Department of Health Care Services




MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES 101

Welcome

California Institute for Behavioral Health Solutions

Established in 1994 as the California Institute for Mental Health (CiMH)

- Consultation, Training & Implementation Support

- Statewide: Contractor to DHCS; Fiscal Leadership Institute, Care Coordination Learning Collaborative; Pathways to Mental Health/Katie A; Evidence-Based Practices Symposium; Drug Medi-Cal Waiver Support

- Regional: Regional Partnerships/Workforce Development Projects in the Greater Bay Area and Central Region (OSHPD); Peer Leadership Institute

- Counties/CBOs: Implementation of Evidence-based Practices; customized implementation, training and TA

Learning Objectives

- Understand the core elements of the Medi-Cal Specialty Mental Health Services (SMHS)

- Understand the requirements that providers must meet in order to become a SMHS provider

Opening Remarks

Dina Kokkos-Gonzales,
Chief
Mental Health Services Division
Department of Health Care Services (DHCS)

Sara Elizabeth Rogers,
Chief
Continuum of Care Reform Branch
Children and Family Services Division
California Department of Social Services (CDSS)

Content

- Overview of Medicaid and Medi-Cal
- Overview of California's 1915(b) Freedom of Choice Waiver for Specialty Mental Health Services
- Specialty Mental Health Services (SMHS)
- Medical Necessity Criteria
- Continuum of Care Reform (CCR)
- Providers of SMHS
- Rates and Claiming for SMHS
- Documentation Requirements
- Resources and Helpful Links
- County Mental Health Plan Perspective

Overview of Medicaid and Medi-Cal

What is Medicaid?

- An entitlement program created in 1965 under Title XIX of the Federal Social Security Act (SSA)
- Makes available medically necessary health care services (including mental health services) for low income families, children, pregnant women, seniors and persons with disability who meet criteria for program services
- Is a Federal-State partnership which plays a key role in health care delivery systems
- Makes available federal funding, known as federal financial participation (FFP) for programs that are in compliance with applicable federal Medicaid statutes, regulations and policies

Overview of Medicaid and Medi-Cal (cont.)

What is Medi-Cal?

- Medi-Cal is California's version of Medicaid established in 1966 under the Welfare & Institutions Code, starting at Section 14000

- Is administered by DHCS, which serves as the Medicaid Single State Agency and is responsible for ensuring the program is administered in accordance with applicable federal and state statutes, regulations and policies

- Medi-Cal program regulations are found under the California Code of Regulations, Title 22, Division 3

Overview of California's 1915(b) Freedom of Choice Waiver for Specialty Mental Health Services

- California administers a Section 1915(b) Freedom of Choice waiver to provide Specialty Mental Health Services (SMHS) using a managed care model of service delivery
- The SMHS waiver program has been in effect since 1995
- The current waiver term is **July 1, 2015 through June 30, 2020**
- DHCS operates and oversees this waiver

Overview of California's 1915(b) Freedom of Choice Waiver for Specialty Mental Health Services (cont.)

- The SMHS waiver program is administered locally by each county's Mental Health Plan (MHP) and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries
- Beneficiaries freedom of choice is waived
- The SMHS waiver population is all Medi-Cal beneficiaries. Therefore, all Medi-Cal beneficiaries have access to SMHS if they meet medical necessity criteria
- To meet SMHS medical necessity criteria, a beneficiary must have an included diagnosis, and must meet specific impairment and intervention criteria

Binding Covenants (DHCS/MHP Contract)

- DHCS contracts with each county MHP for the provision of SMHS
- A contract is required pursuant to state and federal law
- Delineates the MHPs and DHCS' responsibilities and requirements in the provision and administration of SMHS
- Conforms with federal requirements for Prepaid Inpatient Health Plans (PIHPs). MHPs are considered PIHPs and must comply with federal managed care requirements (Title 42, CFR, Part 438)
- Current MHP contract term: May 1, 2013-June 30, 2018

  http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx

Binding Covenants (State Plan)

- The official contract between the Single State Medicaid Agency (DHCS) and the Centers for Medicare and Medicaid Services (CMS) by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding

- Developed by DHCS and approved by CMS

- Describes the nature and scope of Medicaid programs and gives assurances that it will be administered in accordance with the requirements of Title XIX of the Social Security Act, Code of Federal Regulations, and other applicable federal/state policies

http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx

Binding Covenants (Statutes and Regulations)

- Title 42, Code of Federal Regulations

  http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

- California Welfare and Institutions Code (WIC) commencing with 14700 et seq.

  http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic

- Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services, commencing with 1810.100 et seq.

  http://www.oal.ca.gov/CCR.htm

Specialty Mental Health Services (SMHS)

- Mental Health Services (Assessment, plan development, rehabilitation, collateral, individual and group therapy)
- Crisis intervention services
- Crisis stabilization services
- Day treatment intensive services
- Day rehabilitation services

Specialty Mental Health Services (SMHS) (cont.)

- Adult residential treatment services
- Crisis residential treatment services
- Medication support services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management
- Therapeutic behavioral services
- Pathways to Well-Being services (Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care services)

Therapeutic Foster Care Services Model

- The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS service 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 parents will work under supervision of a TFC Agency who will recruit, approve, train, monitor, etc. the TFC parent
- A Licensed Mental Health Professional (LMHP) that is able to direct services and is employed by the TFC Agency will provide direction to the TFC parent

Medical Necessity Criteria

- SMHS are provided to children and youth under the age of 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit

- Mandated under the Medi-Cal program pursuant to federal law (42 U.S.C. § 1396d, subds. (a)(4)(B) and (r)) for beneficiaries under the age of 21 who meet medical necessity criteria and are eligible for the full scope of Medi-Cal services

Medical Necessity Criteria (cont.)

- Medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults

- For children and youth, under EPSDT, the “impairment” criteria component of SMHS medical necessity is less stringent than it is for adults, therefore children with low levels of impairment may meet medical necessity criteria for SMHS whereas adults must have a significant level of impairment

Medical Necessity Criteria (cont.)

- To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria:
  - Have a condition that would not be responsive to physical health care based treatment; and
  - The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MCP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider

Continuum of Care Reform (CCR)

Implementing Legislation

- AB 403 enacted major CCR components (Chapter 77, Statutes of 2015)
- AB 1997 further implements CCR recommendations (Enrolled August 31, 2016)
- Requires Group Homes to transition to Short Term Residential Therapeutic Programs (STRTPs)
- Expands the role of a Foster Family Agency (FFA)
- Enhances FFA licensing standards
- Develops and defines the functions of the Child and Family Team
- Requires all new families to be approved as Resources Families
- Establishes a new rate structure and level of care protocol

Laws that Govern FFAs

EXISTING

- **Community Care Facilities Act**
  - Commencing with 1500 of the Health and Safety Code, et seq.
- **Regulations**
  - Ch. 8.8 Foster Family Agencies (Article 1-8)
  - Ch. 9.5 Foster Family Homes (Apply to Certified Family Homes)

NEW

- **AB 403**
  - (Stats. 2015, Ch. 773)
- **AB 1997**
  - (Stats. 2016, Ch. 612)
- **FFA Interim Licensing Standards**
  - Article 9, CCR
  - Subchapter 1, RFA

Laws that Govern STRTPs

EXISTING

- **Community Care Facilities Act**
  - Commencing with 1500 of the Health and Safety Code, et seq.
- **Regulations**
  - General Licensing Requirements
    (Title 22, Div. 6, Ch. 1)
  - Group Homes
    (Title 22, Div.6, Ch. 5)

NEW

- **AB 403**
  - (Ch. 773, Stats. 2015)
- **AB 1997**
  - (Ch. 612, Stats. 2016)
- **STRTP Interim Licensing Standards**
  - General Licensing Requirements
    (Title 22, Div. 6, Ch. 1)
  - Nonminor Dependents are incorporated in these ILS

Core Services and Supports

(ILS, Art. 9.7, Section 88278.1)
(ILS, Art. 6, Section 87078.1)

FFAs and STRTPs are required to have the:

- Ability to meet the differing needs of children and nonminor dependents
- Capacity to provide core services and supports that are need by both children and nonminor dependents which are trauma informed and culturally relevant

Core Services and Supports

(ILS, Art. 9.7, Section 88278.1)
(ILS, Art. 6, Section 87078.1)

Core services and supports include:

- Medi-Cal specialty mental health services for children and non-minor dependents who meet medical necessity criteria
- Transition support services
- Education and physical, behavioral, and mental health supports , including extracurricular activities and social supports
- Activities designed to support achieving a successful adulthood
- Services to achieve permanency

Core Services and Supports

(ILS, Art. 9.7, Section 88278.1)
(ILS, Art. 6, Section 87078.1)

In addition STRTP's shall:

- Have up to 12 months from the date of licensure to obtain in good standing a mental health program approval that includes a Medi-Cal mental health certification (**Health and Safety Code 1562.01)**

- Have up to 12 months to obtain a contract, subject to an agreement on rates and terms and conditions, with a county mental health plan to provide specialty mental health services **(Welfare and Institutions Code 11462.01)**

Core Services and Supports

(ILS, Art. 9.7, Section 88278.1)
(ILS, Art. 6, Section 87078.1)

In addition STRTP's shall:

- Demonstrate the ability to meet the therapeutic needs of each child, as identified in any of the following:
  - A mental health assessment
  - The child's case plan
  - The child's needs and services plan
  - Other documentation demonstrating the child has a mental health need

Access to Mental Health

(ILS, Art. 9.9, Section 88289.1)
(ILS, Art. 6, Section 87078.1)

Both FFAs and STRTPs shall ensure children and nonminor dependents have access to mental health services consistent with the child or nonminor dependent's case plan, any other assessment, or documentation identifying a mental health need

- Mental heath services may be accessed through a Medi-Cal managed care plan, county mental health plan, or a fee for service providers

Access to Mental Health (cont.)

(ILS, Art. 9.9, Section 88289.1)
(ILS, Art. 6, Section 87078.1)

- An FFA **may provide** Medi-Cal specialty mental health services **directly** to a beneficiary only if they hold a current Medi-Cal site certification and a contract as an organizational provider of that beneficiary's county mental health plan (MHP)

- An FFA that has not obtained a Medi-Cal certification and contract, **shall arrange** for medically necessary Medi-Cal mental health services for children and non-minor dependents as needed

- A STRTP certified by DHCS or by a county mental health plan shall provide direct mental health services

Access to Mental Health

(ILS, Art. 9.9, Section 88289.1)

Program Statement

- Describe whether or not your agency has a direct contract to provide Medi-Cal specialty mental health services, if so for what services
- Describe how your agency will engage and collaborate with counties, including in the Child and Family Team process, to access mental health services for children and NMD
- Identify relationships with county mental health plans to ensure access Medi-Cal specialty mental health services for children and NMD
- Describe the active efforts your agency will take to ensure children and NMD receive mental health services

What Must Group Homes Do to Transition to STRTP

- Attend an STRTP Orientation
- Complete STRTP application and supporting documents
- Prepare a detailed plan of operation and program statement
- Obtain one letter of recommendation in support of your program from a county placing agency
- Ensure your GH administrator completes the mandatory training required to be certified as an STRTP administrator
- Submit application package to your local CCLD Regional Office

Upon Licensure:

- Commence Accreditation Process
- Begin Mental Health Program Certification

Placement Eligibility

(WIC Sections 11462.01 & 4096)

An STRTP may accept for placement a child who:

<u>Meets both of the following criteria</u>:

- Does not require inpatient care in a licensed health facility

- Has been assessed as requiring the level of services provided in an STRTP in order to maintain the safety and well-being of the child or others due to behaviors **OR** prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family

Placement Eligibility

(WIC Sections 11462.01 & 4096)

AND

Has been assessed by interagency placement committee as meeting one of the following:

- Has been assessed, as meeting the medical necessity criteria for Medi-Cal specialty mental health services
- Has been assessed, as seriously emotionally disturbed, as defined in WIC Section 5600.3(a)
- Has been assessed as requiring the level of services provided by the STRTP program in order to meet his/her behavioral or therapeutic needs

Emergency Placement

(WIC Code Section 11462.01)

A child or youth may be placed into an STRTP on an **"emergency basis"** prior to a determination by the interagency placement committee (IPC)

Within 72 hours of the child or youth's emergency placement, a licensed mental health professional must make a determination that the child/youth requires the level of services and supervision provided by the STRTP in order to meet his or her behavioral or therapeutic needs

- **Within 30 days of emergency placement,** the IPC shall make a determination, with recommendations from the child and family team, as to whether or not the STRTP placement is appropriate
- **If it determines that an STRTP placement is not appropriate,** the IPC shall, with recommendations from the child and family team, make a recommendation as to the child's appropriate level of care and placement to meet his or her service needs

- The necessary IPC representative(s) shall **participate in any child and family team meetings** to refer the child or youth to an appropriate placement, as specified
- The child may remain in the placement for the amount of time necessary to identify and transition the child to an alternative, suitable placement

Questions & Answers

SMHS Providers

Provider Types

- **County Owned and Operated Providers**
  - County staff provide services
- **Organizational Providers**
  - Community based organizations operate SMHS programs including administrative and direct care services
- **Individual Providers**
  - County MHP contracts with individual licensed providers to provide services only

SMHS Providers (cont.)

Organizational Provider Requirements

- Contract with county Mental Health Plan(s) for specific SMHS
- Medi-Cal provider certification and tri-annual re-certification
- Minimum certification requirements are provided by DHCS based on the need to comply with federal law. County mental health plans can include additional requirements to meet local requirements

SMHS Providers (cont.)

- For organizational providers, the term “Provider” applies to those facilities delivering mental health services. A Provider **must** have a Legal Entity identification number and must also have an NPI number, if the provider will be billing Medi-Cal

- “Legal Entity” applies to a corporation, individual, or county that directly owns a facility offering public mental health services. Many Providers in California are owned by a corporation or individual (entity) that owns more than one provider

SMHS Providers (cont.)

- The NPI is a 10-digit numeric identifier which is assigned to a service facility location and is assigned to each provider number along with the county code, which is used for claiming in the Short-Doyle/Medi-Cal System. NPI information can be found at: https://nppes.cms.hhs.gov/NPPES/Welcome.do

- Many counties may use the same provider, but each county will have its own provider number for that provider

SMHS Providers (cont.)

- Once a Provider File is established, a site certification must be conducted
- A “Head of Service”, fire clearance, and program description must be in place prior to the provision of services
- The Program Statement submitted to CDSS for licensure may be used and submitted to meet the program description requirement
- The Fire Clearance submitted to CDSS for licensure may be used and submitted to meet the Fire Clearance requirement
- For county owned and operated providers, DHCS will perform the site certification
- For county contract organizational providers, the county Mental Health Plan will perform the site certification
- The site certification must be performed within 6 months of the activation date

SMHS Providers (cont.)

Organizational Provider Certification Elements

- Head of Service
- License
- Beneficiary Informing Materials (i.e., Required Posted Notices, Brochures, and Problem Resolution Process)
- Physical Plant Review/tour (i.e., clean, sanitary, and in good repair)

* CCR, Title 9, Section 1810.435 (c) (3)

SMHS Providers (cont.)

- Policies and Procedures (i.e., general operating procedures; disaster/evacuation; unusual occurrence reporting; confidentiality/HIPAA, service delivery (assessment, intake, discharge), maintenance, and referral to a psychiatrist)

- Additional requirements specific to type(s) of services being certified (i.e., Medication Support, Day Treatment, and Crisis Stabilization)

SMHS Providers (cont.)

- Once the initial site certification is done, site re-certifications are required every 3 years thereafter

- A new site certification may be required depending on the action being requested. For example, a new site certification is required for an address change in order to certify the new location

SMHS – Direct Service Providers

- **Physicians ****
- **Licensed/Waivered Psychologists ****
- **Licensed/Registered/Waivered Clinical Social Workers ****
- **Licensed/Registered/Waivered Professional Clinical Counselor ****
- **Licensed/Registered/Waivered Marriage and Family Therapist ****
- **Registered Nurse ****
- **Certified Nurse Specialist**
- **Nurse Practitioner**

** = Can be head of service (CCR, Title 9, Section 622 through 630)

SMHS - Direct Service Providers (cont.)

- **Licensed Vocational Nurse ****
- **Licensed Psychiatric Technician ****
- **Mental Health Rehabilitation Specialist ****
- **Physician Assistant**
- **Pharmacist**
- **Occupational Therapist**
- **Other Qualified Provider**

** = Can be head of service (See CCR, Title 9, Section 622 through 630)

SMHS - Direct Service Providers (cont.)

Waivered / Registered Professional

- An individual who has a waiver of psychologist licensure issued by DHCS or has registered with the corresponding state licensing authority for psychologists, marriage and family therapists, clinical social workers, or professional clinical counselors, to obtain supervised clinical hours for psychologist, marriage and family therapist, clinical social worker, or professional clinical counselor licensure

SMHS - Direct Service Providers (cont.)

Mental Health Rehabilitation Specialist (MHRS)

- An individual who meets one of the following requirements:
  - Has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment
  - Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis
  - Up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting
- A MHRS may function as the "Head of Service"

SMHS - Direct Service Providers (cont.)

Other Qualified Provider

- An individual at least 18 years of age with a high school diploma (or equivalent) determined to be qualified to provide the service by the MHP

May provide the following services under the direction of a licensed, registered, or waivered LPHA:

- Mental Health Services (including contributing to Assessment, but excluding Therapy)
- Day Rehabilitation or Day Treatment Intensive Services,
- Crisis Intervention Services
- Targeted Case Management
- ICC, IHBS, TFC

SMHS - Direct Service Providers (cont.)

Graduate Students / Interns

- An individual participating in a field internship/trainee placement while enrolled in an accredited and relevant graduate program
- No minimum experience required for graduate students
- Works "Under the Direction" of a licensed, registered, or waivered staff. If under the direction of a waivered staff, the waivered staff must be supervised by a LPHA
- Can complete the following "under the direction" of the LPHA:
  - Comprehensive assessments including Mental Status Exams (MSE) and diagnosis, complete client plans, conduct individual and group therapy
  - Write progress notes
  - Claim for any service within the scope of practice of the discipline of his/her graduate program

SMHS - Direct Service Providers (cont.)

- Can complete the following “under the direction” of the LPHA:
  - Comprehensive assessments including Mental Status Exams (MSE) and diagnosis, complete client plans, conduct individual and group therapy
  - Write progress notes
  - Claim for any service within the scope of practice of the discipline of his/her graduate program

Claiming for SMHS- General Provisions

SMHS are reimbursed on one of the following units of services:

- Per minute
- Hourly
- Daily (half/full day)

*Each SMHS has an established unit of service

Claiming for SMHS- General Provisions

- The provider must document actual time (not estimated time) involved in providing an eligible service

- Travel time and documentation time are to be included in the total time as it is linked to the service

- Group services may include multiple staff and are subject to additional rules for reimbursement

Claiming for SMHS - Interim Payments

- Contractor provides a service to a Medi-Cal beneficiary
- MHP pays the contractor for the service rendered
- MHP submits claims to DHCS for reimbursement. Payments are based on established interim rates or based upon the amount the MHP certifies to the State as public expenditures
- DHCS reimburses the MHP the federal share of the MHP's cost, while the non-federal share comes from a variety of sources, for instance, Realignment funding

Claiming for SMHS - Interim Settlement

- MHPs must submit a cost report package to DHCS by 12/31 following the close of a fiscal year
- The cost report package includes a cost report for the county and all contract providers
- The cost report package determines the actual cost incurred to provide all specialty mental health services

Building Rates

Items to Consider

- Direct costs
- Indirect Costs
- Productivity (How many units over a period?)

Rate Example

- (Direct Costs + Indirect Costs)/Productivity

Non-Reimbursable Activities

Non-reimbursable SMHS activities include but are not limited to the following:

- SMHS for which medical necessity criteria requirements are not met
- No service provided (i.e. missed appointment)
- Solely Academic/Educational services
- Solely Vocational services that have as a purpose actual work or work training
- Solely Recreation
- Solely Socialization, if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the youth involved

Non-Reimbursable Activities

- Solely clerical, solely transportation (i.e., of a beneficiary to/from a service), or solely payee related activities
- Supervision of staff (including clinical internship, clinical hours, discipline, etc.)
- Personal care services provided to youth (i.e. grooming, personal hygiene, assisting with medication, and meal preparation when performed **for** the child)

Non-Reimbursable Activities (cont.)

- Services provided to youth residing in juvenile hall when ineligible for Medi-Cal (If the client has been adjudicated and is just awaiting placement, services may be provided)
- Services provided to youth residing in other institutional settings such as a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility

Questions & Answers

Lunch

Documentation Requirements

- Medical Necessity Criteria
- Assessment
- Client Plan
- Medication Consents
- Progress Notes

Documentation Requirements
Medical Necessity Criteria

- Must have a covered diagnosis
- Must have at least one of the following impairments:
  - A significant impairment in an important area of life functioning;
  - A reasonable probability of significant deterioration in an important area of life functioning;

*Except as provided in section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years of age.

  - The beneficiary has a condition that would not be responsive to physical health care based treatment.
  - The focus of the proposed interventions is to address the identified impairment(s) above

Documentation Requirements
Medical Necessity Criteria (cont.)

The expectation is that the proposed intervention(s) will:

- Significantly diminish the impairment; or
- Prevent significant deterioration in an important area of life functioning, or
- Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
- For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c):
  - The condition would not be responsive to physical health care based treatment.
  - When the requirements Section 1830.205 and 1830.210 are met, beneficiaries shall receive SMHS for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

Documentation Requirements: Assessment (cont.)

- The **foundation for development of goals and interventions**
- Must be **current**
- Must be **comprehensive**
  - **Substantiate the qualifying diagnosis**
  - **Substantiate qualifying MH functional impairment(s)**
    - Direct relationship to the qualifying diagnosis
    - Reason for potential for deterioration

Documentation Requirements: Assessment (cont.)

Required Elements: Ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed

The following elements are required by the MHP Contract:

- Presenting Problem
- Relevant conditions and psychosocial factors
- Mental Health History
- Medical History
- Medications
- Substance Exposure/Substance Use

Documentation Requirements: Assessment (cont.)

The following elements are required by the MHP Contract: (cont.)

- Strengths
  Risks
- A mental status examination
- Most current ICD 10 diagnosis (and should also include corresponding DSM Diagnosis)
- Additional clarifying information, as needed

Documentation Requirements: Assessment (cont.)

Examples of Risks

- A history of Danger to Self (DTS) or Danger to Others (DTO), are examples of “risks” that are to be evaluated as part of the assessment

- Additional examples are previous inpatient hospitalizations for DTS or DTO; prior suicide attempts; lack of family or other support systems; prior arrests; currently on probation; history of alcohol/drug abuse, history of trauma and victimization; history of self-harm behaviors, e.g., cutting; history of assaultive behavior; physical impairment which makes him/her vulnerable to others, e.g., limited vision, deaf, wheelchair bound

Documentation Requirements: Client Plan (cont.)

Pursuant to the MHP Contract

The Contractor shall ensure that Client Plans:

- Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;

Documentation Requirements: Client Plan (cont.)

The Contractor shall ensure that Client Plans: (cont.)

- Have a proposed frequency and duration of intervention(s);
- Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b)); have interventions that are consistent with the client plan goal; and
- Be consistent with the qualifying diagnoses

Documentation Requirements: Client Plan (cont.)

Staff Signatures – For Client Plans without interventions that require licensed staff, the CP must be developed, signed (or electronic equivalent) & dated by either:

- The person providing the services,
- A person representing a team or program providing services, or
- A person representing the MHP providing the services

Documentation Requirements: Client Plan (cont.)

Client Plans where there are interventions provided by or under the direction of an approved staff category (licensed/registered/ waivered staff) must be co-signed by one of the following staff. In these cases these Client Plans may have one or two required signatures.

- A physician
- A licensed/waivered psychologist
- A licensed/registered /waivered social worker
- A licensed/registered/waivered marriage & family therapist
- A licensed/registered/waivered professional clinical counselor
- A registered nurse (except in the case of TBS client plans) including but not limited to NP and clinical nurse specialists.

Effective date is the latest date of the required staff signature(s)

Documentation Requirements: Client Plan (cont.)

Beneficiary Participation in and Agreement with Client Plan

- **There must be documentation of the beneficiary's or their legal representative's participation in and agreement with the Client Plan by any of the following:**
  - Reference to agreement documented in the Client Plan
  - Beneficiary's or their legal representative's signature on the Client Plan
  - Description of participation documented in the medical record, (i.e., progress notes)

Documentation Requirements: Client Plan (cont.)

A beneficiary signature is required when:

- Beneficiary is expected to be in long term treatment* as defined by the MHP AND
- The Client Plan provides that the beneficiary will be receiving more than one (1) type of SMHS
- The MHP written standard requires signature

**The MHP is required to have a written definition of what constitutes a long term beneficiary*

Documentation Requirements: Client Plan (cont.)

Beneficiary Refusal to Sign Client Plan (CP):

- If a beneficiary refuses or is unavailable for signature, the Client Plan shall include a written explanation of the refusal or unavailability. There should be documentation of concerted efforts by the staff to obtain the beneficiary's signature

Copy of Client Plan Offered:

- There shall be documentation in the Client Plan that a copy of the client plan was offered to the beneficiary or their legal representative.

Documentation Requirements: Client Plan (cont.)

Timeliness and Frequency

Per MHP contract: The MHP shall establish standards for timeliness and frequency of the CP, including, for the initial CP and for the review and updates of the CP.

- **If** the MHP **does not** have established standards:
  - Best practices; INITIAL CP **completed within 60 days** of intake unless there is documentation supporting need for more time.
  - UPDATED CP must be reviewed and updated on at least an **annual** basis.
  - ***Remember*:** It is permissible for MHPs to establish additional requirements **but the contract standards are the required minimum**.

Documentation Requirements: Medication Consents

Providers must **obtain** and **retain** a written medication consent form signed by the beneficiary:

- Agreeing to the administration of psychiatric medications;
- For every psychiatric medication prescribed;
- If new medications are added to the current consent form there must be a **new signature**;
- **NOTE:** Each MHP determines timeliness and update frequency of its medication consents.

Documentation Requirements: Medication Consents (cont.)

The beneficiary <u>must</u> be provided with sufficient information by the physician prescribing such medications:

- Reasons for taking such medication;
- Reasonable alternative treatments available, if any;
- Type, range of frequency and amount (including PRN orders), method (oral/injection), and duration
- Common side effects
- Additional side effects after taking such medication beyond three months/long term; e.g. Tardive dyskinesia (persistent involuntary movement of the face or mouth, trunk and extremities)
- Consent, once given, may be withdrawn at any time

Documentation Requirements: Medication Consents (cont.)

For children and adolescents who are wards of the court

- A completed JV220 is not sufficient to administer or to continue the psychotropic medications a child is currently taking and is not signed by the beneficiary or anyone authorized to consent on the minor's behalf

- A JV-220 form is an application for a court order regarding psychotropic medications that is filed in situations where a court order is required to administer psychotropic medications to a minor

Documentation Requirements: Medication Consents (cont.)

- A court order on such an application (JV-223) may be sufficient if it alone or in combination with the application contains all the elements required under the MHP contract. However, in its current form, neither the JV-220 or JV223 require information on the following that are required by the MHP Contract: 1) method of administration (oral or injection), or 2) additional side effects if the child were to take the medication for more than 3 months.
- Youth have a right to give informed consent to medication.
  - Same guidelines apply.
  - Be mindful of putting information in a way that can be understood by the youth

Documentation Requirements: Progress Notes

Progress Notes must:

- Be clear, concise and succinct
- Describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.
- Reflect how the **INTERVENTION** relates to the MH functional impairment and qualifying diagnosis.
- Indicate the beneficiary's response to the intervention

Documentation Requirements: Progress Notes (cont.)

MHP Contract Requirements

- Progress Notes
  - The Contractor shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:
  - Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;

Documentation Requirements: Progress Notes (cont.)

- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied, beneficiary's response to the interventions and the location of the interventions;
- The date the services were provided;
- Documentation of referrals to community resources and other agencies, when appropriate;

Documentation Requirements: Progress Notes (cont.)

- Documentation of follow-up care, or as appropriate, a discharge summary; and
- The amount of time taken to provide services; and
- The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title

Documentation Requirements: Progress Notes (cont.)

Progress notes should reflect the following:

- Individual or group therapies **and** interventions designed to:
  - Reduce mental disability
  - Restore, improve or maintain functioning
  - Consistent with goals of learning, development, independent living and enhanced self-sufficiency
  - Meet medical necessity requirements

CCR, Title 9, Chapter 11, 1810.227

Documentation Requirements: Progress Notes (cont.)

- Progress Note Frequency
- **Every service contact:**
  - Mental Health Services (assessment, plan development, rehabilitation, therapy, collateral)
  - Medication Support Services
  - Crisis Intervention
  - Targeted Case Management
- **Daily:**
  - Crisis Residential
  - Crisis Stabilization (one per 23 hour period).
  - Day Treatment Intensive (DTI)
  - Therapeutic Foster Care (TFC) Services

Documentation Requirements: Progress Notes (cont.)

- **Weekly:**

  - Day Treatment Intensive (DTI) – weekly clinical summary
    - ***NOTE***: MHS including individual therapy are inclusive and not separately billable during DTI hrs. However, TBS services may be claimed if delivered by staff other then the DTI staff.
  - Day Rehabilitation (DR)
  - Adult residential

Documentation Requirements: Maximum Claimable Amounts

- **Certain SMHS have maximum claimable amounts as follows:**
  - **Medication Support** (Max Claimable Amt: **4** hrs. per 24 hour period)
  - **Crisis Intervention** (Max Claimable Amt: **8** hrs. per 24 hour period)
  - **Crisis Stabilization** (Max Claimable Amt: **20** hrs. per 24 hour period)

Documentation Requirements

- **All entries** in the medical record must include:
  - The **date of service**
  - The **signature of the person providing** the service (or electronic equivalent); including:
    - The person's type of professional degree, licensure or job title
    - The relevant identification number, if applicable.
  - The **date the documentation was entered** in the beneficiary record

Documentation Requirements: Electronic Health Records

The MHP must have a **policy** for electronic signatures which includes the processes for:

- **Electronic signature agreements**
- How **electronic signatures are identified**
- How **beneficiaries** sign documents

Oversight and Monitoring

- The MHP is responsible for oversight of their contracted organizational providers and may conduct activities similar to those conducted by DHCS or additional monitoring activities of their providers which would be clarified in the contract between the MHP and the organizational provider.

Oversight and Monitoring

DHCS conducts oversight and monitoring activities of the MHPs including but not limited to:

- Site certification of county owned and operated providers
- Triennial re-certifications of the above providers
- Triennial System Reviews of County MHPs
- Triennial Outpatient Chart Reviews of County MHP (NOTE: FFA and STRTP client records may be pulled as part of the random sample of records pulled for these reviews and out of compliance issues related to chart reviews may result in disallowances)
- Triennial Inpatient Chart Reviews of Short Doyle / Medi-Cal Hospitals

Oversight and Monitoring: Chart Reviews

- The MHP must submit a Plan of Correction for all items identified as being out of compliance.

- DHCS may conduct Enhanced Monitoring Activities of the MHP as a result of significant or continued out of compliance issues and high chart disallowances

- DHCS Enhanced monitoring activities may be conducted as desk reviews of information submitted by the MHPs to the department or by additional onsite reviews and may include, but are not limited to, targeted training and technical assistance, focused reviews, POC validation, and additional chart reviews (either onsite or by desk review)

Questions & Answers

County MHP Perspective

Kim Suderman, **LCSW,** CCR Consultant, CBHDA

Jeff Rackmil, LCSW, Director, Children's System of Care
Alameda County Behavioral Health Care Services

Ken Epstein, PhD, LCSW, Director, Children, Youth, and Families, San Francisco County Community Behavioral Health Services

Questions & Answers

Resources and Helpful Links

- SMHS waiver, contract and state plan
  - http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx
  - http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx
  - http://www.dhcs.ca.gov/formsandpubs/laws/Documents/09-004_ApvPkg.pdf

- SMHS Medi-Cal Billing Manual
  - http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf

Resources and Helpful Links (cont.)

- CDSS CCR
  - http://www.cdss.ca.gov/cdssweb/PG4869.htm
- Questions on Katie A. (ICC, IHBS, TFC)
  - KatieA@dhcs.ca.gov
- Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care Services
  - http://www.dhcs.ca.gov/services/Documents/Medi-cal_manual_9-22-16.pdf

Closing Remarks & Wrap-Up

Send Feedback, Questions, Comments to:

ccr@cibhs.org