STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, GOVERNOR

**DEPARTMENT OF MENTAL HEALTH**
1600 - 9TH STREET
SACRAMENTO, CA 95814

(916) 654-3551

March 14, 1997

DMH INFORMATION NOTICE NO.: 97-06

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, MENTAL HEALTH ADVISORY BOARDS

SUBJECT: IMPLEMENTATION PLAN FOR PHASE II CONSOLIDATION OF MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES

EXPIRES: Retain Until Rescinded

October 1, 1997, is the implementation date for the Consolidation of Medi-Cal Specialty Mental Health Services (Phase II). Counties needing additional time to complete local planning and system changes may elect to begin Phase II of Consolidation on January 1, 1998. All start-up dates and all contents of the Implementation Plan are subject to the approval of the waiver request by the Health Care Financing Administration (HCFA).

As with the Consolidation of Psychiatric Inpatient Hospital Services (Phase I), an Implementation Plan with required components must be submitted to and approved by the Department of Mental Health (DMH). For Phase II, DMH must determine if the county mental health plan (MHP) has substantially complied with these Implementation Plan requirements prior to the proposed start-up date. DMH will notify an MHP of approval to implement Phase II Consolidation two months prior to the county's requested implementation date.

The purpose of the Implementation Plan is fourfold. First, it ensures statewide system integrity by delineating standards and requirements. Second, it demonstrates for both the state and local community the readiness of an MHP to implement Phase II. Third, it updates the Implementation Plan already submitted to the DMH by MHPs for Psychiatric Inpatient Hospital Services Consolidation. Fourth, it describes the policies and procedures, not otherwise defined by regulation or law, that will be employed in the Consolidation of Specialty Mental Health Services. These plans are essential for DMH to comply with its oversight responsibilities and requirements of HCFA and the Department of Health Services as well as federal and state statutes.

Counties requesting an October 1, 1997, start date must submit their Implementation Plan by May 15, 1997. The submission date for counties planning to implement January 1, 1998, is August 1, 1997.

DMH continues to work with the Cultural Competency Task Force, the California Mental Health Directors' Association and other stakeholders to specify the population and organizational needs assessment as well as access and quality standards for cultural competency. An addendum to this document will be issued in the near future specifying these requirements and integrating them throughout the Implementation Plan. Since this is intended to be a dynamic plan, other changes or additions may be made to these requirements in the future.

Enclosure 1 is a listing of "Helpful Hints" from the DMH Client/Family Member Task Force. This document expresses important factors to keep in mind as MHPs and their stakeholders plan for implementation of these changes. Feel free to use this as needed.

When completed, **SEVEN** copies of the Implementation Plan must be submitted to:

Department of Mental Health
Managed Care Implementation
1600 9th Street, Room 120
Sacramento, California 95814

For questions or assistance, contact your Technical Assistance and Training liaison:

| | | |
|---|---|---|
| Bay Area | Ruth Walz | (707) 252-3168 |
| Southern Region | Anne Tracy | (916) 654-2643 |
| Northern Region | Jack Tanenbaum | (916) 224-4724 |
| Central Region | Dee Lemonds | (916) 654-3001 |

Sincerely,

GARY M. PETTIGREW
Deputy Director
Systems of Care

Enclosure

**REQUIRED COMPONENTS FOR IMPLEMENTATION PLAN**
**Consolidation of Specialty Mental Health Services (Phase II)**

INTRODUCTION

The goal of the Department of Mental Health (DMH) is to achieve the maximum benefit for dollars invested in order to improve client outcomes by providing quality, culturally competent and effective mental health services through the public mental health system of care to persons with mental illness and emotional disturbance. The following principles have guided the development of this managed mental health care system:

- Services should be client-centered, family-focused, and achieve positive mental health outcomes for culturally diverse populations across all age groups.

- Systems should be organized, comprehensive, coordinated, cost-effective and accountable.

- Systems should promote coordination, case management, appropriate service delivery, quality of care and reduction of reliance on episodic treatment.

- Services should be provided by a public/private delivery system.

The Implementation Plan provides the Mental Health Plan's (MHPs) detailed description of proposed operations under the consolidation of Medi-Cal Specialty Mental Health Services (Phase II). The plan will be used by DMH as a key component in fulfilling its responsibility to ensure the integrity of the statewide Medi-Cal mental health managed care system. This plan provides the basis for the contractual relationship between the state and counties. Because this is a tool for DMH to determine readiness of the MHP for the Phase II Consolidation of Specialty Mental Health Services it will be reviewed and judged to determine compliance with requirements. The information provided in the Implementation Plan will also serve as a foundation for state oversight reviews.

In this document, the shaded paragraphs cite the legal authority the state is acting under for each of the requested components. The MHP should provide sufficient detail in its responses so that Plan reviewers can determine if the local plan meets the requirements and assures DMH of its readiness to implement Phase II. **If an item has already been addressed in the Inpatient Implementation Plan, so indicate. It is not necessary to resubmit.**

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Note: An Addendum which will specify and integrate cultural competency needs assessment requirements and standards throughout the Implementation Plan will be issued at a later date.

## A. PLANNING, COORDINATION, OUTREACH AND NOTIFICATION

Section 14684 W&I Code requires that the MHP include a public planning process that provides a significant role for beneficiaries, family members, mental health advocates, providers and public and private contract agencies. Section 5604.2 W&I Code requires the involvement of the local mental health board or commission in mental health planning. Section 14683 W&I Code requires that the mental health plan (MHP) employ a process for screening, referral and coordination with other necessary services a beneficiary may require. It also provides that MHPs include a system of outreach to enable beneficiaries and providers to access mental health services.

1. Describe: a) the public planning process utilized for the Consolidation of Specialty Mental Health Services and, b) how members of the local mental health community were involved.

2. Include a letter from the local mental health board or commission advising that they have reviewed the Implementation Plan.

3. Describe the process the MHP will use for screening and when appropriate, referral and coordination with other services, including but not limited to substance abuse services, education, housing, social services, probation, employment and vocational rehabilitation. Indicate if there are differences in the screening, referral and coordination of services for special populations.

4. For clients who require a system of care approach, provide a list of agencies with whom the MHP has interagency agreements. Briefly describe the nature of those agreements. As an alternative, the MHP may include copies of any existing interagency agreements and describe any additional interagency agreements planned or in process.

5. Provide a statement assuring that at least thirty days prior to implementation, the MHP will provide a copy or proposed draft of the MHP's Member Services Handbook/Brochure. The minimum components are: a) information about accessing services, b) description of services available, and c) beneficiary problem resolution processes.

6. Provide a statement assuring that at least thirty days prior to implementation, the MHP will provide a copy or proposed draft of the MHP's Provider Handbook/Brochure which will be distributed to providers of the MHP. The minimum components are: a) procedure for requesting authorization of services, b) procedure for submitting claims for payment, c) beneficiary problem resolution processes, and d) provider problem resolution process.

7. Describe how the MHP will provide for 24 hour phone access including a statewide toll free phone line with linguistic capacity.

## B. CONTINUITY OF CARE

Section 14684(d) W&I Code requires an MHP to assure continuity of care for current recipients of services during the transition to managed mental health care.

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1. For beneficiaries receiving Fee-for-Service/Medi-Cal (FFS/MC) outpatient professional specialty mental health services prior to Phase II consolidation, describe the procedures the MHP will use for the transition of services to protect the continuity of care for beneficiaries. Include procedures: a) when the existing provider will continue as a member of the plan and, b) when a provider will not continue as a member of the plan. Include: c) a description of how the individuals and providers who are receiving or providing specialty mental health services prior to Phase II consolidation will be notified of MHP policies and procedures.

## C. INTERFACE WITH PHYSICAL HEALTH CARE

Sections 14683 and 14684 W&I Code require coordination of care between providers of physical and mental health care as needed by beneficiaries.

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1. Describe how the MHP will interface with physical health care providers and provide clinical consultation and training when a beneficiary belongs to a physical health managed care plan and/or when the beneficiary has a FFS/MC primary health care provider.

   Note: Prior to implementation, DMH will issue a policy letter requiring MHPs to provide a draft or final copy of all Memoranda of Understanding (MOUs) entered into between the MHP and a Medi-Cal physical health care prepaid health plan which meets the standards as specified for both plans by DMH and DHS. The standards for the content of the MOUs are expected to include:

   a) Referral protocols between plans, including how the MHP will provide a referral to a physical health care provider when the MHP determines the condition would be responsive to physical health care-based-treatment.

   b) The availability of clinical consultation, including medications, between plans.

c) Exchange of critical medical records information, within agreed upon confidentiality guidelines.

d) A process for resolving disputes between plans.

## D. ACCESS, CULTURAL COMPETENCE AND AGE APPROPRIATENESS

Under a 1915(b) waiver from the Health Care Financing Administration (HCFA), access to Medi-Cal specialty mental health services must be maintained or enhanced under the waivered program. Section 14684 W&I Code requires the delivery of culturally competent and age appropriate services to the extent feasible.

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1. Describe the level of access to Phase II FFS/MC specialty mental health services which existed prior to consolidation.

2. Describe: a) how access to Medi-Cal specialty mental health services will be maintained under Phase II consolidation including geographical access to services, b) how the MHP will maintain access for special populations and, c) how the MHP will assure adequate service capacity for full scope Medi-Cal beneficiaries under age 21 years.

3. Describe procedures the MHP will use to provide for 24 hour availability of services to address urgent conditions for beneficiaries who need services when a) in-county, or b) out-of-county. Describe how back-up will be provided c) if a single practitioner is available or on-call.

4. Describe how access will be ensured for beneficiaries living out of the county when there may or may not be an in-plan provider available. This includes children in foster care placements, adults in residential placements as well as other individuals who may seek mental health services in another county.

5. Describe: a) the languages in which MHP information will be available, b) the standards for making these determinations and, c) how the MHP will provide information for persons with visual and hearing impairments.

6. Describe the process for ensuring that the beneficiary will: a) have a choice of practitioner whenever feasible and, b) availability of second opinions when there is a dispute regarding medical necessity and the MHP denies services.

7. Describe procedures the MHP will use to maintain a written log of initial contact (telephone, written, or in-person) by beneficiaries requesting specialty mental health services from the MHP.

Note: Cultural competency needs assessment requirements and other standards will be integrated in this section and throughout this document when the Addendum referenced in the cover letter is issued.

## E. CONFIDENTIALITY

State and federal law and regulation require the protection of beneficiary confidentiality.

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1. Describe any changes in current or planned policies and procedures to continue to assure compliance with all applicable state and federal laws and regulations to protect beneficiary confidentiality.

## F. QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT PROGRAMS

Sections 4070, 5777, 14683 and 14684 of the W&I Code require a quality management plan. Section 5777 also allows MHP staff to authorize services.

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1. Describe the MHP's Quality Improvement (QI) Program. MHPs may attach supportive documentation such as organizational charts, process descriptions, policies and procedures to satisfy any of the following required elements of this section. The description must include the QI program description of structure and process including the following:

   a) The role, structure, function and meeting frequency of the QI Committee and other relevant committees.

   b) How practitioners, providers, consumers and family members will be involved in the QI process.

   c) If the MHP delegates any QI activities to a separate entity, the MHP will describe how the relationship meets DMH standards.

2. Provide an assurance that within 90 days after implementation, the MHP will have completed an annual workplan to include the requirements in Attachment 2 Section 2.

3. Describe the MHP's Utilization Management (UM) Program. MHP's may attach supportive documentation such as organizational charts, process descriptions, policies and procedures to satisfy any of the following required elements of this section. The

description must include the UM program description of structure and process including the following:

a) The authorization process used by the MHP, including the process by which the MHP obtains relevant clinical information to support its authorization decisions

b) If the MHP delegates any UM activities to a separate entity, the MHP will describe how the relationship meets DMH standards.

Notes: Quality Improvement and Utilization Review requirements can be found as Attachment 2 and 3. Also, for this section and any other requirements of the Phase II Implementation Plan, if an item has already been addressed in the Inpatient Implementation Plan, so indicate. It is not necessary to resubmit.

## G. PROBLEM RESOLUTION PROCESSES

Section 14684 of the W&I Code require problem resolution processes for beneficiaries and providers.

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1. Beneficiary Problem Resolution Processes -Describe how the MHP will respond to beneficiary concerns regarding service-related issues in compliance with statewide requirements specified in Attachment 4.

   Provider Problem Resolution Process - Describe how the MHP will respond to concerns from providers on any issue, including denial of payment authorization and claims processing delays, in compliance with statewide requirements specified in Attachment 5.

## H. ADMINISTRATION

The Health Care Financing Administration requires that the state ensure oversight of the requirements of the Medicaid program. Section 14683 W&I Code established the Department of Mental Health as the agency responsible for development and implementation of local mental health managed care plans for Medi-Cal beneficiaries.

1. Specify any practitioner provider and organizational provider selection criteria the MHP will utilize that exceed minimum state and federal criteria specified in Attachment 6. Also see Glossary - Attachment 7.

2. Provide a statement assuring that at least thirty days prior to implementation, the MHP will submit a sample boilerplate contract for each type of provider with whom

the MHP intends to contract e.g. hospital, nursing facility, organizational and practitioner provider(s).

3. Describe the method and time frames to be used by the MHP to process claims and payments for a) practitioner and b) organizational providers. (Since payment for nursing facility services will be made directly by the state, this type of service does not need to be addressed.)

4. Identify a contact person who can be reached regarding any questions with this Implementation Plan.

Attachment 1

# HELPFUL HINTS

The Client and Family Member Task Force on Managed Care began as an outgrowth of the public planning process for the Medi-Cal specialty mental health managed services. There was concern that the issues which may be of most importance to clients and family members were not getting the time and attention needed. This Task Force has worked diligently since last November to develop a vision of how a public managed mental health care program can operate in a manner which would meet the needs of clients and family members.

The Task Force developed this letter containing Helpful Hints for stakeholders and MHPs to keep in mind as you develop and review your county's Implementation Plan. It contains some of the issues that they felt were most important for everyone to be aware of. The Task Force has organized their Helpful Hints to parallel the Implementation Plan requirements in this document.

## Interagency Cooperation

- When a beneficiary is in need of services between agencies, there needs to be a process to ensure that they receive appropriate services and are not lost in the system. Avoiding provision of services to a client/family member by referring them elsewhere should not occur.

## Continuity of Care

- Note that the definition of "continuity of care" in the implementation plan is limited to the transition of beneficiaries into the mental health plan (MHP). Continuum of care which encompasses a broader definition is discussed elsewhere.

- The MHP should do everything feasible to ensure continuity of care. It would be helpful to have a process whereby the MHP could offer a limited or client specific "grandfather" contract to current FFS providers (including out of county providers) who do not wish to be full contractors. This would permit clients to continue to see providers they may have seen for years.

## Interface with Physical Health Care

- A smooth transition between services/care systems is needed.

- When a client is referred to a physical health care provider by the MHP, there needs to be a process to verify that the referral was completed and needs were met.

- There should be a method to transport to the nearest psychiatric care facility mental health beneficiaries, especially in rural areas, who present in a physical health care based setting when mental health services are also needed.

- If there is a disagreement over diagnosis between the physical health service and the mental health service, we feel that services must continue as fiscal responsibility is decided between the mental and physical health services.

- If there is a disagreement over the proper medication, there needs to be a joint staff (physician/pharmacist) review team for medication management.

- If there is a change in the physical health care provider, we recommend that there be a process for transition to the new provider, with the least disruption of services to the beneficiary.

- Where possible, the beneficiary will have a choice of his/her physical care provider. If the beneficiary is not satisfied with the medical service provider, there should be a process where he/she can have the issue resolved without fear of reprisal.

- There needs to be an annual review by beneficiaries and family members -- such as satisfaction surveys of the quality of physical health care services received, with the results available to the public. There also needs to be a method for addressing the correction of deficiencies.

**Access**

- Geographic: We feel there must be access to the MHP in all geographic areas of the county. When access points are out of reach of the beneficiary needing continuing care, assistance must be provided.

- Transportation: In rural areas, where public transportation is not readily available or non-existent, the MHP should do what is most reasonable to provide transportation services to beneficiaries. This may include monetary assistance, bus tickets, etc.

- Special populations: We believe the MHP must provide appropriate, competent services to special populations.

- Choice of provider/practitioner: Clients should have a choice of provider/practitioner whenever feasible.

- Availability of alternate practitioner: The MHP should have available more than one practitioner within each discipline so that when irreconcilable differences exist between the beneficiary and their MHP practitioner, the MHP could offer an alternate

practitioner within that discipline. This may be out of county and transportation assistance may be needed.

- Array of services: Since each MHP may offer a different array of services, be aware of the services being offered in your plan.

- Re-access: There should be a method to re-access the system when a beneficiary receives services, recovers, and then during a flare of the illness, needs a higher level of care.

- Release of information: At the time of admission into the system, we feel the beneficiary must be asked if it is permissible to have family member involvement. If so, a release of information will be obtained.

- Protocol of transfer: There should be a method to ensure a beneficiary who moves, but remains within driving distance including out of county, and wishes to continue seeing his/her current therapist may do so.

- Medical Necessity: Although not specifically mentioned in the implementation plan, we believe that medical necessity is an area of concern in the planning process at the county level. Definitions of "impairment" will be different from county to county. Be sure to ask for clarification on what impairment will be in your county to meet medical necessity and qualify a potential beneficiary for services.

**QUALITY IMPROVEMENT**

- The quality management team should be representative of a diverse cross-section of interested parties including mental health, physical health, other county agencies, mental health boards/commissions, providers, clients and family members and the community at large.

- We feel the role and function of the quality management team should include:

  - Assisting in the selection of providers/practitioners

  - Providing ongoing evaluation for contract approval

  - Monitoring performance outcomes, including client satisfaction surveys

  - Assuring a continuum of care including re-access to the system.

- Clients and family members should assist in the continued education for staff and providers in areas of mental health constituency concerns, including special populations and cultural competence.

- Since performance outcomes are not yet fully developed, we want to assure that specified performance outcome domains that are associated with specified quality standards be measured in all MHPs.

**ADMINISTRATION**

- We believe that clients and family members should have a meaningful role in development and implementation of the oversight process at the county level.
- There should be a provider selection criteria that assures continuity of care for existing clients.

- Request information from your county regarding how inpatient consolidation savings are being spent. Some counties are using this money to supplement the outpatient consolidation and some are using the funds elsewhere in the mental health system.

We hope that everyone will share this document with all of the participants in the public planning process for the Medi-Cal specialty mental health managed care services.

# THE CLIENT AND FAMILY MEMBER TASK FORCE ON MANAGED CARE

Karen Hart, Chair
Monterey, California

John Brunges
Ukiah, California

Ann Heater
Visalia, California

Pearl Johnson
Los Angeles, California

Ben Lacey
San Diego, California

Steve Leoni
San Francisco, California

Joyce Ott
Junction City, California

Carol Moss
Sacramento, California

Darlene Prettyman
Bakersfield, California

c) Objectives, scope, and planned activities for the coming year, including QI activities in each of the following areas:

i) Monitoring the service delivery capacity of the MHP:

a) The MHP implements mechanisms to assure the capacity of service delivery within the Plan

(1) The MHP describes the current number, types and geographic distribution of mental health services within its delivery system, including network practitioners and providers

(2) The MHP sets goals for the number, type, and geographic distribution of mental health services

ii) Monitoring the accessibility of services:

a) In addition to meeting statewide standards, the MHP sets goals for:

(1) Timeliness of routine mental health appointments;

(2) Timeliness of services for urgent conditions;

(3) Access to after-hours care; and

(4) Responsiveness of the MHPs 24 hour telephone access

b) The MHP establishes mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24 hour, toll free telephone number

iii) Monitoring beneficiary satisfaction

a) The MHP implements mechanisms to ensure beneficiary or family satisfaction.

b) The MHP assesses beneficiary or family satisfaction by:

(1) Surveying beneficiary/family satisfaction with the MHP's services according to statewide standards

(2) Evaluating beneficiary grievances and fair hearings at least annually; and

(3) Evaluating requests to change practitioners and/or providers at least annually

c) The MHP informs practitioners and providers of the results of beneficiary/family satisfaction activities

iv) Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices.

a) The scope and content of the QI Program reflect the MHP's delivery system and meaningful clinical issues that affect its membership.

(1) Annually the MHP identifies meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.

(a) These clinical issues shall include a review of the safety and effectiveness of medication

practices. The review shall be under the supervision of a person licensed to prescribe or dispense prescription drugs

(b) In addition to medication practices, other clinical issue(s) will be identified by the MHP

(2) The MHP implements appropriate interventions when individual occurrences of potential poor quality are identified

b) At a minimum the MHP adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement

c) Practitioners, providers, consumers and family members evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system

v) Monitoring continuity and coordination of care with physical health care providers and other human services agencies

a) The MHP works to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries

(1) When appropriate, the MHP exchanges information in an effective and timely manner with other agencies used by its beneficiaries

(2) The MHP will monitor the effectiveness of its MOU with physical health care plans

vi) Monitoring provider appeals

d) The MHP follows these steps for each of the QI activities:

i) Collects and analyzes data to measure against the goals, or prioritized areas of improvement that have been identified

ii) Identifies opportunities for improvement and decides which opportunities to pursue

iii) Designs and implements interventions to improve its performance

iv) Measures the effectiveness of the interventions

3. If the MHP delegates any QI activities, there is evidence of oversight of the delegated activity

a) A written mutually agreed upon document describes:

i) The responsibilities of the MHP and the delegated entity

ii) The delegated activities

iii) The frequency of reporting to the MHP

iv) The process by which the MHP evaluates the delegated entity's performance, and

v) The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

b) Documentation verifies that the MHP:

i) Evaluates the delegated entity's capacity to perform the delegated activities prior to delegation

ii) Approves the delegated entity's QI Program annually or as defined by contract terms

iii) Evaluates annually whether the delegated activities are being conducted in accordance with State and MHP Standards; and

iv) Has prioritized and addressed with the delegated entity those opportunities identified for improvement

Attachment 3

Utilization Management Program

1. The MHP shall have a written description of the Utilization Management (UM) program, in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements are addressed in the Quality Management Plan.
   a) Licensed mental health staff have substantial involvement in UM program implementation
   b) A description of the authorization processes used by the MHP includes:
      i) Authorization decisions are made by licensed or "waivered/registered" mental health staff
      ii) Relevant clinical information is obtained and used for authorization decisions. There is a written description of the information that is collected to support authorization decision making.
      iii) The MHP uses statewide medical necessity criteria to make authorization decisions
      iv) The MHP clearly documents and communicates the reasons for each denial
      v) The MHP sends written notification to members and practitioners or providers of the reason for each denial.
   c) The MHP provides the statewide medical necessity criteria to its practitioners, providers, consumers, family members and others upon request.
   d) Authorization decisions are made in accordance with statewide timeliness standards for authorization of services for urgent conditions, as established by DMH.
   e) The MHP monitors the UM process to ensure it meets the established standards for authorization decision making, and takes action to improve performance if it does not meet the established standards.
   f) The MHP includes information about the beneficiary grievance and fair hearing processes in all denial notifications sent to the beneficiary.

2. The MHP evaluates the UM process:
   a) The UM program is reviewed annually by the MHP, including a review of the consistency of the authorization process
   b) If an authorization unit is used to authorize services, at least every two years, the MHP gathers information from beneficiaries, practitioners and providers regarding their satisfaction with the UM process, and addresses identified sources of dissatisfaction.

3. If the MHP delegates any UM activities, there is evidence of oversight of the delegated activity.
   a) A written mutually agreed upon document describes:
      i) The responsibilities of the MHP and the delegated entity
      ii) The delegated activities
      iii) The frequency of reporting to the MHP
      iv) The process by which the MHP evaluates the delegated entity's performance, and
      v) The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations.
   b) Documentation verifies that the MHP:
      i) Evaluates the delegated entity's capacity to perform the delegated activities prior to delegation
      ii) Approves the delegated entity's UM program annually
      iii) Evaluates annually whether the delegated activities are being conducted in accordance with state and MHP standards, and
      iv) Has prioritized and addressed with the delegated entity those opportunities identified for improvement.

Attachment 4

Beneficiary Problem Resolution Processes

Each mental health plan shall develop problem resolution processes that meet the requirements of Title 9, Section 1795, California Code of Regulations for service-related issues for all Medi-Cal specialty mental health services.

In addition, the beneficiary problem resolution processes must include the following:

1. Any written communication with a beneficiary regarding a denial, termination or reduction of services should be written in clear, concise language, in a format understandable to the client. The information provided about the MHP's client problem resolution process options shall identify both the informal complain resolution and formal grievance procedures. The communication shall state that a formal grievance or fair hearing may be filed without completing the informal complain or grievance process first.

2. MHPs must have an expedited grievance response for Medi-Cal funded residential treatment programs. The process will be client-friendly and timely, in recognition of the danger some psychiatric conditions represent to beneficiaries. Medi-Cal residential treatment services will continue until the MHP responds to the first level grievance. An exception to continuing the service pending the resolution of the grievance will be made when a beneficiary poses a danger to other residents.

3. Notices of complaint and grievance procedures and grievance forms shall be readily accessible and visibly posted in prominent locations in client and staff areas, including client waiting areas. Self-addressed envelopes for mailing back grievances shall be provided next to the descriptions of grievance procedures.

4. Written and oral information explaining the informal complaint resolution, formal grievance procedures and the availability of fair hearings shall be provided to clients upon admission to the MHP specialty MH services system. Written information shall also be provided periodically to clients and be available in client areas where beneficiaries would request or receive services. Grievance information will be available through the 24 hour phone access system.

5. A specific staff person is designated by the MHP to provide information upon beneficiary request regarding the status of their grievance.

ATTACHMENT 5

Provider Problem Resolution and Appeals for Phase II*
Consolidation of Medi-Cal Specialty Mental Health Services

**Informal Problem**
The Mental Health Plan (MHP) shall have an informal problem resolution process to identify and resolve provider concerns and problems quickly and easily.

**Provider Appeals - Services**
Providers may appeal denied requests for authorization to the MHP. A written appeal shall be submitted to the MHP on a timely** basis. Subsequent to the date of receipt of the non-approval of the request for authorization.

The MHP shall inform the provider in writing of the decision and its basis in a timely** manner. The MHP shall use personnel not involved in the initial denial decision to respond to the provider's appeal.

**Provider Appeals - Claims Payment**
Providers who receive payment from the state's fiscal intermediary, currently Electronic Data Systems (EDS), may file an appeal concerning the processing or payment of its claim directly to the fiscal intermediary.

Providers who receive payment from the MHP may file an appeal concerning the processing or payment of its claim directly to the MHP.

The MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short-Doyle/Medi-Cal system to the Department of Mental Health.

*Requirements for provider appeals for emergency services will remain unchanged.
**Statewide requirements for timeliness may be established in the regulations.

ATTACHMENT 6

Statewide
Provider Selection Criteria

**All Providers**

- Meet MHP requirements
- Maintain a safe facility
- Provide information to verify
- Store and dispense medications according to state and federal requirements
- Maintain client records that meet state and federal requirements
- Comply with the Quality Management standards of the MHP
- Is a provider in good standing with the Medicaid program

**Practitioner Providers**

- Practitioners are licensed to practice psychotherapy independently

**Organizational Providers**

- Have accounting/fiscal practices that meet the standards of DMH
- Have a head of service that meets Title 9 requirements

**Hospitals**

- Licensed as a hospital

**Nursing Facilities**

- Licensed as a nursing facility
- Certified as a special treatment program (STP).

Attachment 7

Glossary

**Organizational Provider** - These providers were formerly called clinics. They are able to provide the full range of rehabilitative and case management services by licensed and other mental health staff.

**Practitioner Provider** - These practitioners must be licensed to practice psychotherapy independently. They may be practicing independently or in a group. These providers may not bill for services provided support staff who are not licensed to practice independently. (An MHP may opt to have a clinic function under practitioner provider requirements when all individuals providing services meet these qualifications.)

**Urgent Condition** - These practitioners must be licensed to practice psychotherapy independently. They may be practicing independently or in a group. These providers may not bill for services provided support staff who are not licensed to practice independently.