Tehama County Health Services Agency
Behavioral Health Services
Implementation Plan Update

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Betsy Gowan, LMFT, Behavioral Health Director
Joann Jeffery, LMFT, CHC, Behavioral Health Assistant Director

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

INTRODUCTION AND OVERVIEW

TEHAMA COUNTY HEALTH SERVICES AGENCY BEHAVIORAL HEALTH SERVICES

Tehama County Health Services Agency (TCHSA) Behavioral Health Services serves the communities of Tehama County, including the cities of Red Bluff (the county seat with a population of 14,076 based on the 2010 census), Corning (population 7,663) and Tehama (population 418), and 14 census designated places with populations ranging from 57 to 3,054. The total population of Tehama County in 2010 was 63,463. The racial makeup of Tehama County was 51,721 (81.5%) White, 406 (0.6%) African American, 1,644 (2.6%) Native American, 656 (1.0%) Asian, 76 (0.1%) Pacific Islander, 6,258 (9.9%) from other races, and 2,702 (4.3%) from two or more races. Hispanic or Latino of any race were 13,906 persons (21.9%).

Recent population growth in the county has been close to level according to California Department of Finance ("County Population Estimates and Components of Change by Year — July 1, 2010–2017"), increasing by 1.2% between fiscal years 2010-11 and 2016-17, a growth rate that is significantly lower than the statewide total (5.9%) as well as the national total population increase (also 5.9% as of 2018 and per the US Census website).

Tehama County has a strong local culture based on long-established, tight-knit communities in a striking rural setting. The county's cultural base includes an important Native American presence and a substantial Latino community. Straddling the basin of California's Central Valley and framed by mountainous regions in both the east and west, the county benefits from tourism while maintaining an industrial base in agricultural and animal production. The following map shows the location of cities within Tehama County and the county within the State of California.

While Tehama County maintains a strong and diverse local culture, it faces unique challenges in service provision. A significant county and regional issue is poverty: 2016 American Community Survey (ACS) data shows that—at 21.5%—Tehama County's poverty rate is significantly higher than both state (16%) and national averages (15%). Because most counties in the superior region have similar poverty levels, this may compound the effects of rural poverty including, and for example, a regional service level that may be relatively low, static or limited but that is serving a high needs region.

Also based on federal 2016 ACS data, the median household income in Tehama County is $40,687: This is 36% less than the California median income of $63,783 and 26% less than the national median income of $55,322. Conversely, while income is significantly lower than average, the price of a home is not lower: Home prices in Tehama County are about the same as the national median, approximately $180,000 in 2016. The combination of average lower incomes in conjunction with the average cost of a home not being lower may result in a sharper climb to home ownership (and the attendant life stability and benefits of home ownership).

Tehama County has characteristics that, in combination, create unique challenges in both providing care and to community members who are accessing care. These characteristics include poverty, geographic isolation, transportation barriers, a lack of providers and stigma.

Poverty: Based on 2016 census data, the percent of people living in poverty in Tehama County is 20.9%, approximately 25% higher than both the state average of 14.4% and the national average of 14%.

Geographic isolation: Tehama County is rural and sparsely populated, with a population density of 22 people per square mile (the California average is 239 people per square mile). Tehama County is geographically isolated, with a car travel time of two to three hours to the nearest major metropolitan area (Sacramento).

Within the county, communities are geographically isolated. 60% of Tehama County residents live in unincorporated areas, almost four times the state average of 14%. The county's size (nearly 3,000 square miles) and sparse population result in significant distances within the county to reach services. Most major services—including the county's only acute care hospital—are in the county seat of Red Bluff.

Limited transportation options: Because of the county's size and sparse population, public transportation is limited, and travel is private-vehicle dependent. One example regarding public transportation is that the community of Rancho Tehama receives bus service on Wednesday's only, one time a day. Poverty, lack of affordable public transportation and large distances may result in transportation being an economic challenge and potential barrier to care.

Workforce shortage: Tehama has a significant behavioral health workforce shortage. As a behavioral health employer, the County struggles to find and retain qualified behavioral health staff including; psychiatrists, clinicians, nurses, rehabilitation specialists, case managers and other qualified providers.

Stigma discourages individuals from seeking services: Tehama County residents may be wary of accessing mental health services in a small, deeply interconnected county where maintaining anonymity and privacy may add a layer of complexity.

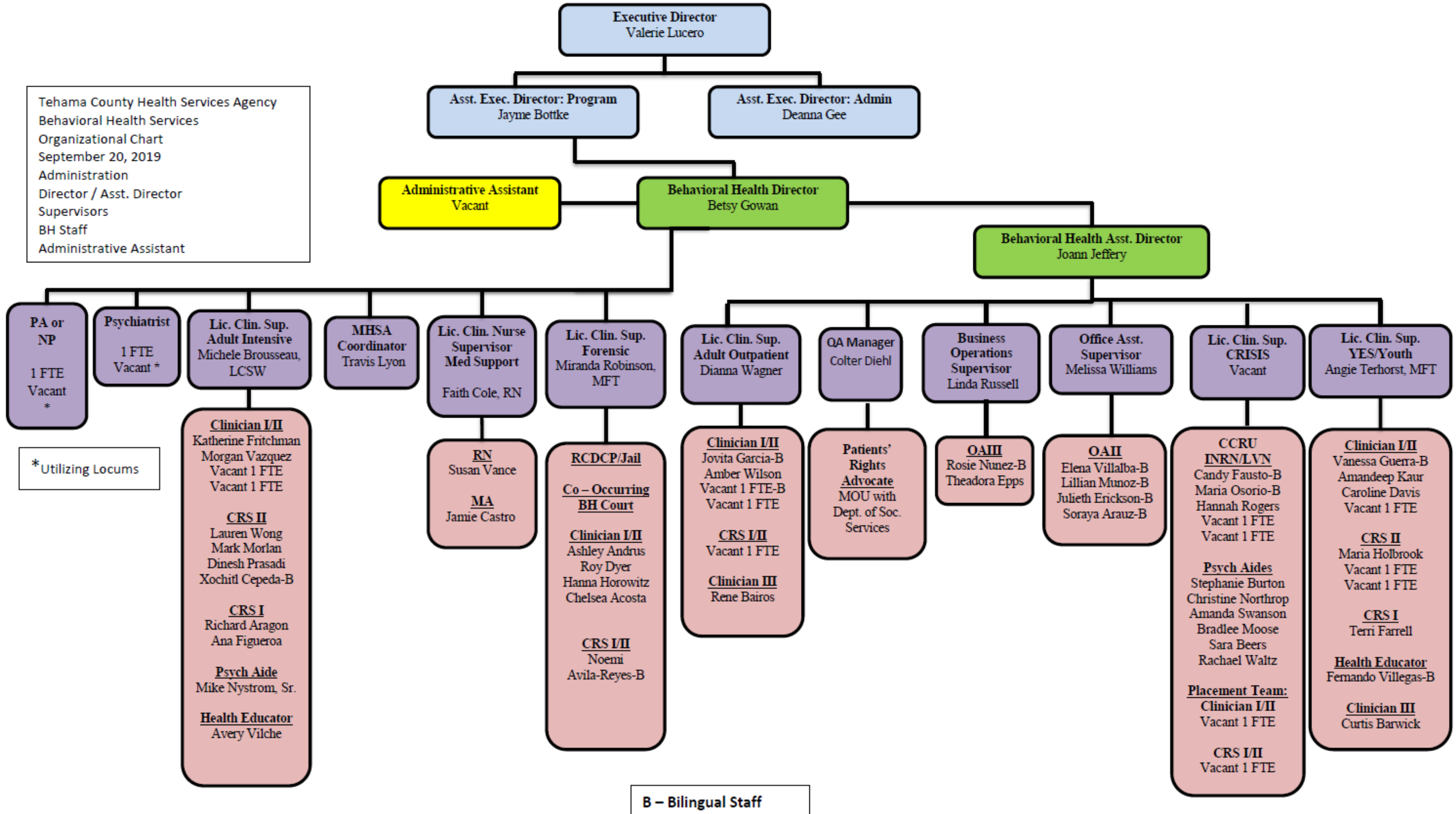
TCHSA Behavioral Health Services is charged with the responsibility for developing and coordinating a comprehensive system of programs to meet its residents' behavioral health

needs. These programs address the problems of acute and chronic mental disorders, life crises, and other health and social problems that occur concurrently with mental health and substance use issues. Services are provided directly by county staff or contracted providers.

Specialty mental health services are primarily available to Tehama County residents who meet medical necessity criteria for services and are Medi-Cal beneficiaries, or who are uninsured with low incomes. Emergency psychiatric services are provided regardless of insurance and income.

The Tehama County Behavioral Health Board evaluates Tehama County's mental health needs, services, facilities and special challenges. The Behavioral Health Board also ensures that all duties established by California Welfare and Institutions Code (W&I) Section 5604 are met. The Behavioral Health Board always has a representative from the Tehama County Board of Supervisors and the Tehama County Sheriff's Department. Additional members represent interested community members, agency representatives and consumers and family members of consumers who are receiving or have received mental health services.

On the next page is a TCHSA governance structure organizational chart, including the reporting relationship for Behavioral Health including areas of responsibility for the Director, Assistant Director and supervisors:


Tehama County Health Services Agency
Behavioral Health Services
Organizational Chart
September 20, 2019
Administration
Director / Asst. Director
Supervisors
BH Staff
Administrative Assistant
Executive Director
Valerie Lucero
Asst. Exec. Director: Program
Jayme Bottke
Asst. Exec. Director: Admin
Deanna Gee
Administrative Assistant
Vacant
Behavioral Health Director
Betsy Gowan
Behavioral Health Asst. Director
Joann Jeffery
PA or NP
1 FTE Vacant *
Psychiatrist
1 FTE Vacant *
*Utilizing Locums
Lic. Clin. Sup. Adult Intensive
Michele Brousseau, LCSW
Clinician I/II
Katherine Fritchman
Morgan Vazquez
Vacant 1 FTE
Vacant 1 FTE
CRS II
Lauren Wong
Mark Morlan
Dinesh Prasadi
Xochitl Cepeda-B
CRS I
Richard Aragon
Ana Figueroa
Psych Aide
Mike Nystrom, Sr.
Health Educator
Avery Vilche
MHSA Coordinator
Travis Lyon
Lic. Clin. Nurse Supervisor Med Support
Faith Cole, RN
RN
Susan Vance
MA
Jamie Castro
Lic. Clin. Sup. Forensic
Miranda Robinson, MFT
RCDCP/Jail
Co – Occurring BH Court
Clinician I/II
Ashley Andrus
Roy Dyer
Hanna Horowitz
Chelsea Acosta
CRS I/II
Noemi Avila-Reyes-B
Lic. Clin. Sup. Adult Outpatient
Dianna Wagner
Clinician I/II
Jovita Garcia-B
Amber Wilson
Vacant 1 FTE-B
Vacant 1 FTE
CRS I/II
Vacant 1 FTE
Clinician III
Rene Bairos
QA Manager
Colter Diehl
Patients' Rights Advocate
MOU with Dept. of Soc. Services
Business Operations Supervisor
Linda Russell
OAIII
Rosie Nunez-B
Theadora Epps
Office Asst. Supervisor
Melissa Williams
OAII
Elena Villalba-B
Lillian Munoz-B
Julieth Erickson-B
Soraya Arauz-B
Lic. Clin. Sup. CRISIS
Vacant
CCRU
INRN/LVN
Candy Fausto-B
Maria Osorio-B
Hannah Rogers
Vacant 1 FTE
Vacant 1 FTE
Psych Aides
Stephanie Burton
Christine Northrop
Amanda Swanson
Bradlee Moose
Sara Beers
Rachael Waltz
Placement Team:
Clinician I/II
Vacant 1 FTE
CRS I/II
Vacant 1 FTE
Lic. Clin. Sup. YES/Youth
Angie Terhorst, MFT
Clinician I/II
Vanessa Guerra-B
Amandeep Kaur
Caroline Davis
Vacant 1 FTE
CRS II
Maria Holbrook
Vacant 1 FTE
Vacant 1 FTE
CRS I
Terri Farrell
Health Educator
Fernando Villegas-B
Clinician III
Curtis Barwick
B – Bilingual Staff

IMPLEMENTATION PLAN CONTEXT AND PURPOSE

As required by the California Code of Regulations, Title 9, Chapter 11, § 1810.310, each Mental Health Plan (MHP) must submit an Implementation Plan in order to be designated as a MHP and contract with the Department of Health Care Services (DHCS) to provide or arrange for the provision of specialty mental health services to all eligible Medi-Cal clients residing in the MHP's county. All MHPs submitted their original Implementation Plans soon after the Medi-Cal specialty mental health services program began in Fiscal Year 1997-98.

Title 9, § 1810.310(c) requires that "An MHP will submit proposed changes to its approved Implementation Plan in writing to the Department for review." Furthermore, § 1810.310(c)(1) requires that "An MHP will submit proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan prior to implementing the proposed changes." This Implementation Plan Update is to fulfill the MHP's requirement to submit proposed changes since the last approved Implementation Plan.

Title 9, § 1810.310(a)(1) through (11) provides the content requirements for the Implementation Plan: In accordance with this regulation, the Implementation Plan will include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.
(2) A description of the process for:
    (A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.
    (B) Outreach efforts for the purpose of providing information to clients and providers regarding access under the MHP.
    (C) Assuring continuity of care for clients receiving specialty mental health services prior to the date the entity begins operation as the MHP.
    (D) Providing clinical consultation and training to clients' primary care physicians and other physical health care providers.
(3) A description of the processes for problem resolution as required in Subchapter 5.
(4) A description of the provider selection process, including provider selection criteria consistent with §§ 1810.425 and 1810.435. The entity designated to be the MHP will include a Request for Exemption from Contracting in accordance with § 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH (Disproportionate Share Hospital).
(5) Documentation that demonstrates that the entity:
    (A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of clients that will be served by the MHP, and
    (B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of clients that will be served by the MHP.
(6) A description of how the MHP will deliver age-appropriate services to clients.
(7) The proposed Cultural Competence Plan as described in § 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to § 1810.410(c).

(8) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.
(9) A description of the MHP's Quality Improvement and Utilization Management Programs.
(10) A description of policies and procedures that assure client confidentiality in compliance with State and Federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to clients.
(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to clients as described in this Chapter.

The TCHSA Implementation Plan Update addresses all the required elements outlined in the California Code of Regulations (CCR), Title 9, §1810.310. Care was taken to follow the structure established in the regulation, to ensure all the necessary descriptions of policies, procedures and processes, are included. Elements that were required in the original Implementation Plan but are not applicable to the update are so noted.

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

(3) If the changes are consistent with this Chapter, the changes will be approved by the Department.
(4) The Department will provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP.
(5) The MHP may implement the proposed changes 30 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

IMPLEMENTATION PLAN UPDATE

TABLE OF CONTENTS

Title 9 § 1810.310 (a) Requirement	**Implementation Plan Content Description** (a) The Implementation Plan will include:	**Page**
(1)	Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.	1
(2)	A description of the process for:	
(2)(A)	Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.	8
(2)(B)	Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.	11
(2)(C)	Assuring continuity of care for clients receiving specialty mental health services prior to the date the entity begins operation as the MHP.	12
(2)(D)	Providing clinical consultation and training to clients' primary care physicians and other physical health care providers.	12
(3)	A description of the processes for problem resolution as required in Subchapter 5.	12
(4)	A description of the provider selection process, including provider selection criteria consistent with §§ 1810.425 and 1810.435. The entity designated to be the MHP will include a Request for Exemption from Contracting in accordance with § 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH.	22
(5)	Documentation that demonstrates that the entity:	
(5)(A)	Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of clients that will be served by the MHP, and	26
(5)(B)	Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of clients that will be served by the MHP.	
(6)	A description of how the MHP will deliver age-appropriate services to beneficiaries.	33
(7)	The proposed Cultural Competence Plan as described in § 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to § 1810.410(c).	34
(8)	A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.	34
(9)	A description of the MHP's Quality Improvement and Utilization Management Programs.	34
(10)	A description of policies and procedures that assure client confidentiality in compliance with State and Federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to clients.	38
(11)	Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to clients as described in this Chapter.	39

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

Tehama County Health Services Agency (TCHSA) Behavioral Health Services is committed to ensuring beneficiaries have appropriate access to Specialty Mental Health Services (SMHS). Authorization and utilization management of services provided by TCHSA-Behavioral health adheres to the following principles:

A. Are based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
B. Are developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
C. Are evaluated, and updated if necessary, at least annually; and,
D. Are disclosed to beneficiaries and network providers.

TCHSA ensures that all medically necessary covered SMHS are sufficient in amount, duration and scope to achieve the purpose for which the services are rendered. TCHSA will not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. In addition, TCHSA shall, through policy and utilization review, ensure consistent application of review criteria for authorization decisions, and shall consult with requesting providers when appropriate.

Communication Requirements

TCHSA shall adhere to the following communication requirements:

1. Notify the Department of Health Care Services (DHCS) and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2. Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of outpatient services requiring prior authorization;
3. A physician shall be available for consultation and for resolving disputed requests for psychiatric inpatient hospital or PHF authorizations;
4. Disclose to DHCS, organizational providers, beneficiaries and members of the public, upon request, the utilization review policies and procedures that TCHSA or its' contracted providers use to authorize, modify, or deny SMHS. These policies and procedures shall be available electronically and in hard-copy upon request
5. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for services authorizations and/or referrals for SMHS; and,
6. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

Payment Authorization for Psychiatric Inpatient Hospital Services

In accordance with Title 9, § 1820.220, TCHSA has designated a Point of Authorization (POA) where psychiatric inpatient hospitals submit written requests for Mental Health Plan

(MHP) payment authorizations for Medi-Cal psychiatric inpatient hospital services provided to Tehama County clients. The contact information for the TCHSA POA is:

Tehama County Health Services Agency
Behavioral Health Services
P. O. Box 400 (mailing address)
1860 Walnut Street, Bldg. A (physical address)
Red Bluff, CA 96080
Phone: (530) 527-5631
Fax: (530) 527-0249 or (530) 527-0232

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

Consistent with state requirements, TCHSA shall conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services. Concurrent review of treatment authorizations shall be conducted on the day following the first day of admission. TCHSA may elect to authorize multiple days, however, each day of treatment must meet medical necessity and/or continued stay criteria.

Authorization of Psychiatric Inpatient/PHF Services

TCHSA does not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a PHF, whether the admission is voluntary or involuntary when the beneficiary meets medical necessity criteria for inpatient services. Upon notification by a hospital, TCHSA shall authorize payment services when a TCHSA beneficiary with an emergency psychiatric condition is admitted to a hospital/PHF to receive inpatient services. After the date of admission, hospitals must request authorization for continued stay services. TCHSA shall ensure that services furnished to beneficiaries are medically necessary and meet all requirements necessary for Medi-Cal reimbursement. All authorization determinations are made by a Licensed Practitioner of the Healing Arts (LPHA).

1. When a Tehama County Medi-Cal beneficiary or individual without a third-party payor source placed by Tehama County is admitted to a psychiatric inpatient hospital or PHF, the hospital/PHF shall contact the Tehama County Access Line at (800) 240-3208 and request to speak with the Crisis Supervisor to review status of the beneficiary/client and request initial authorization. Initial authorization may be made for multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.
2. If a Medi-Cal beneficiary placed by Tehama County has Medi-Cal from another county, concurrent review and authorization will not be conducted by Tehama County. The hospital/PHF shall be responsible to coordinate authorization and payment with the county of responsibility.
3. After consultation with a supervisor crisis staff will complete the Inpatient Authorization Form, note on the inpatient census log and file in Inpatient authorization binder for supervisor review.
4. For continued stay services, the hospital/PHF shall contact the crisis supervisor who will direct crisis staff to update the Inpatient Authorization Form. A Licensed Clinical Supervisor shall review form, hospital documentation or consultation with hospital and

make authorization determination based upon medical necessity criteria. The hospital/PHF may be required to submit documentation to support medical necessity for authorization of services.

5. In the event an authorization request is disputed, the Licensed Clinical Supervisor will request consultation from the TCHSA Psychiatrist.
6. Crisis staff shall notify the hospital/PHF of decisions to approve, modify or deny requests in writing within 24-hours of the decision. All authorization determinations shall be logged on the Inpatient census log.
7. In the case of concurrent review, if TCHSA denies or modifies the request for authorization care shall not be discontinued until the beneficiary's treating provider(s) have been notified of the decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. Beneficiaries must be notified, in writing, of the adverse benefit determination prior to services being discontinued.

Authorization for Crisis Residential and Adult Residential Treatment Services

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

If TCHSA does not initiate the referral for CRTS or ARTS, the TCHSA shall conduct concurrent review of treatment authorizations following the first day of admission to the facility through discharge. TCHSA may elect to authorize multiple days as long as the services are medically necessary.

If TCHSA does not initiate the referral for CRTS or ARTS, the TCHSA shall conduct concurrent review of treatment authorizations following the first day of admission to the facility through discharge. The TCHSA may elect to authorize multiple days as long as the services are medically necessary.

Notification of decisions to approve, modify, or deny requests for authorization of CRTS or ARTS shall follow the notification procedure outlined above for notification to hospitals/PHF.

Prior Authorization or MHP Referral for Outpatient SMHS

TCHSA does not require prior authorization for the following services/service activities:

1. Crisis Intervention;
2. Crisis Stabilization;
3. Mental Health Services;
4. Targeted Case Management;
5. Intensive Care Coordination; and,
6. Medication Support Services.

As a regular practice, assessments are conducted by TCHSA's clinical staff. TCHSA does not require prior authorization in the event that an organizational provider conducts an assessment, however, prior to the commencement of services, TCHSA's Quality Assurance Manager (QAM) or designee will review and approve the beneficiaries'

completed assessment and Client Plan. Assessments and Client Plans completed by organizational providers may be faxed to (530) 527-1179.

Prior authorization or MHP referral is required for the following services:

1. Intensive Home-Based Services
2. Day Treatment Intensive
3. Day Rehabilitation
4. Therapeutic Behavioral Services
5. Therapeutic Foster Care

Initial authorization for these services will be provided by referral from TCHSA, and shall specify the amount, scope and duration of the treatment TCHSA has authorized. All authorizations will be completed by an LPHA. Prior to the expiration of the initial referral, TCHSA requires organizational providers to request payment authorization for the continuation of services at the following intervals:

1. Every month
   a. Day Treatment Intensive
   b. Therapeutic Behavioral Services
   c. Therapeutic Foster Care
2. Every six months
   a. Intensive Home-Based Services
   b. Day Rehabilitation

TCHSA shall log all authorization determinations. If TCHSA denies or modifies an authorization request, notification will be given to the beneficiary, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow guidelines outlined in the TCHSA policy on Problem Resolution, Grievances and Appeals: Medi-Cal Beneficiaries.

<u>Outpatient Authorization Timeframe and Documentation Requirements</u>

TCHSA will review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the TCHSA receipt of the information reasonably necessary and requested by TCHSA to make the determination.

<u>Out of County Services for Children and Youth</u>

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

1. Medi-Cal Eligible Children in a Foster Care Aid Code
   TCHSA shall provide specialty mental health services to foster children upon presumptive transfer to TCHSA from the MHP in the county of original jurisdiction

without any delay in timeliness. Upon presumptive transfer, the MHP in the county in which the foster child resides shall assume responsibility for the authorization and provision of Medi-Cal Specialty Mental Health Services, and the payment for services, unless a waiver based on an exception to presumptive transfer exists, based on DHCS MHSUDS Information Notices No. 17-032 and 18-027.

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

2. Medi-Cal Eligible Children in an Aid to Adoptive Parents Aid Code
   a. The MHP in the child's adoptive parents' county of residence must provide medically necessary specialty mental health services to a child in an AAP aid code residing outside his or her county of origin <u>in the same way</u> that it would provide services to any other child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS). When a MHP receives a request for specialty mental health services for a child in an AAP aid code, the MHP must determine if the child's adoptive parents reside in the county that the MHP serves. If the child's adoptive parents are residents of the county that the MHP serves, the MHP must provide services to that child as it would provide services for any other Medi-Cal eligible child.
   b. The MHP in the child's adoptive parents' county of residence shall submit an authorization request (whether for an initial assessment, initial treatment or ongoing services), prepared by the provider, to the MHP in the child's county of origin. The MHP in the child's adoptive parents' county of residence must complete the authorization process (including authorization by the MHP in the county of origin) within the MHP's established authorization timelines for in county beneficiaries.
   c. The MHP in the child's county of origin must make an authorization decision (approve or deny services) within 3 working days following the date of receipt of the request for services.
   d. The MHP in the child's county of origin must notify the MHP in the child's adoptive parents' county of residence and the requesting provider of the decision to approve or deny services within 3 working days following the date of receipt of the request for services.
   e. If the MHP in the child's county of origin needs additional information not submitted with the initial request, the authorization decision must be made within 3 working days from the date the additional information is received, or 14 calendar days from the receipt of the original authorization request, whichever is less.
   f. The MHP in the child's county of origin does not need to make payment arrangements with the MHP in the child's adoptive parents' county of residence because funds for claims submitted for children in an AAP aid code will be sent to the MHP submitting the claim.
      i. The MHP in the child's county of origin may make payment arrangements with the requesting provider within 30 days of the date that the MHP authorized services.
      ii. To avoid situations where a child in an AAP aid code living outside his or her

county of origin is denied services solely on the basis that the child has out of county Medi-Cal, MHPs shall ensure their providers are aware that a child in an AAP aid code living outside his or her county of origin shall be served in the same way as a child living in his or her county of origin.

3. Medi-Cal Eligible Children in a KinGAP Aid Code
   a. The MHP in the child's legal guardians' county of residence must provide medically necessary specialty mental health services to a child in a KinGAP aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility on MEDS. When an MHP receives a request for specialty mental health services for a child in a KinGAP aid code, the MHP must determine if the child's legal guardians reside in the county that the MHP serves. If the child's legal guardians are residents of the county that the MHP serves, the MHP must provide services to that child as it would provide services for any other Medi-Cal eligible child.
   b. The MHP in the child's legal guardians' county of residence shall submit an authorization request (whether for an initial assessment, initial or ongoing treatment), prepared by the provider, to the MHP in the child's county of origin. The MHP in the child's legal guardians' county of residence must complete the authorization process (including authorization by the MHP in the county of origin) within the MHP's established authorization timelines for in county beneficiaries.
   c. The MHP in the child's county of origin must make an authorization decision (approve or deny services) within 3 working days following the date of receipt of the request for services.
   d. The MHP in the child's county of origin must notify the MHP in the child's legal guardians' county of residence and the requesting provider of the decision to approve or deny services within 3 working days following the date of receipt of the request for services.
   e. If the MHP in the child's county of origin needs additional information not submitted with the initial request, the authorization decision must be made within 3 working days from the date the additional information is received, or 14 calendar days from the receipt of the original authorization request, whichever is less.
   f. The MHP in the child's county of origin must make payment arrangements with the MHP in the child's legal guardians' county of residence or with the requesting provider within 30 days of the date that the MHP authorized services.
   g. The MHP submitting the Short-Doyle/Medi-Cal claim for services will receive the State and Federal funds.
   h. To avoid situations where a child in a KinGAP aid code living outside his or her county of origin is denied services solely on the basis that the child has out of county Medi-Cal, MHPs shall ensure their providers are aware that a child in a KinGAP aid code living outside his or her county of origin shall be served in the same way as a child living in his or her county of origin.

<u>Out-of-County Access Procedures When Conditions for Presumptive Transfer Do Not Exist</u>

1. This section provides the procedure when Tehama County is requesting authorization to provide treatment to an out-of-county beneficiary/client. This means the treatment will be in Tehama County. **Tehama County is the placement county and another county is the funding county.**
   a. TCHSA completes the assessment.

b. The other county (funding county) is determined during the Personal Financial Information (PFI) telephone call, **or** first "face to face" meeting with the beneficiary, **or** during the triage process (see Out of County Questionnaire located on the TCHSA shared network).
c. The Triage Team will complete the Service Authorization Request (SAR) during the team review of the assessment.
d. The Office Assistant (OA) III 's will enter the information into the Excel tracking sheet that they maintain. This spreadsheet is located on the TCHSA network shared drive. This is a password-protected document and the Business Operations Supervisor will provide the password to those needing access to the spreadsheet.
e. The OA III 's will fax the SAR (and all required information such as a service plan, copy of the assessment, etc.) to the funding county. Contact information for all counties can be obtained on the DHCS website at https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx#t

f. The funding county responds to the SAR (must be within 3 business days). The funding county may request more information. The OA III's will coordinate obtaining the information and faxing it to the funding county. Alternatively, the funding county will fax the completed SAR (indicating services and dates authorized) to the OA III's.
g. The OA III 's enter the authorized service dates into the Excel tracking sheet and file the SAR in the chart.
h. The Triage Team is responsible for monitoring the outstanding SARs to ensure that authorizations for needed services do not expire.

2. This section provides the procedure when Tehama County is authorizing an out-of-county request to treat a Tehama County funded beneficiary in another county. This means the treatment of a Tehama County client (usually a minor) will be in another county. **Another county is the placement county and Tehama County is the funding county.** Another county will be requesting Tehama County to authorize services.
   a. The other county (placement county) faxes a SAR to TCHSA. The fax will come to or be routed to the OA III 's.
   b. The OA III 's will verify that Tehama County is the funding county (i.e., that the client has County 52 Medi-Cal eligibility).
   c. TCHSA must respond to the SAR within 3 business days.
   d. The OA III 's will take the SAR to the next triage session.
   e. The Triage Team may request more information from the placement county. The OA III 's will coordinate obtaining the requested information and taking it to the next triage session following receipt.
   f. The Triage Team authorizes services and service dates (conforming to TCHSA's normal authorization periods) and signs the SAR.
   g. The OA III's will enter the authorized service dates into the Excel tracking sheet that they maintain. This spread sheet is located on the TCHSA shared network. This is a password-protected document and the Business Operations Supervisor will provide the password to those needing access to the spreadsheet.

h. The OA III's will fax the signed SAR to the placement county. Contact information for all counties can be obtained on the DHCS website at https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx#t
i. The OA III's will file the SAR in the chart.
j. The Triage Team is responsible for monitoring the outstanding SARs to ensure responses occur within three business days.

(2) A description of the process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.

Access and Screening Procedures

County Behavioral Health services are open to Tehama County residents and Medi-Cal beneficiaries. Eligibility is determined through our assessment process to identify if an individual has a severe and persistent mental illness or is a child with severe emotional disturbance. You can access services by calling 1-800-240-3208. The first step in the process is to have an assessment, which can occur either by walk in or by appointment. All assessments are triaged to determine whether the client meets criteria to receive SMHS, and if so, what types of services are to be provided. Once an assessment is completed and the individual's unique needs are identified, a plan for treatment and services can be developed. Depending on eligibility, treatment and ongoing service may take place with the County or with an outside provider.

Substance Use Disorder Services

If the assessment determines that there is a substance abuse issue, mental health staff refer the beneficiary to Substance Use Recovery Services (SURS). As an integrated agency, all clinicians are trained in mental health and substance use disorder diagnoses.

We provide services that focus on treating mental health conditions as well as substance use disorders simultaneously in partnership with TCHSA Substance Use Recovery Services Center to combine expertise of Clinicians and Drug and Alcohol Counselors to treat individuals that are experiencing both conditions. These services are primarily provided in groups with ongoing assessment and medication referrals as determined necessary. Additionally, a dual diagnosis group is offered to all community members as a means of outreach.

To facilitate coordination of services, a SURS crossover meeting is held bi-weekly and both executive administration and supervisors discuss various topics related to Behavioral Health and SURS such as Juvenile Behavioral Health Court, Health and Justice Sub-committee, Co-occurring, Charting, Referral process, etc.

Educational Services

If the triage and screening process determines that the client could benefit from Educationally Related Mental Health Services (ERMHS), TCHSA will refer and link the client with the appropriate educational professional staff. School based services are provided by TCHSA when indicated by the client plan.

Health Care Services

When a TCHSA beneficiary who is receiving specialty mental health services has an identified physical health problem, the TCHSA physician or therapist will refer and coordinate services with the beneficiary's PCP. If a PCP has not previously been established, they will refer the beneficiary to an appropriate clinic or doctor. PCPs may, at any time, refer patients to TCHSA for screening assessments. Referred patients may access TCHSA services in the same manner as any other individual.

Anthem Blue Cross Partnership Plan and California Health and Wellness are the Managed Care Plans (MCPs) that serve the physical health care needs of Medi-Cal clients in Tehama County. The MCPs also provide the mental health benefit for clients with “mild or moderate” mental health issues. Care coordination and effective communication between TCHSA and the MCPs including procedures for exchanges of medical information are included in the Memorandums of Understanding (MOUs) between TCHSA and the MCPs. The MOUs are available upon request.

If a client is assessed by TCHSA as not meeting medical necessity criteria for specialty mental health services due to having a mild to moderate impairment or having a condition that would be more responsive to appropriate physical health care, a referral is made to the MCP and a Notice of Adverse Benefit Determination (NOABD) is issued. If a MCP member is screened by the MCP as potentially requiring specialty mental health services, they will be referred to TCHSA for an assessment to determine medical necessity.

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

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

Housing

If a client is assessed by TCHSA as needing housing, they may be referred for transitional housing or permanent supportive housing, funded through the Mental Health Services Act (MHSA).

Transitional Housing

The MHSA requires mental health services and program designed to avoid homelessness, incarceration, hospitalization and other negative outcomes. Related to housing, transitional housing provides housing while a client is being stabilized and is pending permanent supports. Transitional housing participation includes bedrock services of case management, psychiatry and med support, rehabilitation and individual and group therapy. Clients in transitional housing are almost always involved in services at Vista Way or YES Center and are often FSP-level clients.

Transitional housing is a key tool in stabilization and rehabilitation. Existing transitional housing in Tehama County is not sufficient to serve the needs of severely mentally ill clients. TCHSA has two transitional housing units, Gentry House and Madison House, and can accommodate eight clients. Typically, both Gentry House and Madison House are full: The limited space within transitional housing creates issues for both clients and Behavioral Health programs/staff.

As of Spring 2018, homeless sheltering in Tehama County is provided in Red Bluff only, at separate church locations on a rotating schedule and limited to winter months (November through April).

Permanent Supportive Housing

TCHSA is in the process of identifying affordable housing partners to develop permanent supportive housing (PSH), utilizing MHSA's local government Special Needs Housing Program (SNHP) funds. In supportive housing, the local government commits to providing supportive services to residents for a certain length of time (usually the term of the SNHP loan which can range from 20-57 years).

Permanent supportive housing (PSH) is housing with no limits on length of stay. Housing units are restricted to individuals with serious mental illness, who are chronically homeless, homeless or at risk of homelessness. Linked to housing are voluntary support services available both on- site and off-site (within the community). Support services help tenants retain housing and increase self-sufficiency.

Stakeholder Meetings

Tehama County Housing and Homelessness Stakeholders Meetings are held regularly as the County partners with the community in addressing the needs of the homeless. Tehama County has approved a 10-year plan to end homelessness and various projects are moving forward toward providing additional resources to the homeless.

Vocational Rehabilitation Services

If a client is assessed by TCHSA as needing vocational rehabilitation services they may be referred to a program to serve those needs.

Through the MHSA, TCHSA Behavioral Health provides both vocational training to adult/older adult and Transition Age Youth (TAY) clients as well as employment of peer advocates. Formerly TCHSA "stipend" workers, in 2016 and 2017 TCHSA restructured and improved the consumer employment program including moving the program under a contract with Northern Valley Catholic Social Services (NVCSS). The new employment program has fewer employees who receive more training and the experience of being a full employee of a non-profit agency. As paid employees, these positions more fully mirror "real world" employment experience and, therefore, better support goals of growth and employment in the community.

As vocational trainees, Peer Assistants complete wellness and recovery-focused training provided by NVCSS supervisors. After completing the training, participants are assigned to work in one of several areas: Vista Way center front desk, mental health outpatient, Youth Empowerment Service (YES) Center and a landscaping program. Peer Assistants are hired for a nine-month period (additional employment series are considered depending on circumstances), receive supportive employment and to develop marketable skills with the goal of finding work in the community.

(2) A description of the process for:

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

TCHSA provides a Guide to Medi-Cal Mental Health Services (beneficiary handbook) and provider directory to clients upon request and when first receiving specialty mental health services. The handbook and directory are available in English and Spanish at the TCHSA county service locations and on the TCHSA website. The content and format are consistent with the California Code of Regulations (CCR), Title 9, §1810.360 and the Title 42, Code of Federal Regulations (CFR), § 438.10.

Community Outreach and Engagement

TCHSA values the importance of community outreach and engagement, especially with identified racial, ethnic, cultural and linguistic communities with mental health disparities. As required by the MHSA, the Agency conducts a community outreach process focuses on at risk communities (people who are homeless, migrant workers, TAY, older adults and others) and culturally-specific communities including the Latino community. To conduct outreach, TCHSA participates in events serving those living in poverty, cultural events and celebrations, health fairs and others. Every year, TCHSA maintains a booth at the Tehama County Fair and conducts May is Mental Health Month events and stigma-reduction activities. In addition to its main service center in Red Bluff, TCHSA developed and maintains a presence in other areas of the county including (recently) Los Molinos and Rancho Tehama, as well as a long-standing presence in Corning: These locations facilitate outreach to historically under-served populations. Importantly, TCHSA continues to recruit bi-lingual therapists and staff, providing a 7.5 % pay differential.

Community Education and Latino Outreach

Through the MHSA, TCHSA has established a Community Education and Latino Outreach (CELO) program. CELO includes a variety of activities including expanding services for the Latino community including bilingual Spanish clinicians, provision of cultural sensitivity training to service providers, Latino community outreach activities and general community education activities. Corning (south county) and Los Molinos (east county) are key communities that need services in Spanish and Latino outreach.

TCHSA is actively reviewing other opportunities to spread outreach and services to more parts of the county. Tehama is geographically large, and a barrier to accessing care is lack of affordable transportation and/or not being able to travel into Red Bluff or another regional center for services. An example is a weekly therapeutic group provided in Rancho Tehama. Providing services in Manton, Payne’s Creek and other areas of the county remain strong goals of TCHSA.

TCHSA continues to partner with Latino Outreach of Tehama County, a local non-profit, to provide events and services. Major outreach events include Cinco de Mayo family event and a county multi-cultural health fair in collaboration with multiple community partners. In addition to events, TCHSA staff actively network with the Latino community. One example is the community outreach events in Corning and Los Molinos staffed with Spanish speaking staff members.

(2) A description of the process for:

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

TCHSA is a fully operational MHP and provides a range of specialty mental health services to Medi-Cal clients to assure continuity of care for all persons needing medically-necessary mental health services. TCHSA has been the MHP in Tehama County since 1997, providing specialty mental health services to the county's Medi-Cal clients.

Although not related to continuity for clients when TCHSA began operations as an MHP, TCHSA does ensure that clients who meet medical necessity criteria for SMHS have the right to request continuity of care. Clients with pre-existing provider relationships who make a continuity of care request to TCHSA are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., a former TCHSA employee or a contracted organizational provider, provider group, or individual practitioner).

SMHS will continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined TCHSA, in consultation with the beneficiary and the provider, and consistent with good professional practice.

This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

1. The provider has voluntarily terminated employment or the contract with TCHSA;
2. The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program;
3. Transitioning from another county MHP to TCHSA due to a change in the beneficiary's county of residence;
4. Transitioning from a MCP to TCHSA; or,
5. Transitioning from a Medi-Cal Fee-for-Service provider to TCHSA.

(2) A description of the process for:

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

Anthem Blue Cross and California Health and Wellness are the two Managed Care Plans (MCPs) that provide physical health care services for Medi-Cal clients in Tehama County. As required by Title 9 § 1810.370(a), TCHSA and both MCPs have entered into MOUs. In accordance with § 1810.370(a)(2), TCHSA provides the availability of clinical consultation, including consultation on medications, to the MCPs for clients whose mental health conditions are being treated by the MCPs.

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

<u>Beneficiary Problem Resolution Policy</u>

It is the policy of the TCHSA to promptly address client concerns and complaints in a respectful manner. TCHSA expressly prohibits any punitive or retaliatory action against any person who files a complaint, concern, grievance, appeal, expedited appeal or State Hearing. TCHSA does not discourage the filing of grievances.

Medi-Cal beneficiaries have specific rights regarding filing complaints and grievances at the County and state levels. These rights are outlined in our Member Problem Resolution Guide and in the Guide to Medi-Cal Mental Health Services.

TCHSA is required to provide a “grievance process,” an “appeal process,” and an “expedited appeal process” for Medi-Cal beneficiaries. This policy and procedure is written to comply with that mandate. The same general grievance resolution process is used for all TCHSA clients; however, the written notices and the actions related to the appeal and expedited appeal processes listed below are for Medi-Cal beneficiaries.

Definitions

1. **Adverse Benefit Determination (ABD)**: Any of the following actions taken by TCHSA related to Medi-Cal beneficiaries:
   a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
   b. The reduction, suspension, or termination of a previously authorized service;
   c. The denial, in whole or in part, of payment for a service;
   d. The failure to provide services in a timely manner;
   e. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
   f. The denial of a beneficiary’s request to dispute financial liability.
2. **Notice of Adverse Benefit Determination (NOABD)**: The document that notifies Medi-Cal beneficiaries of an adverse benefit determination. A NOABD contains:
   a. The adverse benefit determination made;
   b. The reasons for this determination. If the determination is based on medical necessity criteria, the NOABD must include the clinical reasons for the determination and must explicitly state why the beneficiary’s condition does not meet SMHS medical necessity criteria;
   c. A description of the criteria used to make the determination, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in making determinations; and
   d. The right for the beneficiary to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination
3. **Appeal:** The review of an adverse benefit determination.
4. **Notice of Grievance Resolution (NGR):** The document that notifies Medi-Cal beneficiaries of the resolution of a grievance. An NGR contains a clear and concise summary of the grievance filed, actions taken by TCHSA to address the grievance, and an explanation of the decision(s) made.
5. **Notice of Appeal Resolution (NAR):** The document that notifies Medi-Cal beneficiaries of the resolution of an appeal. A NAR contains:
   a. The adverse benefit determination that was appealed
   b. The results of the appeal resolution process and the date it was completed [42 CFR, §438.408(e)(1)]
   c. The reasons for the results of the appeal resolution process, including the criteria, clinical guidelines, or policies used in reaching the determination [42 CFR §438.404(b)(2)]
   d. If the appeal is not resolved wholly in favor of the beneficiary, the NAR also contains

    i. Information regarding the right to a State Hearing and how to request it,
    ii. Information regarding the right to request and receive services while the hearing is pending and how to make the request, and
    iii. Notification that the beneficiary may be held liable for the cost of those services if the hearing decision upholds the ABD.
  e. If the appeal is resolved wholly or partially in favor of the client, the NAR also contains information on TCHSA's requirement to authorize any denied services with 72 hours of the appeal resolution

6. **Nondiscrimination Notice:** The document that notifies Medi-Cal beneficiaries of TCHSA's adherence to Section 1557 of the Affordable Care Act (ACA). This document is sent with all NOABDs, NGRs, NARs, and Acknowledgment of Receipt letters.
7. **Language Assistance Taglines:** The document that informs Medi-Cal beneficiaries of their right to receive language assistance. This document includes taglines from all California State threshold languages, as well as large print, and information on alternative formats. This document is sent with all NOABDs, NGRs, NARs, and Acknowledgment of Receipt letters.
8. **State Hearing:** Process for resolving disagreements between TCHSA and Medi-Cal beneficiaries about services, eligibility, or any decision or adverse benefit determination by TCHSA with which the beneficiary disagrees.
9. **Grievance:** An expression of dissatisfaction about any matter other than an ABD. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the client's rights regardless of whether remedial action is requested, and a Medi-Cal beneficiary's right to dispute an extension of time proposed by the MHP to make an authorization decision. [42 CFR §438.400(b)] There is no distinction between an informal and formal grievance.
10. **Complaint:** A complaint is the same as a grievance. A complaint shall be considered a grievance unless it is against an ABD, at which point it shall be considered an appeal. A complaint can be made by telephone, orally in face-to-face contact, or in writing.
11. **Exempt Grievance:** A grievance that is received over the phone or in-person that is resolved to the beneficiary's satisfaction by the close of the next business day following receipt of the grievance. These grievances are exempt from the requirement to send a written acknowledgement and resolution letter.
12. **Mental Health Plan (MHP):** Includes TCHSA and all providers who are contracted with TCHSA to provide specialty mental health services to Tehama County Medi-Cal beneficiaries.
13. **Resolved/Resolution:** TCHSA has reached a decision with respect to the grievance/appeal and has notified the beneficiary of the disposition.

Rights and Responsibilities

1. A client can file a grievance or appeal orally, by telephone, in-person, or in writing at any time.
    a. Medi-Cal beneficiaries must file appeals within 60 calendar days of the date of the NOABD.
    b. If a standard appeal is made verbally, the beneficiary must follow up by filing the appeal in writing.
    c. When an expedited appeal is made verbally, the beneficiary does not have to follow-up by filing the expedited appeal in writing.
    d. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

    e. TCHSA treats the oral appeal as an appeal to establish the earliest possible filing date.
    f. If a written and signed appeal is never received, TCHSA will continue to address the appeal without delay.

2. A beneficiary need not use the term “grievance” for an expression of dissatisfaction to be captured as a grievance. Even if a beneficiary expressly declines to file a formal grievance, their expression of dissatisfaction shall still be categorized as a grievance. As with other grievances, these will be analyzed to monitor trends.
3. With written consent from the beneficiary, a provider or authorized representative may file a grievance, request an appeal, or request a State Hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits.
4. A beneficiary may request a State Hearing within 120 calendar days from the date of the NAR.
5. Any TCHSA staff may assist a beneficiary with the grievance or appeal process. Beneficiaries have a right to be given assistance by someone other than the person providing direct services to the beneficiary or by any person who is the subject of the grievance or appeal. Assistance can include completing forms, preparing a written appeal, notifying the beneficiary of the location of the necessary forms on TCHSA’s website, or providing the form(s) to the beneficiary upon request. Assistance can also include advising and assisting the beneficiary in requesting continuation of benefits during an appeal.
6. The Quality Assurance Manager (QAM) is designated to monitor, process, and follow-up on all grievances, appeals, and State Hearings. The QAM is notified of all oral or written grievances, appeals, and State Hearings as soon as possible.
    a. When the QAM is unavailable, or is the subject of the grievance or appeal, the Behavioral Health Director can designate another licensed mental health professional to fill this role.
7. TCHSA empowers staff at a supervisory level or above to resolve grievances in order to resolve them quickly and efficiently. After resolving a grievance, the supervisor must inform the QAM about the grievance and a description of actions taken to resolve it.
8. Grievances and appeals are never reviewed by a person who was previously involved in a review of the grievance or appeal, nor by a person whom the grievance was about or by a person who made the adverse benefit determination which is being appealed.
9. When a grievance or appeal is related to clinical issues or judgment, the person reviewing the grievance or appeal and the person making the final decision must have a license in a related and relevant clinical field.
10. The QAM provides information regarding the status of the grievance or appeal upon request of the client or his/her representative.
11. The QAM ensures there is no discrimination, penalty, or any retaliatory action against a client for filing a grievance or appeal.
12. Grievance and appeal log and any related files are available for review by California DHCS and any other appropriate oversight agency.
13. These grievance and appeal processes do not replace the duties of the county patients’ rights advocates as described in Welfare and Institutions (W&I) Code, § 5520. It is the duty of the QAM and Behavioral Health Director to ensure these grievance and appeal processes do not conflict with the duties of the county patients’ rights advocates.

State Hearings

1. The parties to a State Hearing include TCHSA, the beneficiary, and the beneficiary's authorized representative.
2. For standard hearings, the QAM, or other designated State Hearing contact person, will notify the beneficiary that the State must reach its decision on the hearing within 90 calendar days of the date of the request of the hearing.
3. For expedited hearings, the QAM, or other designated State Hearing contact person, will notify the beneficiary that the State must reach its decision on the hearing within 3 working days of the date of the request of the hearing.
4. If a State Hearing results in an ABD being overturned, TCHSA will authorize or provide the disputed services as expeditiously as the beneficiary's condition requires and no later than 72 hours after TCHSA receives notice reversing the ABD.

Informing beneficiaries about the grievance and appeal processes

1. Information describing the grievance, appeal, and expedited appeal processes is in the Member Problem Resolution Guide, which is available at all MHP sites and the TCHSA website. This information includes the procedures for filing and resolving grievances and appeals, the toll-free and local telephone numbers to call in order to file a grievance or appeal, and the address used when mailing a grievance or appeal. This information is also offered to all beneficiaries receiving services at TCHSA during the intake process.
2. Grievance and appeal forms, along with self-addressed envelopes, are available for beneficiaries at all MHP sites in a location that can be accessed without making a verbal or written request to anyone.
3. All informing materials and forms related to the grievance and appeal processes, including NOABDs, NARs, NGRs, and related attachments are available in Tehama County's threshold languages and alternative formats.
4. All contracted specialty mental health service providers are provided information on the beneficiary problem resolution process via the Provider Handbook at the time they enter into a contract with TCHSA.

Issuing NOABDs

1. Whenever TCHSA makes an ABD, this decision is communicated to the beneficiary in writing using the appropriate NOABD. The person making this decision must also notify the provider first by telephone or fax and then in writing, except for decisions made retrospectively. Written notification to the provider must include the name and telephone number of the decision maker as well as the QAM, who oversees the ABD process.
2. NOABDs must be mailed to the beneficiary within the following timeframes:
    a. For termination, suspension, or reduction of a previously authorized SMHS, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214.
    b. For denial of payment, at the time of any action denying the provider's claim.
    c. For decisions resulting in denial, delay, or modification of all or part of the requested SMHS, within 2 business days of the decision.
3. TCHSA will communicate the ABD to the affected provider within 24 hours of making the decision.
4. Any NOABD sent will include the "NOABD: Your Rights" attachment, which provides beneficiaries with the following required information pertaining to a NOABD:
    a. The beneficiary's or provider's right to request an internal appeal with TCHSA

within 60 calendar days from the date on the NOABD.

   b. The beneficiary's right to request a State Hearing only after filing an appeal with TCHSA and receiving a notice that the ABD has been upheld.
   c. The beneficiary's right to request a State Hearing if TCHSA fails to send a resolution notice in response to the appeal within the required timeframe.
   d. Procedures for exercising the beneficiary's rights to request an appeal.
   e. Circumstances under which an expedited review is available and how to request it.
   f. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits.
5. All NOABDs sent must include the Nondiscrimination Notice and Language Assistance Taglines.

Delegating responsibility for the grievance process and/or appeal process

Contract providers are allowed to establish grievance and appeal processes for Medi-Cal beneficiaries receiving services from them. When such processes exist, TCHSA will not require beneficiaries to use or exhaust the provider's processes prior to using the TCHSA grievance or appeal process unless:

1. TCHSA delegated the responsibility for the client grievance process to the provider in writing, specifically outlining the provider's responsibility under that delegation;
2. The provider's client grievance process fully complies with state and federal beneficiary grievance and appeal requirements; and
3. No client is prevented from accessing the grievance or appeal process solely on the grounds that the grievance or appeal was incorrectly filed with either the provider or TCHSA.

Beneficiary Problem Resolution Procedures

Receiving/Reporting grievances or appeals

1. Telephone:
   a. When a caller phones in stating he/she has a complaint, grievance, or is requesting an appeal, forward the call in the following order as available:
      i. Quality Assurance Manager (QAM)
      ii. Any Mental Health Supervisor
   b. QAM or Supervisor determines if the issue is a grievance, appeal, or expedited appeal
      i. For a grievance, the QAM, or Supervisor attempts to remedy the situation immediately
      ii. For a request for appeal, the QAM or Supervisor provides the caller with information on the appeal process and assists the caller as needed.
      iii. The QAM, BHAD, BOS, or Supervisor offers information on Patients' Rights Advocates, if appropriate or requested.
   c. The QAM, BHAD, BOS, or Supervisor ensures the issue is documented on the Verbal Grievance, Appeal, Expedited Appeal form, including any actions taken and any resolution reached. This form is then forwarded to the QAM for processing.
      i. For expedited appeals, the time of day must be documented on the Verbal Grievance, Appeal, Expedited Appeal form to ensure timeframe is met.

ii. For expedited appeals, in addition to forwarding the Verbal Grievance, Appeal, Expedited Appeal form, the Supervisor calls the QAM as soon as possible after receiving the call, to initiate expedited processing.

2. In-person:
    a. A staff person taking a grievance/appeal contacts his/her Supervisor immediately. The staff person may also contact the QAM or any Mental Health Supervisor in the event that his/her supervisor is unavailable.
    b. The QAM or Supervisor ensures the issue is documented on the Grievance, Appeal, Expedited Appeal form, including any actions taken and any resolution reached. This form is then forwarded to the QAM for processing.
        i. For expedited appeals, the time of day must be documented on the Grievance, Appeal, Expedited Appeal form to ensure timeframe is met.
        ii. For expedited appeals, in addition to forwarding the Grievance, Appeal, Expedited Appeal form, the Supervisor calls the QAM as soon as possible after receiving the call, to initiate expedited processing.
3. Written:
    a. The client completes the Written Grievance, Appeal, Expedited Appeal form, which is available in the lobbies of all TCHSA-BH service locations with self-addressed envelopes.
        i. Alternatively, the client can provide a letter or other written document expressing a grievance or appeal. If providing a letter or other written document, it is helpful if the client provides similar information as is indicated on the Written Grievance, Appeal, Expedited Appeal form.
    b. Using the form, the client:
        i. Writes the date, his/her name, address, and phone number in the appropriate spaces.
        ii. Indicates whether the subject matter is in regard to a grievance, response to a notice of action, or "other" matter by checking the appropriate box below the phone number.
        iii. Writes an explanation of his/her concerns under "Explanation".
        iv. Describes how he/she wishes the concerns to be resolved by completing the "What do you want to happen?" section.
        v. Writes the name of an individual he/she wishes to act on his/her behalf, if applicable. This may be left blank.
    c. The client may mail the form, letter, or other written document to the QAM using the self-addressed envelope or give it to any staff member.
    d. The staff member stamps or notes the date the Written Grievance, Appeal, Expedited Appeal form was received on the form itself or the envelope it is sealed in and immediately submits the form/envelope to the QAM.

B. Processing received grievances and appeals

1. When a grievance or appeal is received, the QAM sends an acknowledgement of receipt letter to the client or his/her representative within (postmarked) 5 calendar days of receipt of the grievance/appeal. This letter includes the date of receipt of the grievance/appeal as well as the name, telephone number, and address of the MHP representative who the beneficiary can contact about the grievance/appeal.
    a. When an appeal is received, this letter also includes

i. information about the client's right to continuation of services during the appeal and State Hearing process
ii. information about the client's right to present evidence and allegations of fact or law in person or in writing
iii. information about the client and/or his/her representative's right to examine the client's case file, including medical records, and any other documents or records that are considered during the appeal process before and during the appeal process
iv. information about the client and/or his/her representative or the legal representative of a deceased client's right to be parties to the appeal

b. If the grievance/appeal is resolved within 5 calendar days, the acknowledgement letter can be merged with the resolution letter (below).
c. Grievances received over the phone or in-person that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgement and resolution letter. Appeals are never exempt from this requirement and must always include a written acknowledgement and resolution letter.

2. All grievances and appeals are to be handled in a timely manner. If a grievance or appeal is not resolved within the designated timeframes, the QAM will issue a Grievance and Appeal Timely Resolution Notice to the client or his/her representative. This notice must include that status of the grievance/appeal and the estimated date of resolution, which shall not exceed 14 additional calendar days. [42 CFR, §438.408]
   a. Grievances must be resolved within 90 calendar days from receipt of the grievance [42 CFR, §438.408]
      i. Grievances related to disputes of TCHSA's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days. [Title 28, CCR, §1300.68]
   b. Appeals must be resolved within 30 calendar days from receipt of the appeal
   c. Expedited appeals must be resolved, and notice given within 72 hours from receipt of the expedited appeal, which may be written or oral.
      i. The QAM or designated qualified Licensed Clinical Supervisor (LCS) reviews any request for an expedited appeal to determine if expedited resolution is indicated, based on clinical soundness and client need.
      ii. If the QAM or designated LCS denies the request for expedited resolution, the timeframe for standard appeals is applied. The QAM will also:
      (a) make reasonable efforts to provide, within 1 business day, the beneficiary with oral notice of the decision to transfer the appeal to the timeframe for standard resolution of appeals;
      (b) give the beneficiary, within 2 business days, written notice of the decision to transfer the appeal to the timeframe for standard resolution of appeals, including notifying the beneficiary's right to file a grievance if he/she disagrees with the decision; and
      (c) ensure the appeal is resolved as expeditiously as the beneficiary's health condition requires and within the timeframe for standard resolution of appeals
   d. An extension of up to 14 calendar days may occur if TCHSA determines that there is need for additional information and the delay is in the beneficiary's interest OR the beneficiary requests an extension. [42 CFR §438.408] If an extension is required, the QAM will

i. make reasonable efforts to provide, within 1 business day, the beneficiary with oral notice of the delay;
ii. give the beneficiary, within 2 business days, written notice of the reason for the decision to extend the timeframe, including demonstrating how the decision is in the beneficiary's best interest, and the beneficiary's right to file a grievance if he/she disagrees with the decision to extend the timeframe; and
iii. ensure the grievance/appeal is resolved as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires,

3. When a grievance or appeal is received, an investigation is initiated to determine the facts and make a decision.
    a. The investigation is conducted in a discrete, objective manner.
    b. The decision on clinical appeals must take into account all comments, records, and other information submitted by the beneficiary and/or the beneficiary's representative, regardless whether such information was submitted or considered in the initial ABD. [42 CFR §438.406(b)(2)(iii)]
    c. All rights regarding confidentiality are followed throughout the investigation.
        i. If it is necessary to speak with multiple parties during the fact-finding process, appropriate releases of information must be obtained before sharing any client information.
        ii. When speaking with TCHSA employees, the QAM uses discretion when determining if a client's identity must be revealed to facilitate resolution.
        iii. The QAM consults with the Compliance Officer, as needed, to protect client confidentiality.
4. When a decision about the grievance or appeal is reached, the QAM sends the client, or his/her representative, a letter, notifying them of the resolution. This is called a Notice of Grievance Resolution (NGR) or a Notice of Appeal Resolution (NAR) (see section B above for details).
    a. The QAM ensures a copy of this final disposition letter is given to any provider cited by the client in their grievance.
    b. If the QAM is unable to complete this written notification, the QAM will document all efforts made.
    c. All NGRs and NARs sent must include the Nondiscrimination Notice (6) and Language Assistance Taglines (7).
    d. Any NAR sent for appeals not resolved wholly in favor of the beneficiary will include the "NAR: Your Rights" attachment, which provides beneficiaries with the following required information pertaining to a NAR:
        i. The beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the written appeal resolution and instructions on how to request a State Hearing [42 CFR §438.408(e)(2)(i); Title 22, CCR, §53858(e)(5)], and
        ii. The beneficiary's right to request and receive continuation of services while the State Hearing is pending and instructions on how to request continuation of services, including the timeframe in which the request shall be made (i.e. within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420. [42 CFR, §438.408(e)(2)(ii)]

5. In the event that an ABD is overturned, TCHSA will authorize or provide the disputed services as expeditiously as the beneficiary's condition requires and no later than 72 hours after making the decision to overturn the ABD. [42 CFR §438.424(a)]
6. In the event that TCHSA fails to adhere to timeline requirements for the appeal process, the beneficiary is deemed to have exhausted TCHSA's appeal process and may initiate a State Hearing. [42 CFR §438.408(f)(1)]

Tracking grievances and appeals

1. The QAM ensures all grievances and appeals, including exempt grievances and expedited appeals, are logged and tracked within one working day of the date of receipt of the grievance or appeal. This log includes:
   a. the beneficiary's name;
   b. the name of the representative filing the grievance or appeal, if applicable;
   c. the date and time of receipt of the grievance, appeal, or expedited appeal;
   d. a general description of the grievance, appeal, or expedited appeal;
   e. a description of the action taken by TCHSA to investigate and resolve the issue;
   f. the date of each review, or, if applicable, review meeting;
   g. the resolution at each level of the grievance or appeal, if applicable;
   h. the name of the staff member who received and resolved the grievance;
   i. the date of resolution at each level, if applicable;
   j. the date the acknowledgement of receipt letter was sent to the client;
   k. and date the resolution letter was sent to the client.
2. The QAM sends a summary of this log to DHCS by October 1st every year.
3. The QAM reports on grievances and appeals to the Quality Improvement Committee (QIC) on a quarterly basis. This report includes:
   a. data regarding the number and types of grievances/appeals, including issues related to access to care, quality of care, and denial of services;
   b. issues identified as a result of the grievance/appeal/expedited appeal process, including actions taken; and quality assurance reviews that all grievances and appeals were handled in compliance with this policy and procedure, and any related laws and regulations.

Provider Problem Resolution Process

A provider may appeal a denied request for reimbursement of SMHS directly to TCHSA. The written appeal must be received by the TCHSA Quality Assurance Officer or the TCHSA Behavioral Health Director within 90 calendar days of the date of notification of the non-approval of payment.

TCHSA will have 60 calendar days from the receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision. If no basis is found for altering the decision or remedy is not within the purview of TCHSA, the provider will be notified of its right to submit the appeal to DHCS pursuant to CCR, Title 9, §§ 1850.320 or 1850.350.

1. If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.
2. If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the Department pursuant to Section 1850.320.
3. If applicable, the provider shall submit a revised request for MHP payment

authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

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

If TCHSA does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by TCHSA.

Inpatient Provider Appeals – Claims Processing

A Fee-for-Service/Medi-Cal hospital or a psychiatric nursing facility may file an appeal concerning the processing or payment of its claims for payment for services directly to the fiscal intermediary postmarked or FAXED within 90 calendar days of the date the payment was due. The fiscal intermediary shall have 60 calendar days from the receipt of the appeal to make a determination in writing to the provider.

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

Contractor must ensure that any individuals providing services to County clients are qualified in accordance with current legal, professional, and technical standards, and are appropriately licensed, registered, waivered, and/or certified. Contractor must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of individuals who provide services to County clients.

Provider Credentialing

For all licensed, waivered, registered and/or certified providers, Contractor must verify and document the following items through a primary source (an entity, such as a state licensing agency, with legal responsibility for originating and ensuring the accuracy of the document's information), as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by Contractor unless Contractor can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

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

In addition, Contractor must verify and document the following information for each provider, as applicable, but need not verify this information through a primary source.

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration Identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/:
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal;
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

For all individuals providing services to County clients, the Contractor will include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions; with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. Any information provided is accurate and complete

Provider Re-credentialing

Contractor will verify and document at a minimum every three years that each individual providing services to a County client continues to possess valid credentials, including verification of each of the credentialing requirements listed above. Contractor must require each individual who provides services to a County client to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that Contractor has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, client grievances, and medical records reviews.

Additional Information

Contractor may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, Contractor remains contractually responsible for the completeness and accuracy of these activities. If Contractor delegates credential verification activities to a subcontractor, Contractor shall establish a formal and

detailed agreement with entity performing those activities. To ensure accountability for these activities, Contractor must establish a system that;

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures the subcontractor meets the County's and California Department of Health Care Services' standards; and
- Continuously monitors, evaluates, and approves the delegated functions.

Contractor must maintain a system for reporting serious quality deficiencies that result in suspension or termination of a provider to County and other authorities as appropriate. Contractor must maintain policies and procedures for disciplinary actions, including reducing, suspending or terminating a provider's privileges. Contractor must implement and maintain a process by which providers may appeal credentialing decisions, including decisions to deny a provider's credentialing application, or suspend or terminate a provider's previously approved credentialing approval.

Database Check Requirements

1. TCHSA will check, at the time of hiring/contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:
   a. Social Security Administration‘s Death Master File.
   b. National Plan and Provider Enumeration System (NPPES)
   c. Office of the Inspector General List of Excluded Providers and Entities (LEIE)
   d. System of Award Management (SAM)
   e. DHCS Medi-Cal Suspended and Ineligible List (S&I List).
2. TCHSA will confirm monthly that no provider is on the:
   a. OIG List of Excluded Individuals/Entities (LEIE).
   b. System of Award Management (SAM)Excluded Parties List System (EPLS).
   c. DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List).

Procedure for Verifying Licensure and Checking Exclusions Lists

1. TCHSA-Behavioral Health Employees
   a. A Fiscal Data Administrative Assistant verifies current licensing before the Executive Director signs the "green sheet " (hiring authorization form).
   b. The new employee provides a copy of his/her license to a Fiscal/Data Administrative Assistant when meeting with the Administrative Assistant to review and sign new employee paperwork.
   c. License number, type of license, and expiration date are entered in the TCHSA-Behavioral Health staff database.
   d. A Fiscal Data Administrative Assistant verifies that the individual is not currently excluded from participation in federal health care programs by checking the exclusion list database websites listed above under "Database Check Requirements".
   e. A Fiscal/Data Administrative Assistant runs monthly reports from the database to identify upcoming license expiration dates. Upcoming is defined as within two months of the report date.

f. Supervisors, Directors, Assistant Executive Directors, and the Executive Director receive copies of the monthly reports.
g. A Fiscal/Data Administrative Assistant sends a reminder memo directly to any employee who has a license expiring within two months.

2. TCHSA Local Outside Providers
   a. A spreadsheet is maintained with the current license status for every local outside provider who bills TCHSA for Medi-Cal specialty mental health services.
   b. License status is obtained from the pertinent state licensing board website. The spreadsheet also contains the most recent verification that the provider is not currently excluded from participation in federal or state health care programs as outlined in the exclusion list database websites listed above under “Database Check Requirements”.
   c. The Compliance Officer or designee verifies the license is current prior to preparing the monthly Explanation of Benefits (EOB). The EOB identifies Medi-Cal specialty mental health services the outside provider has billed TCHSA that have been denied payment.
   d. Payment is denied for a variety of reasons, including the service provider having no current license.
   e. The Compliance Officer or designee notifies the local outsider provider of the license expiration as soon as it is detected (and prior to the issuance of the EOB).
3. Short-Term Licensed Staff (Locum Tenens, Registry, etc.)
   a. For Locum Tenens providers, Registry providers, and other short-term licensed providers, the Fiscal Administrative Assistant verifies that the individual is not currently excluded from participation in federal health care programs by checking the exclusion list database websites listed above under “Database Check Requirements”.

<u>Hospital Selection Criteria</u>

TCHSA requires that each hospital:

1. Comply with federal Medicaid laws, regulations and guidelines and State statutes and regulations and not violate the terms of the MHP contract between TCHSA and DHCS.
2. Sign a provider agreement with DHCS.
3. Provide psychiatric inpatient hospital services, within its scope of licensure, to all clients who are referred by TCHSA, unless compelling clinical circumstances exist that contraindicate admission, or TCHSA negotiates a different arrangement with the hospital.
4. Refer clients for other services when necessary.
5. Not refuse an admission solely on the basis of age, sex, race, religion, physical or mental disability, or national origin.

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

1. History of Medi-Cal certification, licensure and accreditation.
2. Circumstances and outcomes of any current or previous litigation against the hospital.
3. The geographic location(s) that would maximize client participation.
4. Ability of the hospital to:
   a. Offer services at competitive rates.
   b. Demonstrate positive outcomes and cost effectiveness.
   c. Address the needs of clients based on factors including age, language, culture,

physical disability, and specified clinical interventions.

d. Serve clients with severe mental illness and serious emotional disturbances.
e. Meet the quality improvement, authorization, clinical and administrative requirements of TCHSA.
f. Work with clients, their families and other providers in a collaborative and supportive manner.

(5) Documentation that demonstrates that the entity:

(A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of clients that will be served by the MHP, and
(B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of clients that will be served by the MHP.

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

Range of Specialty Mental Health Services

TCHSA offers the following range of Medi-Cal reimbursable specialty mental health services:

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

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

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

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

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

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

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

Medication Support Services – A service that includes one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

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

Targeted Case Management – Targeted Case Management is a service to assist clients access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

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

- Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child/youth.
- Facilitate a collaborative relationship among the child/youth, his/her family and involved child-serving systems.
- Support the parent/caregiver in meeting their child/youth's needs.
- Help establish the Client and Family Team and provide ongoing support.
- Organize and match care across providers and child serving systems to allow the child/youth to be served in his/her home community.

Intensive Home-Based Services - Intensive home-based services (IHBS) are mental health rehabilitation services provided to children and youth who are assessed to be in need of IHBS. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help the child/youth successfully function in the home and community.

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

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

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

Psychiatric Health Facility (PHF) - Therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitation services provided in a psychiatric health

facility licensed by the Department of Social Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. The PHF is accredited by the Joint Commission and Medicare and provides services to adults and adolescents.

Psychiatric Inpatient Hospital Services – 24-hour inpatient services provided by a hospital to clients for whom the facilities, services and equipment described in CCR Title 9 §1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with CCR Title 9 § 1820.205. Inpatient services are only available for adults and adolescents in county, at the PHF. Children under 12 are referred out of county for inpatient services. Any adults or adolescents needing psychiatric inpatient hospital services rather than services provided by the PHF are admitted to an out-of-county hospital. *TCHSA contracts with out-of-county hospitals for the availability of Psychiatric Inpatient Hospital Services.*

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

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

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

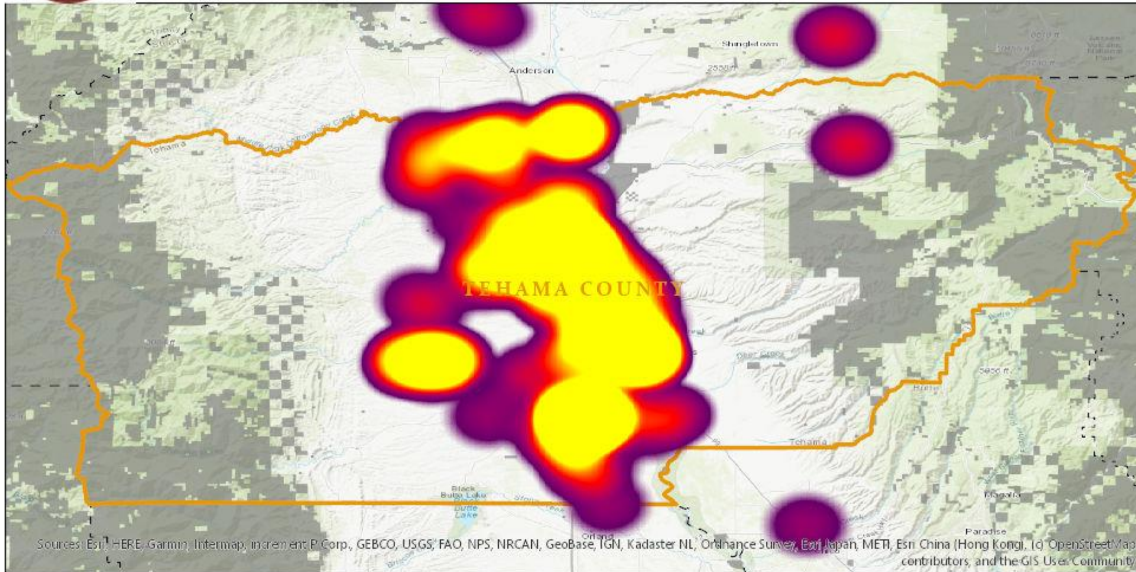
Day Treatment Intensive - A structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals.

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

Service Provided by Geographic Distribution

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

Tehama County MHP
Beneficiary Overview Map



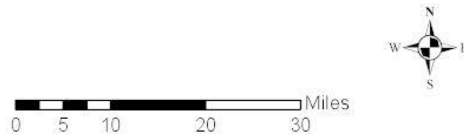
Beneficiary Density

Boundaries

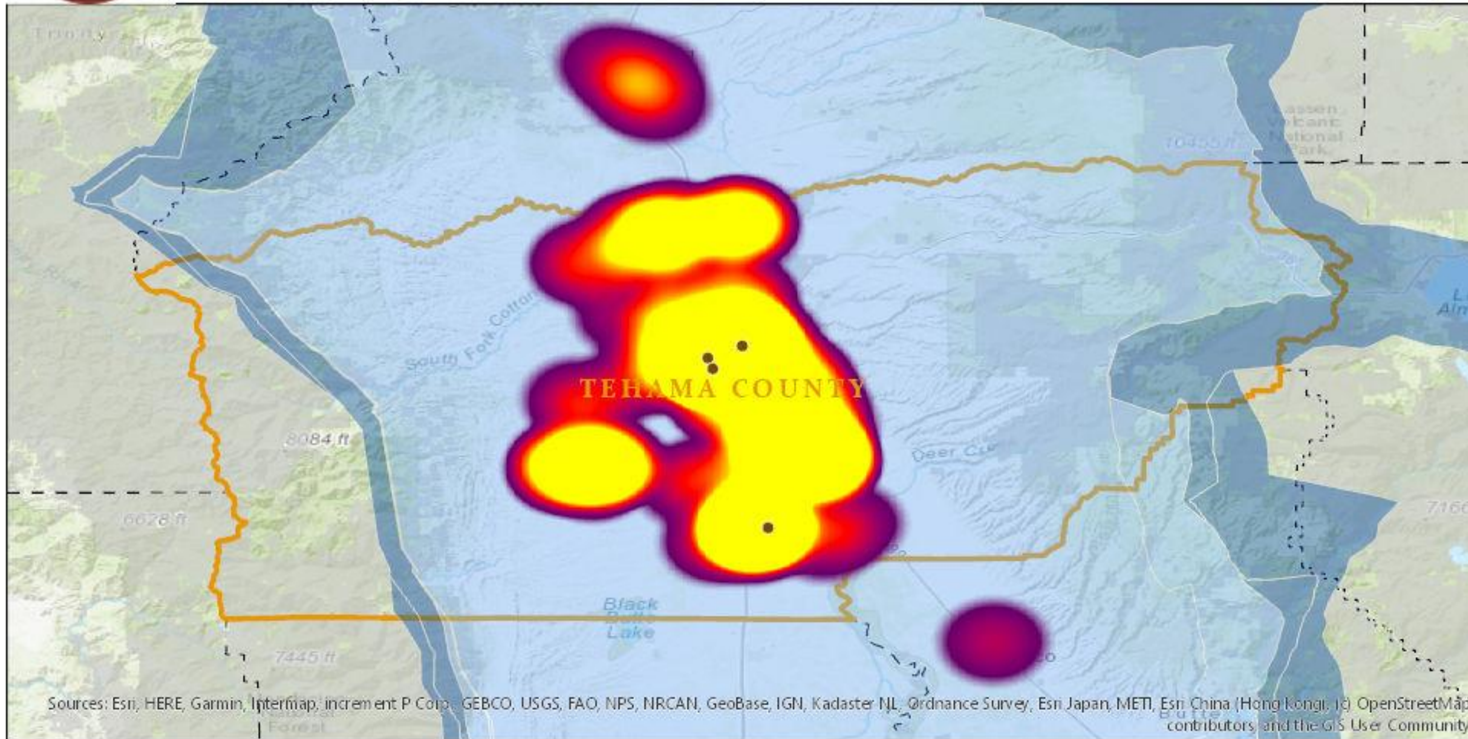
Tehama County Boundary

Other Counties

USA Federal Lands



Tehama County MHP
Adult Outpatient Service Provider Map with Beneficiaries and Service Area



Facilities Driving Buffer
- 60 Mile
- 90 Min
- Facilities

Beneficiaries_Adult
- Sparse
- Dense

Counties
- Tehama
- Other

USA Federal Lands

TCHSA
Tehama County Health Services Agency

Tehama County MHP
Child Outpatient Service Provider Map with Beneficiaries and Service Area

Redding

TEHAMA COUNTY

Black Butte Lake

Chico

Sources: Esri, HERE, Garmin, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, GeoBase, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hong Kong), (c) OpenStreetMap contributors, and the GIS User Community

Facilities Driving Buffer
- 60 Mile
- 90 Min
- Facilities

Beneficiaries
- Sparse
- Dense

Counties
- Tehama
- Other

USA Federal Lands

0 5 10 20 30 40 Miles

N S W E

The GeoMaps show that clients are located well within the 60 miles distance or 90 minutes travel time from the provider locations. In our experience as the MHP for Tehama County we have found that the network of providers is sufficient in number, mix and geographic distribution to meet the needs of our Medi-Cal beneficiaries. This assertion is borne out by the Network Adequacy Certification Tool submissions to DHCS based on the requirements of DHCS MHSUDS Information Notice No, 18-011, which provides Network Adequacy standards for MHPs.

Whenever client needs a change of provider, we make sure to employ or contract with provider types to meet those needs.

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

TCHSA ensures that the needs of each age category are addressed. Age-appropriate services are available, including individual/family therapy, group therapy, medication support, rehabilitation services, and case management services.

TCHSA provides each beneficiary with services guided by behaviors, attitudes, and policies that enable effective service provision in cross-cultural and age-appropriate settings to the fullest extent within the medical necessity criteria. If there is a specialized service needed for a beneficiary that TCHSA cannot meet, TCHSA oversees provision of the service through referral.

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

As a result of the Settlement Agreement in Katie A. v. Bonta, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services.

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

ICC links beneficiaries to collaborative services provided by other children/youth serving entities to facilitate teaming and coordinate mental health care. When a child/youth is engaged with two or more child serving agencies, TCHSA will utilize ICC to facilitate well-coordinated communications and planning, between child welfare, probation, drug/alcohol, special education, legal, and other health/human services to improve outcomes.

IHBS services are not traditional therapeutic services. IHBS function is to provide intervention services that are intensive, individualized, strength-based and needs-driven. IHBS engages the child/youth and significant family/caregiver support persons participating with the child/youth to build skills to reach attainable goals and objectives of the service plan.

The CPM is a set of practices and principles that promotes a set of values shared by all who seek to support children, youth and families involved in child-serving agencies including, but not limited to, the child welfare system, special education, probation, drug

and alcohol and other health and human services agencies or legal systems with which the child or youth is involved. To effectively provide ICC, IHBS (and arrange for TFC if needed by the client), TCHSA utilizes the principles of the CPM, in which the services are provided in conjunction with a Child and Family Team (CFT).

It is the policy of TCHSA that children and youth will be screened to determine their mental health needs and whether Katie A eligibility criteria have been met during the assessment process. ICC and IHBS may be provided to children and youth as EPSDT services, regardless of whether the child/youth is a Katie A subclass member, consistent with DHCS guidance in Information Notice No. 16-004. Katie A class and subclass membership is not a requirement for receiving medically necessary services, therefore an Open Child Welfare Services Case is not a requirement for children/youth to be eligible to receive ICC, IHBS or TFC services.

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

The TCHSA Cultural Competence Plan was updated in 2019 in accordance with the terms of the MHP Contract and DMH Information Notice No. 10-02 and Title 9 § 1810.410. The Cultural Competence Plan is available upon request.

(8) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

Planned admissions to non-contract hospitals occur very rarely, but if they do, they will be arranged by contacting the TCHSA Point of Authorization described under “Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization,” which may be found in the first section of this Implementation Plan Update. Medical necessity criteria for acute psychiatric inpatient services apply to planned admissions.

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

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

Quality Assessment and Performance Improvement (QAPI)

In the Medicaid Managed Care rules at 42 CFR § 438.330 “Quality Assessment and Performance Improvement” (QAPI) has replaced previous terminology of “quality improvement” or “quality management” and is reflected in the MHP Contract. The term “Quality Improvement Committee” and “Quality Improvement Work Plan” remain the same in the MHP Contract.

1. The QAPI Program will include collection and submission of performance measurement data, including any required by the DHCS or the federal Center for

Medicare and Medicaid Services (CMS), which may include performance measures specified by CMS. TCHSA will measure and annually report to DHCS its performance, using the standard measures identified by DHCS.

2. TCHSA will conduct performance monitoring activities throughout TCHSA operations. These activities will include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.

3. The QAPI program is implemented in accordance with Title 9, CCR, § 1810.440 and MHP contract, for evaluating the appropriateness, including over utilization and underutilization of services and quality of the covered services provided to beneficiaries.

QAPI Program Description

The QAPI Program is designed to develop, implement, coordinate, monitor and evaluate performance activities throughout the Mental Health Plan (MHP). The primary concerns of the QAPI Program include, but are not limited to:

1. Beneficiary Access to services and authorization for services
2. Program Integrity and Compliance
3. Grievances and Appeals
4. Beneficiary and Provider Satisfaction
5. Performance Improvement
6. Beneficiary and System Outcomes
7. Utilization Management and Clinical Reviews

The QAPI program is comprised of the Quality Improvement Committee (QIC), Quality Assurance Manager (QAM), and service teams. The QAPI program is accountable to the Mental Health Director and will be evaluated and updated annually. The QAPI Program includes a QI Workplan which is evaluated annually for effectiveness. New QI goals are created annually based on this evaluation.

Quality Improvement Committee

The purpose of the QIC is to improve the quality of mental health care and services provided by Tehama County Health Services Agency (TCHSA). It is the aim of TCHSA to provide accessible, timely, culturally competent, and cost-effective services to the community. The QIC monitors and evaluates quality and appropriateness of services at the beneficiary, provider and system levels. The QIC is responsible for recognizing inefficient processes, assessing barriers to quality of care, identifying solutions with measurable objectives and goals, taking actions to meet these objectives and goals, and evaluating the subsequent outcomes. Integral to the QIC's success in improving TCHSA services and quality of care is the continued integration of health services among agency centers and between agency centers and community health care providers, especially primary care providers. Collaboration among clinicians, supervisors, outside providers, consumers, patients' rights advocates, and community partners is essential to improve the integration of health care services.

QIC membership includes:

1. Quality Assurance Manager (QAM) [CHAIR]
2. Behavioral Health Director

3. Behavioral Health Assistant Director
4. Tehama County Mental Health Board Member(s)
5. Contract Provider Representative(s)
6. Business Operations Supervisor
7. Licensed Clinical Supervisor(s)
8. Cultural Competency Committee representative(s)
9. Clinician(s)
10. Medical Support staff
11. Case Recourse Specialist(s)
12. Patients' Rights Advocate(s)
13. Consumer(s)

The QIC functions include (but are not limited to):

1. Review new or pending laws, regulations, or policies in mental health.
2. Review issues, challenges, improvements, and successes related to quality of care.
3. Review and evaluate the results of QI activities including Performance Improvement Projects.
4. Initiate necessary QI actions and follow-up of QI processes.
5. Review of grievances and appeals to determine appropriate actions.
6. Monitor and evaluate the quality and appropriateness of services at the beneficiary, provider and system levels and recommend solutions to identified issues.
7. Review and evaluate the results of QI activities (internal and external) such as medication monitoring, audits of local outside providers, internal audits, annual reviews by an external quality review organization (EQRO) contracted by the State, and triennial review by the State.
8. Review critical unusual occurrences (suicides/homicides), reports of sub-standard or unethical behavior/treatment by therapists, psychiatrists and other clinical staff.
9. Recommend policies, procedures and system changes to improve beneficiary care and outcomes as a result of QI activities or QIC actions.
10. Review and evaluate data to identify strengths, common trends and areas for improvement.
11. Document all activities through dated and signed minutes of committee meetings that reflect QIC decisions and actions.
12. Standard report evaluations quarterly with an annual review.

Quality Assurance Manager (QAM)

The QAM is responsible for coordinating, managing and reporting on all aspects of the QI/Management processes of the MHP. The QAM chairs the QIC, prepares standard reports, coordinates annual consumer satisfaction surveys, manages all grievances and appeals, provides liaison services with the Department of Health Care Services personnel, verifies the credentials of licensed staff, audits contracted providers (both individual and organizational), oversees contracting with outside providers, performs site certification reviews for private and organizational providers, and develops Performance Improvement Projects in cooperation with systems of care.

Service Teams

The service teams consist of representatives from Adult Outpatient, Crisis, Medication Support, Case Management, Adult Drop-In Center, Transitional Age Youth, and Mental Health Services Act programs. The teams work on QI from a clinical perspective in conjunction with and at the direction of the QAM and the QIC.

Quality Improvement Work Plan

Monitoring and Tracking

The QI Program collects data for the following quality-related quantitative and qualitative reports:

1. Service delivery capacity/network adequacy
   a. Network Adequacy Certification Tool (NACT)
   b. Medi-Cal penetration rates
2. Accessibility of services
   a. Timeliness of access to services
   b. Timeliness of authorizations
3. Beneficiary satisfaction of services provided
   a. Change of provider requests
   b. No-show rates
   c. Trends of grievances and appeals
   d. Results of bi-annual consumer satisfaction surveys, including comments
4. Service delivery system, including meaningful clinical issues and safety/effectiveness of medication practices
   a. Results of internal peer chart reviews
   b. Results of medication compliance monitoring
   c. 24/7 Access/Crisis Line test call reports
5. Continuity of care with physical health care and other providers
   a. Inpatient hospitalization follow-up appointments
   b. Re-hospitalization rates
6. Provider appeals and satisfaction
   a. Timeliness of Treatment Authorization Requests (TARs)
   b. Trends of provider grievances and appeals

The QI Program may collect additional data in response to changes in regulation, ongoing QI projects, or as requested by management. Data is analyzed and evaluated at QIC meetings to identify quality issues, establish improvement initiatives, set goals, and document progress toward these quality improvement initiatives quarterly and annually.

Sustaining Improvement Through Performance Improvement Projects (PIPs)

The MHP is committed to sustaining improved gained through quality improvement projects. The QAPI Program will have at least one clinical PIP and one non-clinical PIP every year. A PIP may last more than one year, but once finished, a new PIP must be started. PIPs are determined by the QIC based on data collected by the QAPI Program.

Evaluation and Goal Setting

The QI Workplan will be evaluated annually, demonstrating that QI activities have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in process QI activities, including performance improvement projects. Upon completion of this evaluation, new goals for the QAPI Program will be set.

Utilization Management

The TCHSA triage and utilization management process is responsible for assuring that beneficiaries have appropriate access to specialty mental health services by evaluating medical necessity, appropriateness and efficiency of services provided to Medi-Cal

beneficiaries.

All assessments and treatment plans are reviewed by a licensed professional and either returned for corrections or approved. TCHSA also utilize a peer review process where notes are reviewed as well, and comments then are reviewed by supervisors or quality assurance manager.

(10) A description of policies and procedures that assure beneficiary confidentiality in compliance with State and Federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

TCHSA takes client confidentiality very seriously and has numerous policies and procedures on this topic, including:

1) Access to PHI
2) Accounting of Disclosures of PHI
3) Alternate Confidential Communications
4) Amendments to PHI
5) Confidentiality
6) Consent to Photograph, Videotape, Record, or Display Materials
7) De-identification of PHI
8) Disposal of PHI and Confidential Information
9) E-mail
10) Exclusions Lists
11) General Lockup Procedures
12) HIPAA Training
13) Identity Verification
14) Internet Access & Usage
15) Inter-Office Mail
16) Medical Records Copying – In House
17) Medical Records Management
18) Medical Records Outside Copier Service
19) Minimum Necessary
20) Mitigation
21) Non-Employee Agency Worker
22) Notice of Privacy Practices (NPP)
23) Opportunity to Object
24) Password
25) Portable Devices and Removable Media
26) Protected Health Information (PHI) and Personal Information (PI)
27) Redacting/Editing Medical Records
28) Release of Information Review
29) Release of Information
30) Restricted Charts
31) Restrictions to Uses and Disclosures of PHI
32) Retaliation Directed at Agency Workers
33) Retaliation Directed at Clients
34) Return Address on Envelopes
35) Safeguards

36) Sanctions
37) Security Incidents
38) Service Activity Log (SAL) Reprints
39) Telephone Messages
40) Workstation Use and Security

TCHSA also has a Code of Conduct and a Code of Professional Ethics, which also address confidentiality. TCHSA workers are trained on these documents and policies through various required training sessions:

- Privacy and Confidentiality – This is a 3-hour training required of all new employees.
- Release of Information – This is a 1.5-hour training required of all new employees.
- Security Awareness – This is a 2-hour training required of all new employees.
- Compliance – This is a 2-hour training required of all new employees.
- Compliance, Confidentiality, and Security Refresher – This is a 1-hour training required of all employees annually.

(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this Chapter.

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