assessment must be in the client chart. Additionally, a Client Clinical Problem List must be in place to cover medication only services.

When the child or adolescent has a therapist in a different organizational provider program, that program shall be contacted as to why the needed medications are not being provided by the assigned therapist's program. If the child's therapist is a fee-for-service provider, the child's legal representative shall be provided the number to the Access and Crisis Line for assignment to a fee-for-service psychiatrist.

In the event that service goals have been met, that a Utilization Management (UM) Committee has denied further treatment, or if in the opinion of the therapist, client, and caregiver, a break in psychotherapy treatment is appropriate, the client shall be assessed for the need for ongoing medication support by provider's staff psychiatrist or referred to the Center for Child and Youth Psychiatry program.

Criteria for requiring such support shall include:

1. The client has been stabilized on a medication regime for a minimum of three (3) months under the care of the provider's staff psychiatrist

2. In the opinion of the prescribing psychiatrist, the child or adolescent would experience an exacerbation of symptoms or impairment if removed from the medication,

3. The child's primary care physician is unable or unwilling to continue the medication, even with consultation from the program psychiatrist,

4. The continuation of medication support is desired by the client and caregiver; and

5. For School Based clients, clinician shall have the outpatient services removed from the student's Individual Education Program (IEP).

When the decision is to continue the case as medication-only, within the same program, the case shall remain open, but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the MIS, the name of the server shall be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization management requirements.

Documentation for a medication only case shall include: a complete and up to date Behavioral Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow up medication management session), and an active Client Clinical Problem List. Medication only cases are exempt from completion of Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC) and Youth Services Survey (YSS).

Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. In the event that case management or formal assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

Medication-only cases are not subject to UM, but cases open in this status for twelve (12) months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:

1. Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.

2. Whether a return to active psychotherapy is indicated.

If a client who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the client's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UM authorization is in place.

When authorization is in place, therapy may resume, however a new Client Clinical Problem List is indicated. When authorization has expired, the UM Committee must first authorize services for billing of therapy to resume. In the MIS (EHR) the name of the server shall be updated to reflect the name of the current clinician.

School Interface

Effective 7-1-12 Children, Youth & Families services are no longer contracted through County Office of Education to provide Educational Related Mental Health Services (ERMHS) which is in line with repeal of AB2726/3632 in October of 2010. Aligned with AB114, students with behavioral health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access Children, Youth & Families services through the County system when they meet access criteria for specialty mental health services.

Children, Youth & Families standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical. Through contracts with Community Based Organizations, School ink services are offered on identified school campuses. Information about School ink can be accessed through the HHSA-BHS webpage.

Intensive Services

Day Rehabilitation - a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries

and is available at least four hours and less than twenty-four (24) hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and coordination of care.

Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four (4) continuous hours for a full-day program and a minimum of three (3) continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three (3) hours per day for full-day programs and an average of two (2) hours per day for half-day programs.

The milieu includes staff and activities that teach, model, and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions.

Day Intensive - a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the member in a community setting, with service available at least three (3) hours for half-day programs, four (4) hours for full-day programs and less than twenty-four (24) hours each day the program is open.

Service activities may include, but are not limited to: assessment, plan development, therapy, rehabilitation and coordination of care.

Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four (4) continuous hours for a full-day program and a minimum of three (3) continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three (3) hours per day for full-day programs and an average of two (2) hours per day for half-day programs. The milieu includes staff and activities that teach, model, and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions.

Day School Services – an intensive outpatient program that includes a full range of short-term specialty mental health services including assessment, evaluation, plan development, coordination of care, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services.

These services may be provided to children and youth identified through an IEP or school district process as needing a Special Education Classroom setting to be successful in school. Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive classroom setting.

Short-Term Residential Therapeutic Programs (STRTP) –include a full range of short-term Outpatient Specialty Mental Health Services (SMHS) including assessment, evaluation, plan development, case management, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services provided in a residential facility. Some STRTPs include Day services in addition to Outpatient SMHS. Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive, community based or family care setting through an aftercare program component.

Intensive Outpatient Program (IOP) - IOP offers outpatient specialty mental health services to children and youth up to age 21 who would benefit from time limited programming in an intensive outpatient setting. Average length of stay for services is typically 6-8 weeks with a cohort of similar age youth and presenting problems. Program services are typically offered three (3) to five (5) times a week after school hours where youth attend Day Intensive Half (DIH) programming consisting of an evidenced based approach to addresses specific treatment issues.

Additionally, the local model offers weekly caregiver groups and multi-family group once a month. The design calls for a full range of ancillary Outpatient Specialty Mental Health Services (SMHS) inclusive of medication monitoring which is offered outside of the Day Treatment program hours. Referrals to IOP typically come through an outpatient service provider and/or emergency screening/crisis stabilization unit when it is determined that intensive services are needed or as a step-down service from an acute setting. A prior authorization is required for Medi-Cal beneficiaries receiving DIH.

Partial Hospitalization Program (PHP) - PHP offers outpatient specialty mental health services to children and youth up to age 21 who would benefit from time limited intensive programming. Average length of stay is typically 2-4 weeks with a cohort of similar age youth and presenting problems. Program services are typically offered Monday through Friday. Throughout the day, youth attend an all-inclusive Day Intensive Full (DIF) program with individual, group, and family treatment sessions utilizing an evidenced based approach, as well as educational instruction. Medication Services are available as ancillary.

Referrals to PHP typically come from the emergency screening/crisis stabilization unit to prevent an escaladed need for inpatient psychiatric care, from intensive hospital teams as a step down from an acute setting and/or from an Intensive Outpatient Program

who determine a higher level of care is needed. A prior authorization is required for Medi-Cal beneficiaries receiving DIF.

Prior Authorization Processes For Day Services

Prior to obtaining authorization to receive services within the program, each client must have:

- a face-to-face assessment to establish access criteria for SMHS
- an assessment that documents a recommendation for applicable level of care (STRTP, PHP, IOP or traditional outpatient)
- documentation that lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted
- documentation that highly structured mental health program is needed to prevent admission to a more intensive level of care.

Programs are responsible to check on a monthly basis all Medi-Cal and UMDAP clients for eligibility and update the MIS as appropriate. If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable. Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4.

The Day Service Request for STRTP, IOP, and PHP essentially states that the client cannot be served at a lower level of care and that a recommendation for intensive services has been made. If access or service necessity criteria are not met, the Medi-Cal client will be issued an NOABD (which must also be documented in the NOABD log) and the member rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD shall be issued by Optum.

The initial *IOP or PHP Prior Authorization Day Services Request (DSR)* is to be completed and submitted to Optum prior to the provision of services and re-authorized every four (4) weeks for PHP and every twelve (12) weeks for IOP if indicated. Initial IOP & PHP DSRs shall be submitted to Optum at least five (5) business days prior to the initial provision of Day Services, and continuing authorization requests shall be submitted to Optum at least five (5) business days prior to the expiration of the IOP or PHP Day Services authorization.

The IOP & PHP Day Service Request (DSR) form is located on the Optum Website > BHS Provider Resources> SMH & DMC-ODS Health Plans> *UCRM* tab. DSRs are faxed to Optum for all Day Service Authorization Requests regardless of client's insurance coverage or lack thereof. DSRs should be filed in the medical record in the Plans section or be accessible upon request.

If any of the above is not done correctly, Optum will return the DSR for correction and services will not be authorized until the corrections are made and the form is faxed back to Optum for review.

Ancillary Services

An Ancillary Service Request Form must be submitted if a client is going to receive Outpatient services in addition to the Day Intensive services. This form is located on the Optum Website > BHS Provider Resources> BHP Provider Documents> *UCRM* tab. If Day Service and Outpatient Services are provided by the same program, the Ancillary Services Request section in the DSR form will be completed as part of the prior authorization. If Outpatient services are provided by another program, an Ancillary Services Request form must be completed by the OP provider and sent to IOP for submission to Optum. When the DSR Ancillary information is done incorrectly, Optum will send the DSR to the Day program with whom the outpatient program is coordinating.

Short-Term Residential Therapeutic Programs (STRTPs)

California's **Continuum of Care Reform (CCR)**, AB403 (2015) and AB1997 (2016), requires that Residential Care Level (RCL) group homes who serve foster youth and/or non-minor dependents (NMD) transition to licensure as an STRTP. The legislation ensures that youth with the most acute mental health treatment needs receive specialized, trauma informed, and intensive treatment focused on stabilization to allow for a successful transition to a family setting.

The Quality Management Unit will monitor Day Treatment Programs in accordance with state standards. For more information, see links: Day Treatment Intensive and Day Rehabilitation Service Components - Attachment A DMH Information Notice NO. 02-06 . Monitoring includes but it not limited to: the annual collection of schedules, program descriptions and group descriptions for pre-approval programs must submit any changes to the schedule, or group descriptions for review and pre-approval

IPC and CFT Meeting

Prior to placement in an STRTP, all children and youth shall participate in a **Child and Family Team meeting** and be evaluated by the **Interagency Placement Committee (IPC)** to ensure that the youth's needs cannot be met in a less restrictive environment and that they meet the criteria listed in All County Letter No. 17-22 , including that the child/youth:

1. Does not meet criteria for inpatient care and has been assessed as requiring the level of services provided by an STRTP in order to maintain their safety and well-being AND one of the following:

   i) Meet **access criteria** for Medi-Cal Specialty Mental Health Services,

   ii) is assessed as **seriously emotionally disturbed**, or

   iii) is assessed as **requiring the level of services** provided by the STRTP in order to meet their behavioral or therapeutic needs, or

   iv) meets criteria for **emergency placement** prior to determination by the IPC.

The IPC consists of representatives from Child and Family Well-Being (CFWB), Probation, and Behavioral Health Services as well as representatives from Public Health, and Educational sectors. Interagency Placement Committee meetings are held weekly by both Probation and CFWB. For children 6-12 years old, placement in an STRTP shall not exceed six (6) months. For children aged 13 and up, placed under supervision of CFWB, the placement shall not exceed 6 months. For children aged 13 and up, placed under supervision of Probation, the placement in an STRTP shall not exceed 12 months. **Placement criteria and extension requests** beyond the stated timelines are outlined in **All County Letter No. 17-22**. For more information regarding **Child and Family Team meeting** requirements for youth placed in an STRTP, please reference *OPOH Section D, Child and Family Team*.

Family First Prevention and Services Act

On February 9, 2018, the Bipartisan Budget Act of 2018 – Public Law (P.L) 115-123, which includes the Family First Prevention and Services Act (FFPSA), was signed into law. The FFPSA amends Title IV-B of the Social Security Act, subparts1 and 2 programs, and makes other revisions to the Title IV-E foster care program. FFPSA is designed to enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services,

increasing oversight and requirements for placement, and enhancing the requirements for congregate care placements.

As of October 1st, 2021, per the FFPSA Part IV and Welfare and Institutions Code 4096, as outlined in BHIN NO. 21-060, a **Qualified Individual (QI)** shall **conduct an independent assessment and determination** regarding the **needs of a child prior to placement in a Short-Term Therapeutic Residential Program (STRTP)** or in an out-of-state residential facility. The Qualified Individual shall include engagement with the child and family team members and, in the case of an Indigenous child, the Indigenous child's tribe, in conducting the assessment. The QI shall conduct the independent assessment and determination prior to placement in a STRTP. In the case of emergency placement, the QI shall conduct the independent assessment and determination within 30 days of the start of the placement.

Also, effective **October 1, 2021**, per FFPSA Part IV, **Short-Term Residential Therapeutic Programs** (**STRTPs) aftercare component will routinely extend for at least six (6) months post discharge and will include a connection to wraparound services** as the youth transitions out of the STRTP. The goal of the aftercare component is to support youth in the transition from congregate care to a family-based setting. STRTPs are responsible for discharge planning and ensuring family-based aftercare supports are in place for at least 6 months.

STRTPs have authorization to make direct referrals to BHS contracted wraparound programs and shall routinely discuss the implementation of wraparound services in the Child and Family Team (CFT) meeting during the transition period fromthe STRTP to aftercare to ensure the team is a part of the recommendation. Wraparound providers can begin providing services up to three months prior to a youth's planned discharge from the STRTP in order to prepare for the transition to a family-based placement.

Mental Health Program Approval

STRTPs must have a contract with the BHP to provide Specialty Mental Health Services (SMHS) and must apply for and maintain STRTP **Mental Health Program Approval from DHCS**. Children/youth placed in an STRTP must receive intensive treatment services in a therapeutic milieu, outlined in **Section D: Intensive Services**. The Utilization Management process for STRTPs is outlined in *OPOH Section D: Authorization Process for Intensive Services*. The process for serving out of county Medi-Cal Clients in an STRTP is outlined in *OPOH Section D: Out of County Medi-Cal Clients*. STRTPs are required to comply with the program, documentation and staffing requirements outlined in the most current **Interim STRTP Regulations** provided in BHIN No: 20-005.

Utilization Review for Day Treatment Intensive and Day Rehabilitation Services

The initial STRTP Prior Authorization Day Services Request (DSR) is to be completed and submitted to Optum prior to the provision of services and re-authorized every ninety (90) calendar days for STRTP services. Initial STRTP DSRs shall be submitted to Optum at least five (5) business days prior to the initial provision of STRTP Day Services, and continuing authorization requests shall be submitted to Optum at least five (5) business days prior to the expiration of the STRTP Day Services authorization. Optum sends completed DSRs (STRTP only) to the BHS Continuum of Care Reform (CCR) Team on a monthly basis for review of the Clinical Review Report section. The BHS CCR Team will follow up with the STRTP regarding the Clinical Review Report when indicated.

The STRTP Day Service Request (DSR) form is located on the Optum Website> BHS Provider Resources> BHP Provider Documents> *UCRM* tab. Additional STRTP resources are located on the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> *MH Resources* tab

Utilization review of day treatment intensive and day rehabilitation services for Medi-Cal clients is delegated to Optum and managed on a ninety (90) day cycle for STRTPs, twelve (12) weeks for IOP & and four (4) weeks for PHP.

Short-Term Residential Therapeutic Programs (Outpatient only)

Short-Term Residential Therapeutic Programs (STRTPs) providing Outpatient Services only shall document Utilization Management Requests on the STRTP UM Request form for all youth within ninety (90) calendar days of arrival, and within each ninety (90) calendar days thereafter while a youth is residing in the STRTP.

STRTP UM Request Form

The STRTP UM Request form is completed by a STRTP Mental Health Program clinical staff and reviewed by the STRTP Program Manager and designated STRTP UM Committee STRTP UM Request form includes Clinical Review Report section, which is monitored by QM annually in accordance with current DHCS Interim STRTP regulations. STRTP UM Requests shall be completed and reviewed by the program level UM Committee within ninety (90) calendar days of arrival into the STRTP and within every 90 calendar days thereafter.

Out of County Medi-Cal Clients

Authorization of Reimbursement of Services

Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their country of origin, have had difficulty receiving timely access to specialty mental health services. Assembly Bill (AB) 1299 and Senate Bill (SB) 785 intend to improve the timely access to services.

AB 1299 for Foster Youth: Establishes the presumptive transfer of responsibility and payment for providing or arranging mental health services to foster children from the county of original jurisdiction (placing county) to the foster child's county of residence. MHSUDS Information Notice No. 17-032 (Dated 7/14/17)

SB 785 for AAP and KinGAP : Transfers the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP and KinGAP children. DMH Information Notice No. 08-24 and 09-06 (Dated 8/13/08 and 5/4/09). Although the statutory sections included in the originally enacted version of SB785 have been amended over time, none of these amendments changed any of the original provisions of SB785. Furthermore, the original provisions of SB 785 did not change as a result of AB1299. However, the provisions of SB785, including Service Authorization Request (SAR) provisions, are no longer necessary or required for foster children or youth under the conditions of presumptive transfer, or under a waiver of presumptive transfer. However, for children and youth who receive assistance under Kin-GAP and AAP, the county of original jurisdiction continues to retain responsibility for authorizing and reauthorizing SMHS.

Program Procedure(s) for Medi-Cal Eligible Children in Foster Care under AB1299

(For foster children whose care is presumptively transferred to San Diego)

1. Placing agency from the county of original jurisdiction may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The placing agency informs Optum of the presumptive transfer.

3. If requested by the placing agency of the county of original jurisdiction, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

4. Services shall be entered into the EHR by the MIS.

5. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.

6. STRTPs who provide day services shall submit DSR to Optum.

7. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR, BHS CCR team, and Optum San Diego with a copy of the Notice of Presumptive Transfer form by the 15th day of the month following admission to the STRTP.

Program Procedure(s) for Medi-Cal Eligible Children in AAP/KinGAP under SB 785

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The program providing the services will submit the Service Authorization Request (SAR) to the county of origin for authorization and signature.

3. For outpatient services, if county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.

4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

5. Services shall be entered into the EHR by the MIS.

6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.

7. SPA shall submit the notification SAR and the DSR to Optum.

8. STRTPs shall contact the COR for written prior authorization for admission to mental health treatment services and confirm that out-of-county youth has a San Diego connection/caregiver to whom they will be discharging to.

9. STRTPs shall submit the completed SAR to the county of jurisdiction and forward a copy of the SAR and DSR to Optum with a written COR approval to serve youth under County contract due to discharge to San Diego residence.

10. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR and BHS CCR team by the 15th day of the following month and clearly indicate that the AB1299 STRTP Admission Report is being utilized to provide information about an out of county KinGAP or AAP youth under a COR written authorization.

There are, in essence, two types of OOC Medi-Cal clients:

1. OOC clients who fall under the aid codes AAP or KinGAP. For those clients the program shall submit a SAR to the Behavioral Health Plan (BHP) from the County of Jurisdiction. The clients are subject to our local UM process and the services are entered into our EHR.

2. OOC clients who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for programs to serve them. Programs need to get written authorization from COR to serve those kids prior to Medi-Cal shifting to San Diego. When authorization is granted prior to the Medi-Cal shift it is with the expectation that the program is actively and promptly collaborating with the guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process.

All BHS CYF contracted programs are to ensure that the "County of Responsibility" code is accurate and up to date for each youth admitted to the program to also track all youth's Medi-Cal County of origin.

Therapeutic Behavioral Services (TBS)

Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, Child & Family Wellbeing (CFWB), and Probation Department.

The referring party will complete and return an authorization request form and to the Administrative Services Organization (ASO) who provides authorization for TBS. Optum acts as the ASO. Prior authorization must be submitted prior to the opening of the assignment or the provision of services. All prior authorizations are sent via FAX to Optum secure fax (866) 220-4495. The required authorization request forms are located on the Optum Website > BHS Provider Resources> SMH & DMC-ODS Health Plans> *MH Resources* tab .

Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria according to California Department of Mental Health guidelines provided in *DMH Letter 99-03* and *DMH Notice 08-38*. Optum UM licensed clinicians will then send authorization response to the referring party within five (5) business days of receipt of request. The provider assigned to the client/family will conduct an assessment to ensure the client meets the class, service, and other TBS criteria prior to services being delivered.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review for TBS

Authorization management for extended Therapeutic Behavioral Services is retained by the BHP. If a client requires more than twenty-five (25) hours of coaching per week of TBS, the Contractor shall contact COR for approval. But if client requires more than four (4) months of services, provider will use internal/tracking request system that does not require COR approval. Authorization for services for San Diego clients placed out of county are referred to the COR for authorization for TBS services.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Brochure

In accordance to CCR, Title 9, Chapter 1, Section 1810.310 (a)(1), providers are to provide the DHCS issued *Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT)* brochures, which include information about accessing Therapeutic Behavioral Services (TBS) to children and young adults (under age 21) who qualify for Medi-Cal EPSDT services and their caregivers or guardians at the time of admission to any of the following facilities: Specialized Treatment Program (STP), Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution of Mental Diseases (IMD), Rate Classification Level (RCL) 13-14 Foster Care Group Home, Short Term Residential Therapeutic Program (STRTP) or RCL 12 Foster Care Group Home. Providers shall document in the client chart that brochure was provided to the client/family/caregiver. See the link to the EPSDT brochures: Medi-Cal for Kids and Teens Resources

Pathways to Well-Being and Continuum of Care Reform

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, which was filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates, alleging violations of multiple federal laws. The lawsuit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California.

Katie A., the youth identified in the name of the lawsuit, was a foster youth in the County of Los Angeles who had over 30 out of home placements, including psychiatric hospitalizations and placement in residential treatment, between the ages of 4 and 14 years-old, due to unmet behavioral health needs. The State of California settled the lawsuit in December 2011, and in March 2013, issued the Core Practice Model (CPM) Guide.

In May 2018, the CPM was revised and renamed the Integrated Core Practice Manual (ICPM). The ICPM provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health, and partners in the delivery of timely, effective, and collaborative services. PWB was implemented in March 2013 in the County of San Diego as a joint partnership between Behavioral Health Services (BHS) and Child and Family Well-Being (CFWB), in collaboration with Probation and Youth/Family Support Partners. The County of San Diego is dedicated to collaborative efforts geared toward providing safety, permanency, and well-being for youth identified as having complex or severe behavioral health needs and to establish long term permanency within a home-like setting.

PWB includes services that are needs driven, strengths-based, youth and family focused, individualized, culturally competent, trauma informed, and are delivered in a well-coordinated, comprehensive, community-based approach with a central element of engagement and participation of the youth and family. These values mirror the Children, Youth and Families (CYF) System of Care Principles. PWB services are available to youth up to age 21 across the System of Care, including Transitional Age Youth (TAY) who are involved in County of San Diego Behavioral Health Services.

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR), which was initiated across California on January 1, 2017, builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care.

CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive supports through teaming and youth not having to change placement to get services and support. CFWB and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as**:**

- Court hearing schedules
- Placement changes
- Child removed from his or her home and a plan is needed for the youth and family
- Child is in out of home care and a change in placement is required or requested
- Child returning home
- Permanent plan for a child needs to be made
- Child/youth's mental health needs or placement in a group home should be assessed
- Any family member involved in a child's case requests to meet to talk about the child's placement or the family's service plan.

BHS providers will be invited to participate in CFWB and/or Probation initiated CFT meetings to represent the youth's behavioral health treatment and needs. Whenever possible, CCR and PWB mandated CFT meetings are combined to create as few formalized meetings as necessary for the youth and family. It is the behavioral health provider's responsibility to ensure that behavioral health needs are discussed in all CFT meetings.

To further build on the efforts of California's CCR, Assembly Bill 2083 was released in 2018. AB2083 requires counties to develop and implement an MOU outlining the roles and responsibilities of local systems to serve youth in foster care who have experienced severe trauma. The goal of the MOU is to address systemic barriers to the traditional provision of interagency services and ensure services provided to children and youth are coordinated, timely, and trauma informed.

The County of San Diego AB2083 System of Care MOU, executed in March 2021, partners include Behavioral Health Services, Child and Family Well-Being, Probation Department, San Diego County Office of Education, and San Diego Regional Center, as well as

representatives from Voices for Children, Special Education Local Plan Area (SELPA), and Tribal Communities.

Serving Youth with an Open Child and Family Well-Being Services Case

Per BHIN 21-058, BHP's must make individualized determinations for each child/youth's need for ICC, IHBS or TFC upon intake and at each assessment interval. Having an open child welfare services case is not required for a child or youth to receive ICC, IHBS or TFC. BHP's are obligated to provide ICC, IHBS, and TFC to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet access criteria for these services.

The BHP cannot develop or utilize a screening or assessment tool or policy that narrows the eligibility for ICC, IHBS or TFC *beyond being medically necessary.* Providers should be considering ICC and IHBS services for all youth as part of the assessment process and indicate as such in their documentation at intake and re-assessment. Clients identified as meeting criteria for these services will be indicated as a "Special Population" in the EHR.

CFT Meetings

Under Pathways to Well-Being, all children entering the CFWB system receive a mental health screening conducted by CFWB and based upon need, are part of a collaborative, youth and family-centered teaming process, referred to as the *Child and Family Team (CFT)*. There is a distinction between a CFT and a CFT meeting. The CFT consists of people identified to ensure the youth has access to appropriate mental health and supportive services to promote safety, permanency, and well-being. The CFT, including the Intensive Care Coordinator, makes individualized determinations of each child/youth's need for Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), based on strengths/needs and reassesses the strengths and needs of child/youths, and their families, at least every ninety (90) days and as needed. The CFT meeting is just one way in which the team members communicate. The team composition is guided by the youth and family's needs and preferences.

For children or youth who are receiving ICC, IHBS, or TFC, a CFT meeting must occur as needed, but at least every ninety (90) days.

The CFT meeting process is initiated through completion of the CFT Meeting Referral Form, which is sent to the CFT Meeting Facilitation Program, unless the provider has been

granted written COR approval to facilitate their own CFT meetings. The BHS provider maintains a copy of the CFT Meeting Referral Form in the hybrid medical record chart. If the BHS provider did not initiate the CFT Meeting Referral Form, they request a copy of the form from the CFT meeting facilitator.

Following a CFT meeting, the CFT Meeting Facilitation Program is responsible for all members of the team receiving a copy of the **Child and Family Team Meeting Progress Summary and Action Plan** which includes specific action steps and timelines developed for the team members. If the provider has a COR-approved exemption from utilizing the CFT Meeting Facilitation Program, the BHS clinician is responsible for all members of the team receiving a copy of the CFT Meeting Summary and Action Plan.

There are some circumstances in which CFWB facilitates CFT meetings and when this occurs and the provider attends, the CFWB facilitator is responsible for ensuring all members receive a copy of the Child and Family Team Meeting Summary and Action Plan. The clinician also completes a service note in the EHR using the TCM/ICC procedure code.

The CFT is comprised of the following members ([M]indicates mandatory member):

- Child/youth/TAY (Mandatory)
- Family/caregiver (Mandatory)
- CWS social worker (Mandatory)
- BHS provider (Mandatory)
- Probation (Mandatory when youth is a ward of the court)
- Tribal Members (When applicable)
- Court Appointed Special Advocate (CASA) ((Mandatory when assigned by a judge)
- Natural supports
- Education and Other Formal Supports

All youth who receive Enhanced Services will have a Care Coordinator. BHS and CFWB will work together to identify the Care Coordinator who will take the lead in identifying CFT members with input from the youth/family. The Care Coordinator is also responsible for adherence to CFT meeting requirements, timelines, and referrals to the CFT Meeting Facilitation Program. A Care 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 youth

CFT Meeting Facilitation Program

All mental health treatment programs (other than those with a written COR-approved exception) that serve youth and families who are participating in CFT meetings, are required to utilize the CFT Meeting Facilitation Program.

The CFT Meeting Facilitation Program is responsible for scheduling, organizing, and facilitating CFT meetings for children/youth up to 21 years of age, within the BHS Children, Youth and Families system of care who are receiving Intensive Care Coordination (ICC) and are either required to have CFT meetings due to Pathways to Well-Being criteria, or would benefit from a CFT meeting due to multi-system involvement. The program also serves Child and Family Well-Being and Probation involved youth while closely collaborating and coordinating with all pertinent people in the youth and family's life including CFWB workers, Probation Officers, BHS providers, educational supports, other identified formal supports, and natural supports. Providers will initiate the CFT meeting process by completing the Child and Family Team Meeting Referral Form and faxing to the CFT Meeting Facilitation Program.

Documenting and Billing for CFT Meetings in SmartCare

DHCS no longer requires the identification of class or subclass when determining eligibility for ICC/IHBS services, however, counties are recommended to continue tracking of those youth who would have been subclass to facilitate data collection and reporting of all services provided. BHPs must continue to ensure appropriate claiming of ICC, IHBS, and TFC services. When ICC/IHBS services are assessed to be medically necessary, these youth should be entered into the appropriate **Special Populations** category in SmartCare – this will link the appropriate modifier (HK) for billing and tracking purposes when providing these services.

Special populations "ICC/IHBS" is used for any youth receiving ICC/IHBS services.
Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria**. Resource**: How To Identify a Client as Katie-A or Other Special Population

Youth identified as being eligible for ICC and/or IHBS services are required to be provided CFT meetings at minimum of every 90 days. Providers should utilize **Procedure Code: CFT/MDT** when documenting a CFT meeting. This procedure code has been updated on the SmartCare Service Code Crosswalk. There have been no changes to the documentation or claiming requirements for CFT meetings. Each treatment team member that plans to bill for their time spent discussing the client with other treatment team members must create their own service note. Additional guidance: Document Treatment Team Meetings - 2023 CalMHSA

Providers should also ensure that youth receiving these services have been identified in the appropriate **Special Populations** category in SmartCare which will link the appropriate required modifier (HK) to the service for billing purposes as well allowing for tracking of these youth/services.

Intensive Care Coordination

The BHP is obligated to provide ICC to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet access criteria for these specialty mental health services. ICC is provided through collaboration between the members of a CFT. **A Child and Family Team must be identified to provide ICC.** ICC requires active, integrated, and collaborative participation by the provider and at least one member of the CFT. ICC is a service that is used for the identification and coordination of ancillary supports and systems which promote safety, permanency, and well-being. ICC services are offered to clients with significant and complex functional impairment and/or whose treatment requires cross-agency collaboration.

Examples of ICC include facilitating or attending a collaborative team meeting or CFT Meeting, collaboration with formal and/or informal supports to ensure the complex behavioral health needs of youth are met and collaboratively developing Client Plan/Teaming Goals to address identified needs.

BHS providers comply with both the California Department of Health Care Services (DHCS) Medi-Cal Manual Third Edition or current edition, in adherence to considerations for when to provide ICC, Intensive Home-Based Services, and Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries. Both manuals provide guidelines for ICC, Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries.

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the Child and Family Team (CFT) in coordination with the family's overall service plan.

They may include but are not limited to assessment, plan development, therapy, rehabilitation, and coordination of care services. IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet access criteria for specialty mental health services. Prior authorization is required to access IHBS services. IHBS Prior Authorization Request form process is the following: BHS Mental Health Organizational Treatment Provider submits the IHBS Prior Authorization Request Form to Optum via FAX (866) 220-4495 or electronically via the IHBS Prior Authorization Request Web-Based form

Optum reviews and provides authorization determination within five (5) business days of receipt. Authorization is forwarded to the requesting provider to be filed in the client's hybrid medical record. Optum issues a NOABD to provider and Medi-Cal member if IHBS request is denied, modified, reduced, terminated, or suspended. If a request for authorization is considered incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable. The required authorization request forms are located on the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> *UCRM* tab > MH Only section.

A Child and Family Team must be identified to provide IHBS. IHBS are individualized, strength-based interventions that assist the client in building skills necessary for successful functioning in the home and community. IHBS is offered to clients with significant and complex functional impairment. These services are primarily delivered in the home, school, or community and outside an office setting.

Examples of IHBS include providing support to address obstacles that interfere with being successful in the home, school, and community such as maintaining housing, gaining employment, and/or achieving educational goals.

There are situations where ICC or IHBS are a lock out, including youth currently incarcerated and when the service is provided during day treatment hours, which is inclusive of these services. If a CFT meeting is provided during (IOP/PHP) Intensive/Day Rehab hours, a Service Note will be completed, utilizing the Procedure Code "CFT/MDT."

Special Populations Selection for Children/Youth receiving ICC and/or IHBS Services

BHPs are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services. All youth under age 21 and eligible for full scope MediCal must be assessed for criteria to receive ICC/IHBS

services Neither membership in the *Katie A.* class nor subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to be considered for receipt of these services. All children and youth should be screened for ICC and IHBS services as part of the Assessment process, and these services should be provided to youth when medically necessary.
Resource: Medi-Cal Manual for ICC, IHBS and TFC for Medi-Cal Beneficiaries

Therapeutic Foster Care

The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized Specialty Mental Health Service (SMHS) activities to children and youth up to 21 years of age who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. Prior authorization through Optum is required preceding the provision of TFC services. An authorization request form shall be completed and returned to the Administrative Services Organization (ASO) who provides authorization for TFC. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria. Optum UM licensed clinicians will then send authorization determination to the requestor within 5 business days or receipt of request. Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> *MH Resources*.

The TFC service model is intended for children and youth who require intensive, individualized, and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS services available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional settings such as group homes and, in the future, as an alternative to Short-term Residential Therapeutic Programs (STRTPs).

The TFC home also may serve as a step down from STRTPs. The TFC service model components consist of plan development, rehabilitation, and coordination of care. The SMHS service activities provided through the TFC service model are ancillary to other SMHS that the child or youth receives. Children and youth receiving SMHS service activities through the TFC service model must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the client plan.

A Child and Family Team (CFT) must be identified to provide TFC. CFT members will work collaboratively to determine whether TFC may be appropriate to address the child's or

youth's mental health needs to prevent placement disruption. TFC services can be accessed through a referral to the BHS approved TFC program. During the assessment process, and as recommended by the CFT, the BHS approved TFC program will screen for medical necessity and appropriateness of TFC to meet the youth's mental health needs, as well as assess the parent's willingness and training needs for providing TFC services. Once the child or youth is authorized by Optum to receive TFC service model, CFT team members are responsible for reviewing a child's or youth's progress in meeting client plan goals related to the provision of TFC.

The TFC program is responsible for the oversight of the interventions provided by the TFC parent and for ensuring that the TFC parent follows the client plan. Additionally, the TFC program is responsible for ensuring the TFC parent receive competency-based trainings both initially and ongoing, as outlined in DHCS Medi-Cal Manual. The TFC program conducts an annual TFC parent evaluation, as outlined in DHCS Medi-Cal Manual, to determine if any additional training or needs must be addressed in order for the TFC parent to continue to be successful in their role.

The TFC clinician employed by the TFC program provides ongoing supervision and intensive support to the TFC parent regarding the interventions that the TFC parent provides to the child/youth, as identified in the client plan. The TFC clinician meets with the TFC parent, face-to-face, in the TFC parent's home, at a minimum of one (1) hour per week. Additionally, the TFC clinician reviews and co-signs daily progress notes to ensure progress notes meet Medi-Cal SMHS and contractual requirements.

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent provides trauma-informed interventions daily, up to seven (7) days a week, including weekends, at any time of the day, as medically necessary for the child or youth.

The SMHS provided through the TFC service model assists the child or youth in achieving client plan goals and objectives; improving functioning and well-being; and helps the child or youth to remain in a family-like home in a community setting; thereby avoiding residential, inpatient, or institutional care. As a member of the CFT, the TFC parent participates in planning, monitoring, and reviewing the child/youth's progress in TFC and informing the team of any changes in the child's needs during CFT meetings.

Bulletins: PWB Bulletins are used to inform and provide procedures. Bulletins are located on the BHS Pathways to Well-Being Website

Trainings: All Program Managers and direct service staff shall complete the one-time Pathways to Well-Being and Continuum of Care Reform (San Diego) eLearning training. All mental health Program Managers shall complete the AB 2083 online training within ninety (90) days of hire. Both of these trainings are located on the Pathways to Well-Being website.

Forms: Client related forms specific to Pathways to Well-Being which must be completed include the following below. Forms referenced below are located on the BHS Pathways to Well-Being website under the Tools and Forms tabs. The page includes general information, required forms, training, schedules, and contact information for BHS Pathways to Well-Being staff.

Form	Details
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Pathways to Well-Being BHS/CFWB Information Exchange Form	Provider completes and submits form to CFWB (see secure region fax numbers on form) initially within 30 days of determining eligibility and for any update (upon significant change or revision to either a client plan or problem list).

Resources:

- DHCS Medi-Cal Manual Third Edition (2018):
- DHCS Integrated Core Practice Model Guide (2018):

BHS Pathways to Well-Being and Continuum of Care Reform Programs

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as well as technical assistance for STRTPs and group home providers who are transitioning to a STRTP.

The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CFWB, Probation, and Youth/Family Support Partners. Program staff can be reached through the BHS Pathways to Well-Being Website link here.

QA Program Monitoring

The BHS Quality Assurance Unit shall monitor each organizational provider and county operated program for compliance with these requirements, to assure that activities are conducted in accordance with both State and BHP standards. If the delegated entity's activities are found not to be in compliance, the BHP shall require that a corrective action plan be formulated. Progress toward change will be affected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Assurance Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing, and collections. The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* is provided by CYFS for providers as a guide for determining financial eligibility, billing and collection procedures. These are "living" handbook/manuals that are revised as new processes/procedures are implemented.