County of Orange
Behavioral Health Services
Mental Health Plan and Drug Medi-Cal-Organized Delivery System
Quality Assessment and Performance Improvement Program
Work Plan Fiscal Year 2019/20
Updated July 2019

The Behavioral Health Services (BHS) Quality Assessment and Performance Improvement (QAPI) Program consists of four parts: The Quality Management (QM) Plan, the Quality Assurance (QA) Plan, the Utilization Management (UM) Plan and Clinical Records Review, and the Quality Improvement (QI) Work Plan. All parts apply to the County's Mental Health Plan (MHP) and to Drug Medi-Cal-Organized Delivery System (DMC-ODS). Because the definitions of these types of activities vary between organizations and, to some degree, even between persons within an organization, these separate sections should be viewed as a whole.

The Director of Authority and Quality Improvement Services coordinates the formal Quality Assessment and Performance Improvement Program. The plan is reviewed, monitored and updated with input from the Community Quality Improvement Committee (CQIC) which includes stakeholders as required by the MHP and DMC-ODS contracts. This includes but is not limited to practitioners, providers, beneficiaries and family members. The Quality Assessment and Performance Improvement Program is fairly broad and high level by design. More specific activities are documented on the Quality Assessment and Performance Improvement Plan Summary and these two documents should be considered together to understand the Quality Management Program. The development of the Quality Assessment and Performance Improvement Plan Summary is also developed with extensive input from the CQIC including practitioners, providers, beneficiaries and family members.

Each year the QAPI Program is reviewed and evaluated. The review includes a discussion of evidence that QAPI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service. The annual evaluation is reviewed and discussed in the CQIC.

Quality Management Work Plan

A. Ensuring continuity and coordination of care with physical health care providers

The Memorandum of Understanding (MOU) with any physical health care plan shall be reviewed periodically to assess the effectiveness of that MOU. The MOU with CalOptima was revised in October of 2017. Policies and procedures to establish a process for ongoing coordination of services for beneficiaries between CalOptima and BHS were updated in April of 2019. BHS staff continue to participate on the CalOptima Quality Improvement Committee.

B. Ensuring continuity and coordination of care for Medi-Cal beneficiaries receiving mental health services from the MHP and substance abuse treatment from the DMC-ODS

Pursuant to Title 42 of the Code of Federal Regulations, part 438.62 and the Mental Health Parity and Addiction Equity Act of 2008, eligible Medi-Cal beneficiaries who meet medical necessity to receive **specialty mental health services** have the right to request continuity of care from out of network or terminated providers with whom they have a pre-existing relationship for a period of up to 12 months, under certain conditions. The MHP has begun a process for responding to beneficiary requests for service continuity. This includes a system for requests to be made and for decisions to be rendered, beneficiary informing and required reporting of out of network requests and decisions, within the quarterly network adequacy submission. This implementation will continue to mature and be monitored during this fiscal year to ensure any necessary process changes are made.

Pursuant to 42 CFR 438.62(b), the **DMC-ODS** has begun developing a system for responding to beneficiary request for continued access to services during the transition from one DMC-ODS county to another DMC-ODS county when, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. This includes a system for requests to be made and for decisions to be rendered, beneficiary informing and required reporting of out of network requests and decisions, within the quarterly grievance/appeals log submission. Additionally, in accordance with 42 CFR Section 438.206, if the DMC-ODS is unable to provide necessary services to a beneficiary within its network, the plan will cover and arrange for these services out of network for as long as the county is unable to provide them in network. The implementation of these systems will continue to mature and be monitored during this fiscal year to ensure any necessary process changes are made.

C. Monitoring Medication Practices

In order to monitor the safety and effectiveness of medication practices, monitoring activities will be conducted and reported at least annually. The Associate Medical Director for Adult and Older Adult Behavioral Health Services and the Associate Medical Director for Children, Youth and Prevention Behavioral Health Services shall be responsible for the oversight and management of the monitoring and reporting activities. Annual reports shall be completed by approximately three months after the end of the fiscal year and shall cover the prior fiscal year. As specified in the Quality Improvement Section of this plan, the results shall be reported to and discussed in the Community Quality Improvement Committee (CQIC).

D. Monitoring of beneficiary satisfaction through evaluation of grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review.

1) Beneficiary Grievance

Grievances will continue to be monitored quarterly. Data will be collected from the BHS Divisions by Authority and Quality Improvement Services (AQIS) and will include at least the following items: 1) The number of grievances 2) The types of issues leading to grievances 3) Any grievances or fair hearings that may reflect access or other systems issues. Each grievance received by providers will be forwarded to AQIS and will be logged and submitted to DHCS as required in aggregate form. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee at least annually for review, discussion and recommendations for correction.

2) Beneficiary Appeals and Expedited Appeals

Appeals will continue to be monitored quarterly. Data collected from the BHS Divisions by AQIS will include at least the following items: 1) The number of appeals, 2) The types of issues leading to appeals 3) Any appeals that may reflect access or other systems issues. Each appeal received by providers will be forwarded to AQIS. Appeals will be processed by AQIS clinical staff resolution notices will be issued as required. Appeals will be logged and data submitted to DHCS as required in aggregate form. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee at least annually for review, discussion and recommendations for correction.

3) Fair Hearings and Expedited Fair Hearings

Fair hearings will continue to be monitored quarterly. Data collected from the BHS Divisions by AQIS will include at least the following items: 1) The number of fair hearings, 2) The types of issues leading to fair hearings and 3) Any fair hearings that may reflect access or other systems issues. Fair Hearing responses will be processed by AQIS clinical staff and submitted to DHCS as required. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee at least annually for review, discussion and recommendations for correction.

4) Provider Appeals

During Fiscal Year 2018/19, the MHP implemented changes to the inpatient acute psychiatric Treatment Authorization Requests (TAR) process to comply with the parity requirements of Part 438 of the Code of Federal Regulations, which impacted provider appeals and the process by which they are evaluated. This implementation is described elsewhere in this section.

a) A report of appeals from the Administrative Services Organization (ASO) which manages the mental health network providers for BHS will be obtained quarterly. The provider appeal report will be reviewed and any unresolved or problematic cases will be reviewed and discussed in a quarterly joint management meeting with the ASO and BHS staff.

b) Drug Medi-Cal- Organized Delivery System (DMC-ODS) residential services submit Treatment Referral and Authorization Forms (TRAF) for approval to the DMC-ODS Residential Placement Coordinator (RPC). The DMC-ODS RPC submits to AQIS a quarterly report of: 1) The number of TRAF, 2) The outcome of the TRAF (approved, reduced or denied) 3) the number of NOABD issued and 4) The number of TRAF appeals. AQIS will evaluate and process residential authorization appeals and will maintain a database of 1) The number of TRAF denials appealed by providers, 2) The outcome of TRAF appeals, 3) The number of State Fair Hearing requests to appeal TRAF denials and 4) The results of TRAF State Fair Hearings. This data will be presented to the Community Quality Improvement Committee at least annually for review, discussion and recommendations for improvement.

5) Clinical Records Review

Clinical records reviews occur at several levels. For detailed plans, see Documentation Audits under the Quality Assurance Plan.

E. Monitoring efforts for previously identified issues

When appropriate, the Quality Management Program follows up on previously identified issues. Specific items falling into this category each year are noted in the Quality Management Plan Summary. Two items have been repeatedly in the Quality Management Plan Summary and are therefore called out here. They are:

1) Linkage to Physical Health Care:

The CQIC identified as an area for improvement the linkage of seriously and persistently mentally ill (SPMI) adults receiving services through the MHP to physical health care providers. This grew out of a review of charts indicating that evidence of linkage was only infrequently documented. Over several successive years, processes were put in place that resulted in a significant improvement in this area. Monitoring and improvement efforts in this area continue. Ongoing review of performance in this area will continue. See the QI Work Plan sections on Linkage to Physical Healthcare and Performance Improvement Projects for details.

2) Welcoming Services:

Several years ago the CQIC identified the need to improve the welcoming atmosphere in clinics. A Policy and Procedure (P&P) was developed to encourage improvement in this area. This continues to be an area for follow up. See the QI Work Plan section on Welcoming Drop-In Visits for details.

3) For the DMC-ODS, a previously identified issue in the system of care is errors and late submission into the California Outcome Measurement System (CalOMS).

Since 2016, a plan for correction has been in place to reduce errors and late entries by holding monthly meetings to review error rates and to develop plans for correction, such as increased training or reallocation of staff time. The plan was effective in reducing the error and late submission rates that existed prior to 2016. However, the system of care continued to occasionally fall below the 95% compliance rate set by the regulations.

Additionally, with the implementation of the DMC-ODS and transition of providers' data which were previously contracted with DHCS directly, the system experienced a significant increase in CalOMS data late submissions and errors lst fiscal year. In the upcoming FY, the plan will continue to work with providers to reduce these errors and to bring all submissions up to date.

The CalOMS requirement will continue to be addressed in the monthly Quality Improvement coordinators meetings and plans for correction will continue to be developed to ensure that the system's overall compliance rate remains at 95% or above.

F. Implementation of Managed Care Regulations in Part 438 of the Code of Federal Regulations

During Fiscal year 2019/20, the MHP and the ODS health plans will continue to implement and stabilize the following Medicaid Managed Care and parity rules in 438 of the Code of Federal Regulations released by the Center for Medicare and Medicaid (CMS) through the Department of Health Care Services (DHCS).

1) Credentialing

The MHP and DMC-ODS will continue to develop a system for credentialing and re-credentialing all network providers, pursuant to Part 438.214. The health plans will continue to work with key stakeholders to ensure an adequate process is established and implemented. As of July 2018, a workgroup was established to develop a process for delegating the plans' authority to perform credentialing reviews to a professional credentialing verification organization (CVO). A CVO was identified for delegation and they system will be implemented during FY 2019/20. The Plans will remain responsible for the completeness and accuracy of Credentialing activities by establishing a formal and detailed agreement with the entity performing those activities.

2) System of Grievances and Appeals

In Fiscal Year 2017/18, the MHP and the ODS revised required beneficiary informing materials, including the new Notice of Adverse Benefit Determination (NOABD) released by DHCS in compliance with the parity Rule in the Federal Register (81.Fed.Reg. 18390) and 42 CFR Part 438.402 of the Code of Federal Regulations. During Fiscal Year 2018/19, the MHP and the ODS implemented the revised Grievances and Appeals system required under the rule. During FY

2019/20, the Plans will continue to offer training to network providers and administrators and will improve data tracking processes that will be used for reporting system adequacy.

3) Authorization of Specialty Mental Health Services

In Fiscal Year 2018/19, the Mental Health Plan (MHP) evaluated and implemented a process for complying with the Medicaid Managed Care regulations in Part 438 of the Code of Federal Regulations and Parity rule. A work group was convened to determine whether a Specialty Mental Health Service (SMHS) requires authorizations and when services may be authorized, modified or denied.

A revised system for concurrent authorization for inpatient admissions was implemented to ensure the appropriateness of inpatient admission and to determine the level of care and length of stay based on medical necessity. The new system has an impact on Treatment Authorization Requests (TAR) decisions and provider denials, which is expected to result in fewer provider appeals for retrospective denials of services.

The MHP will initially utilize referral for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS) as initial authorization for services within established length of stay parameters. The plan will reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services. Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating provider within 24 hours of the decision. During this fiscal year, ongoing evaluation will continue to make any necessary system changes in response to this initial implementation.

During this Fiscal Year, the plan will finalize the implementation of an authorization process for intensive home based services, day treatment intensive, day rehabilitation, therapeutic behavioral services and therapeutic foster care, as required by the Final and Parity rules.

The Outpatient Specialty Mental Health Services (SMHS) authorization processes will also be evaluated to implement a system of authorizations as required by the rule. As of July 2018, the MHP convened a work group to evaluate this process, and prior authorization for outpatient services is not required. During FY 2019/20, this system will continue and the plan will finalize appropriate policies regarding prior authorization of outpatient services.

This fiscal year, all applicable policies and procedures will be updated to reflect these authorization requirements, including the procedures for conducting retrospective authorization for specialty mental health services when appropriate.

4) The MHPs will submit its written policies and procedures, addressing SMHS authorization requirements to DHCS via email by August 1, 2019.Network Adequacy certification process

During fiscal year 2018/19, the MHP made the required quarterly submissions of its network adequacy certification as required by Title 42 of the Code of Federal Regulations, Part 438.68, Part 438.207 and Assembly Bill (205). The DMC-ODS made its first required annual submission of its network adequacy certification as required. In Fiscal Year 2019/20, the MHP will continue to make quarterly submissions of network adequacy certifications as required by the rule and will evaluate its network to determine if alternative access standards are warranted. Plans of correction will be developed and implemented as needed. Additionally, the ODS will continue to make its required annual submission of network adequacy certification. The ODS will evaluate its network on a regular basis to determine if alternative access standards are warranted. Plans of correction will be developed and implemented as needed.

G. Implementation Short Term Residential Therapeutic Programs (STRTP) and Children's Crisis Residential Programs (CCRP) standards and Medi-Cal certifications

During Fiscal Year 2018/19, the MHP began the process of developing a system for implementation and during Fiscal Year 2019/20 will continue to implement the Quality Management programs for STRTP as required by Assembly Bill 1997. The MHP will continue to implement a Grievances and Appeals system and Utilization Management for the STRTP and will evaluate if delegation for approval for STRTP will be requested from DHCS.

Additionally, consistent with California Code of Regulations, Title 9, Sections 1810.435 and 1810.436, the MHP is responsible for processing Medi-Cal provider selection and certification of its contract providers, including CCRPs. The MHP will certify CCRPs to participate in Medi-Cal pursuant to the same process used for other organizational providers, which includes an initial onsite review and triennial onsite reviews. As of July 2019, no providers have expressed interest in certification as CCRP in the County. If an application is received during the fiscal year, the plan will follow the process as described above.

H. Implementation of the Pediatric Symptom Checklist-35 (PSC-35) and Child And Adolescent Needs and Strengths (CANS) tool

DHCS has selected the Pediatric Symptom Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS) tools to measure child and youth functioning, as intended by Welfare and Institutions Code Section 14707.5. The age ranges for the PSC-35 are for children/youth 4-18 and the age range for the CANS is for children/youth 6-20. During this Fiscal Year, AQIS will continue to implement the Quality Management program and activities for the CANS as required DCHS, including the required monthly data submissions. Support activities include capacity building and training of staff, quality management and outcomes measurement.

I. Implementation of Presumptive Transfer of Medi-Cal eligibility for foster youth placed outside of the county

During Fiscal Year 2018/19, the MHP implemented the presumptive transfer system. During Fiscal Year 2019/20, the plan will continue to implement the Quality Management programs required for the implementation of Presumptive Transfer activities as required by Assembly Bill 1299. AQIS will continue to work with MHP designated staff to ensure the prompt transfer of the responsibility for the provision of, or arranging and payment for SMHS from the County to the County where the child resides.

J. Implementation of Therapeutic Foster Homes (TFC)

In December 2011, the State of California entered into a settlement agreement of the class action lawsuit *Katie A. v. Bona.* One aspect of these settlement activities includes the development of a TFC service model as a way of delivering Specialty Mental Health Services (SMHS) to children and youth. The implementation activities of the TFC model will continue during this fiscal year. AQIS staff will continue to implement the Quality Management programs for TFC as required by law. This includes the establishment of Medi-Cal certification standards and capacity building to ensure compliant billing by TFC parents and LPHA who provide services under the TFC.

H. MHP Triennial review

During this Fiscal Year, the MHP will prepare for its Triennial review under the California Code of Regulations, Title 9, Chapter 11, Section 1810.380, scheduled for November 2019. Preparation will include the required preliminary desk review submissions and any necessary system changes in response to the updated review protocol.

Quality Assurance Plan

In order to support understanding of and compliance with established documentation standards, a number of Quality Assurance (QA) activities will be conducted. These include activities to inform providers of the standards and activities to monitor performance of providers in regards to these standards. Standards will include those required to support claims for Specialty Mental Health Services, Drug Medi-Cal-Organized Delivery System, as well as other providers. Standards include those detailed in the contracts with the Department of Health Care Services (DHCS) for the provision of Specialty Mental Health Services and for the provision of substance use disorder services under the Drug Medi-Cal-Organized Delivery System.

A. Documentation Manuals

1) A documentation manual for specialty mental health plan services will be maintained by Authority and Quality Improvement Services (AQIS). This manual will address specific documentation requirements, including content as well as timelines. Behavioral Health Services has a wide array of programs and some programs may have specific variances from the standard requirements. The manual will be updated as needed.

2) A documentation manual for DMC-ODS services will be maintained by Authority and Quality Improvement Services (AQIS). This manual will address specific documentation requirements, including content as well as timelines. Behavioral Health Services has a wide array of programs and some programs may have specific variances from the standard requirements. The manual will be updated as needed.

B. Annual Provider Training

Service providers are required to take an annual training that includes multiple topics. One of these topics is appropriate documentation of services under the Mental Health Plan and under Drug Medi-Cal-ODS. Training includes examples of acceptable and unacceptable documentation; issues that have been identified by audit/review staff or others as needing improvement during the prior year; reminders of the ways in which staff may obtain guidance for their documentation questions; and other general documentation issues. There are several versions of this training, so that each provider may take the one that most closely matches his/her work assignment. It is a contract requirement for both MHP and DMC-ODS providers that their staff complete this training at least annually.

C. New Provider Training

- AOABH: County service providers receive a variety of trainings within a short time after starting employment. For staff starting with Adult and Older Adult Behavioral Health Services (AOABH), one of these trainings is a two-part training referred to as the New Provider Training. The first part is the Initial Clinician Coding and Documentation Training. This is a 6-8 hour training reviewing documentation standards and expectations as well as the coding of services that ensures proper billing. The second part is a 4-hour training on the development of care plans. This includes training on proper documentation and on development of recovery oriented plans. The second part is available not only to new providers, but is also available as a refresher for staff who express interest or who are requested by their supervisor to attend.

- CYPBH: For staff starting with Children and Youth Behavioral Health (CYBH), a four-hour on line training is required. This training is updated annually and includes documentation training as well as issues related to billing and compliance of the services documented. It includes multiple examples of acceptable and unacceptable documentation.

- For county and contract operated staff starting within a SUD program in any BHS division providing services under DMC-ODS, a tow (2) day in person training is required to review documentation standards and coding services for proper billing. Training is also provided on developing appropriate care plans and determining appropriate level of care placement, utilizing placement criteria from the American Society of Addiction Medicine (ASAM). A one (1) day documentation training is also available as a refresher for staff who have already completed the 2 day training and for staff who have completed training on the criteria of the American Society of Addiction Medicine (ASAM), modules I and II.

Documentation Audits

Periodic review of documentation for both MHP and DMC-ODS will be conducted by AQIS for services provided by both County-operated clinics and those operated by contracted organizations. These reviews will include elements of QI, QA and UM. Services will be reviewed for compliance with documentation standards, for issues of quality of care, and for both over-utilization and under-utilization of services. See the

section Utilization Management Program and Clinical Records Review, section for details.

When documentation at a County-operated clinic is not sufficient to support claims submitted and paid, the provider(s) will be required to correct where possible and if not possible, they will be required to credit back the service to the payor. When documentation at a contract-operated clinic is not sufficient to support claims submitted and paid, it will be recommended to the provider(s) to correct where possible and if not possible, they will be required to credit back the service to the payor.

D. Audit Team Inter-rater Consistency Training

Those staff participating in documentation audits/reviews, both for the MHP and for DMC-ODS, will attend regularly scheduled meetings which include review and discussion of examples of both acceptable and unacceptable documentation.

In addition, at least annually, a formal exercise will be held in which the explicit focus is reviewing of records and developing of concurrence among the audit/review staff regarding the interpretation of standards to be applied during audits/reviews. A write up of this activity will be maintained and included in the annual review of the quality management program, in addition to possibly being presented to the CQIC.

E. Contract QA Training

Contracted providers under the MHP develop their own mechanisms for documentation review and training of their providers. To facilitate this process, AQIS has developed a formal "certification" program for those AOABH contract staff whom the contracted provider assigns responsibility for oversight of their documentation. This includes attendance at several trainings and a review by AQIS of a packet of items that the "applicant" submits as acceptable. Additionally, a monthly meeting, known as "Core Trainers" meeting is held with contracted and county operated programs to review quality items. During this meeting documentation issues are one of the routine topics.

For children's services, the AQIS CYBH Quality and Review Team (QRT) manager conducts a monthly meeting with each contract provider organization. During this meeting documentation issues are one of the routine topics. In addition, the AQIS CYBH QRT manager meets monthly with all contract consultants who monitor the contract provider organizations to discuss documentation and other issues to ensure consistency. Also, a CYBH manager meets quarterly with a group of all contract provider organizations and this meeting is attended by the AQIS CYBH QRT manager

to address any questions that might come up around documentation or other compliance related issues.

For SUD programs, under DMC-ODS, each CYBH and AOABH contracted provider is contractually required to assign responsibility for oversight of their documentation to a designated Q/I staff. The assigned responsible contract staff person must complete the Annual Provider Training and attend at least one in-person training by AQIS SUD Support team staff. Additional documentation training will occur within a monthly Q/I coordinators' provider meeting led by AQIS. A segment of this meeting is dedicated to discussion and review of documentation issues. This practice is intended to develop consistency and to provide a forum for questions related to documentation. An additional opportunity for training occurs by routine contact with County Contract Monitors who also participate in trainings.

Utilization Management Program and Clinical Records Review

The Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries receiving services under the MHP and DMC-ODS. Clinical records reviews are conducted by licensed behavioral health professionals and trained staff.

A. Clinical Records Review – MHP Services in CYBH

All County clinics are subject to internal sampling reviews by AQIS at a minimum twice per year. At least 80 paid claims are selected and reviewed by the Audit Team to ensure appropriate billing and to ensure the documentation for the claims meets County, State and Federal documentation standards. The selection of claims is based on the following criteria: high cost paid claims (of 200 dollars or more) and paid claims which appear to be duplicates. The Audit Team is composed of licensed mental health professionals. Feedback is provided to the Supervisor of the unit reviewed and follow up is conducted to ensure that the non-compliant services have been appropriately repaid. All Contract clinics are subject to sampling reviews by AQIS at least annually, and if the error rate is greater than 5% the next review is conducted within six months. Follow ups are conducted to ensure all required modifications or recoupments are complete. Results of these utilization reviews will be reported to DHCS annually following DHCS guidance for the reporting.
In addition, Contract Clinics are subject to internal reviews by Contract Consultants on a quarterly basis if their prior reviews had an error rate of greater than 5%. Contract Consultants may be from AQIS – CYBH QRT or directly from CYBH. These groups are coordinated through AQIS – CYBH QRT to ensure consistency of the process. At least 10 paid claims per clinic are selected to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. The selection of claims is based on the following criteria: high cost paid claims (of 200 dollars or more) and paid claims which appear to be duplicates. The Contract Consultants are licensed mental health professionals. This review follows the same protocol as the review described above. Feedback is provided to the Supervisor of the unit reviewed and follow up is conducted to ensure that the non-compliant services have been appropriately repaid.

B. Clinical Records Review – MHP services in AOABH

All County and contracted clinics providing treatment services are subject to internal sampling reviews by AQIS at least twice annually. There will be some variations in procedures to adapt to varying program designs and needs, but in general, the procedure will be as follows. At least 40 paid claims are selected and

reviewed by the Audit Team to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. In addition, the supervisors/managers may request that additional items be included in the review for a variety of management and quality review reasons. A paid claims report is run for a designated audit period, usually about 6 months prior to the review. Ten charts are randomly selected and for those ten clients all paid claims within the designated audit month are reviewed. Occasionally there will be a business need for the review to look at services more recent than 6 months past. In these cases the review will be of charges entered into the billing system as billable, regardless of whether or not they have yet been paid. Formal reports of each audit will be prepared by AQIS. For contracted clinics, the report will go to the supervisor/manager providing oversight to that contractor, who will arrange to discuss the findings with the contract administration and QI staff. For County operated clinics the reports will go to the Program Manager and Division Manager. The Audit Team is composed of licensed mental health professionals and trained mental health specialists. Feedback is provided to the supervisors/managers/contract monitors of the unit reviewed for follow up. Follow ups are conducted to ensure that corrections and recoupments for non-compliant services are completed. Results of these utilization reviews will be reported to DHCS annually following DHCS guidance for the reporting.

C. Clinical Records Review – DMC-ODS services in CYBH and AOABH

County and contracted service providers will be subject to periodic internal sampling reviews at least twice per year.

For County clinics, services will be reviewed biannually. Decisions on sampling may be modified for the DMC-ODS depending of system needs, but will use criteria such as the selection of claims will based on the following criteria: high cost paid claims (of 200 dollars or more), claims that show higher than usual times claimed and paid claims which appear to be duplicates. At least 30 paid claims will be selected and reviewed by the QI Team to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. Feedback will be provided to the Supervisor and Program Manager of the unit reviewed and follow up will conducted to ensure that any non-compliant services have been appropriately repaid, as necessary.

All Contract clinics will be subject to sampling reviews by AQIS at least bi-annually, and if the error rate is greater than 5% the next review will conducted within three months. Sampling will follow the same process described above. The report of findings will go to the supervisor and manager providing oversight to that contractor during technical assistance meetings with provider staff to discuss

their review findings and corrective actions required. Follow up will be conducted to ensure all required modifications or recoupments are complete.

D. A service verification process shall be in place to ensure that services claimed to Medi-Cal did occur.

A sampling of claimable services will be selected each month. A mailer will be sent to the beneficiary/parent/guardian offering an opportunity for the beneficiary/parent/guardian to contact BHS if the service did not occur and to provide some satisfaction information if the service did occur.

E. Utilization Review (UR) under DMC-ODS

A process for implementing and capturing utilization review activities, under the DMC-ODS waiver will continue to mature during this Fiscal Year. Utilization review activities include: determination of medical necessity; quality standards; training activities related to monitoring DMC-ODS program integrity; clinical training activities; quality improvement committee activities; administrative time related to QA; clinical QA activities; EQRO and State audit time; medication monitoring UR; training of skilled professionals; information management staff time related QA activities and County QA/UR plan development.

F. The Utilization Management Program shall be responsible for assuring that beneficiaries have appropriate access to Specialty Mental Health Services and DMC-ODS services.

This shall include assessment of 1) responsiveness of the 24/7 toll free telephone number, 2) timeliness of scheduling routine appointments, 3) timeliness for scheduling SMHS and DMC-ODS appointments to meet Federal access standards, 4) timeliness of services for urgent conditions, 5) access to after-hours care, 6) implementation of MHP Client Services Information (CSI) submissions and 7) accessibility to DMC-ODS services at the appropriate levels of care (LOC). These standards are described below.

1) <u>Responsiveness of the 24/7 toll free telephone number</u>

BHS utilizes an Administrative Services Organization (ASO) to maintain its 24/7 access line for both the MHP and the DMC-ODS, also known as the Beneficiary Access Line (BAL). The target for responsiveness of this line is that the ASO will answer at least 95% of telephone calls within 30-seconds. In addition, test calls will be made to the ASO quarterly. The percentage of calls appropriately connected

to a live person speaking the caller's language will be captured and reported for discussion and suggestions for improvement at the QI meeting with the ASO.

2) Timeliness of scheduling routine appointments

Access is monitored by use of an access log at all points of access. This log captures the date of the initial request for Specialty Mental Health Services by Medi-Cal members, as well as the date of the offered appointment. The BHS access standard is for the date of the offered appointment for routine requests to be no more than 10 business days from the date of the request. However, BHS strives to offer appointments for routine requests even sooner. B

For DMC-ODS access is monitored by use of an access log at all points of access. The log captures the date of the initial request for services by Medi-Cal members, as well as, the date of the offered appointment. For outpatient services the access standard is that the offered appointment be no more than 10 business days from the date of the request. For Narcotic Treatment Programs, the standard is for appointments to be offered within 3 days.

3) Timeliness for scheduling SMHS and DMC-ODS services to meet Federal access standards

As required by the Medicaid Managed Care rules in Part 438.68 of the Code of Federal Regulations, access is monitored for required services as follows. For MHP services: for psychiatry appointments, within 15 business day of the request and for mental health services, targeted case management, crisis intervention and medication support services, within 10 business days of the date of request. For DMC-ODS services: for outpatient service appointments, within 10 business days of the request and for Opioid Treatment Programs (OTP) access, within 3 days of the request. Additionally, access to services within 15 miles or 30 minutes from the beneficiary's places of residence. Both the MHP and the DMC-ODS maintain logs to capture access to services. These logs will be utilized to ensure compliance with access standards and to offer corrective action recommendations if standards are not met.

4) Timeliness of services for urgent conditions

Access is monitored by use of an access log at all points of access. This log captures the date of the initial request for specialty mental health services by Medi-Cal members, as well as the date/time of the offered appointment. The BHS access standard for urgent conditions is for the offered appointment to be within 24 hours of the request. Within each Division the target is that at least 90% of clients requiring services for an urgent condition will be offered an appointment within 24 hours of contact.

For DMC-ODS, timelines for urgent conditions is defined as a request for access to clinically managed withdrawal services, and the timeframe to offer assessment of the appropriateness for these services is three days.

5) Access to After-Hours Care

Access to after-hours care through the ASO is monitored during joint ASO-County management meetings. After hours care is also available through the Crisis Stabilization Unit (CSU) and the Crisis Assessment Team (CAT) teams.

6) Monitoring of MHP timely access standards and implementation of Client Services Information (CSI) submissions

Pursuant to the MHP Special Terms and Conditions (STC) and the MediCaid Managed Care final rule, the plan will implement a system to comply with the assessment records data submission requirements through the Behavioral Health Information Services, Client Services Information (BHIS-CSI) System to answer whether the plan provides timely access to appointments, assessment and treatment.

7) Accessibility to DMC-ODS services at the appropriate level of care

The Plan will ensure that beneficiaries have appropriate access to SUD services, medical necessity has been established, the beneficiary is in the appropriate ASAM LOC, and that the interventions are appropriate for the diagnosis and LOC. This includes a system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS

service at the appropriate ASAM LOC following initial request or referral for all DMC-ODS services. Information from ASAM criteria-based screenings and assessments will be reported to DHCS as required.

Additionally, the plan will implement strategies to reduce preventable hospitalizations of beneficiaries. The plan will consider utilizing the data from the DMC-ODS clinical PIP to establish various strategies. One objective of the clinical PIP is to improve treatment outcomes by addressing PTSD symptoms amongst beneficiaries. It is expected that this strategy will result in better treatment results and fewer hospitalizations and incidents of relapse.

G. Implementing mechanisms to assure that authorization decision standards are met and to facilitate access to care

Access to specialty mental health services requires authorization for access to the Network providers (pre-authorization of both initial and follow up requests) through the Administrative Services Organization (ASO), for some specialized services and for inpatient payment (concurrent review and authorization). During this Fiscal Year, a comprehensive SMHS authorizations system will be finalized an implemented in accordance with the MediCaid Managed Care and Parity Rules. More information about this system can be found in the section describing implementation of Managed Care requirements elsewhere in this document.

Access to DMC-ODS services requires authorizations only for residential treatment services (initial authorization for up to 90 days and one subsequent reauthorization for 30 days for adults and initial authorization of 30 days and one subsequent reauthorization for 30 days for adolescents). An additional authorization process exists for clinically and medically managed withdrawal services.

1) Written policies and procedures (P&Ps) for processing requests for initial and continuing authorizations of services.

    a. The Inpatient unit provides concurrent consultation and reviews for payment. Pre-authorization and continuing authorization were not previously required. During the previous Fiscal Year new policies and procedures were develop to comply with the Medicaid Managed Care regulations in Part 438 of the Code of Federal Regulations and Parity rule, which requires concurrent authorization. During this Fiscal Year, this process will continue

to be implemented and mature. Additional P&P will be finalized outlining the authorization process for other SMHS services.

b. The ASO maintains P&Ps regarding initial and continuing authorizations of services.

c. The DMC-ODS RPC follows the SUD Residential Treatment Authorization and Re-authorization P&P, in accordance with the approved State/County contract and County implementation plan.

2) Mechanisms to ensure consistent application of review criteria for authorization decisions

a. At least annually, the inpatient authorization unit shall conduct a formal exercise to increase the consistency of review criteria for inpatient payment authorizations. This report shall be reviewed in the Community Quality Improvement Committee.

b. At the ASO an Inter-Rater Reliability assessment is conducted annually to monitor reliability and validity between clinicians and with the standard. The tool is administered to all utilization review clinicians.

c. The SUD residential services manager for DMC-ODS will be responsible for creating appropriate P&Ps and implementing practices at least annually to ensure residential treatment authorization criteria consistency, in accordance with ASAM and the approved County plan.

3) Decisions to deny service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

a. Responsibility for ensuring that staff on the inpatient unit have the appropriate training to make these decisions rests with the inpatient Program Manager. The Program Manager reviews the staffing list and has involvement in hiring decisions for that unit. Procedures for authorization decisions made regarding other

specialized SMHS will continue to be develop and will include identifying personnel with the appropriate clinical expertise who will have responsibility for these decisions.

b. The ASO conducts an Inter-Rater Reliability assessment annually to monitor reliability and validity between clinicians and with the standard. The tool is administered to all utilization review clinicians.

c. Responsibility for ensuring that Residential Placement Coordinator (RPC) staff have the appropriate training to make these decisions rests with the Residential Services Program Manager. The Program Manager reviews the staffing list and has involvement in hiring decisions for that unit.

4) Decisions are made within the required timelines and Notices of Adverse Benefit Determination (NOABD) related to these decisions must be provided within the required timeframes.

a. The ASO maintains policies and procedures that address timelines for authorization decisions and NOABDs. Timeline compliance is also monitored and reported quarterly.

b. For both the MHP and DMC-ODS, NOABD are generated initially by the treating staff. NOABD are reviewed and approved by each program's designated Q/I coordinator, program director or service chief. All NOABD are submitted to AQIS for logging and Q/A to ensure required timelines are met and notices are composed appropriately.

5) Mechanisms for assessing the capacity of service delivery for beneficiaries, including the number, type, and geographic distribution of mental health and SUD services within the BHS mental health delivery system.

Both the MHP and DMC-ODS participate in the required network adequacy certification process. As a result, databases are maintained that contain the entirety of each network's capacity. Additionally, the following processes are in place to manage and distribute services.

a. The CYBH MHP regional clinics:

i. Spreadsheets are maintained that monitor case assignments and type of health plan in order to distribute cases effectively to ensure compliance with mandate to serve specific populations.

ii. Health plan type and billing are input into IRIS and reports used to monitor services and expenditures to different mandated populations.

iii. Staff conduct supervisory review to monitor effectiveness of services provided and to monitor need for changes when service capacity may be over-extended.

iv. Monthly Direct Service Hours (DSH) reports are reviewed. These reports facilitate analysis of distribution of workload and allow meaningful assignment of cases to clinical staff.

v. Monthly meetings are held with contract providers to monitor the utilization of clinical staff and distribution of services to mandated populations.

vi. Monthly meetings are held with CYBH Service Chiefs to review workflow issues and clinic capacity to serve more clients.

b. The CYBH MHP Central Programs:

i. Referrals are generated by the agencies with which the client is already linked, primarily Probation and the Social Services Agency (SSA). There are periodic meetings with CYBH referral sources and service delivery problems are addressed at that time. Each agency has a policy for referral and an expectation of CYBH response time. Each service delivery site differs due to the nature of the clients they serve and the work that the service delivery site does. Agencies are required to let CYBH know when service delivery expectations are not met. CYBH addresses service delivery problems in a timely fashion, whether they stem from a one-time glitch or a need to

redistribute existing resources to meet the changing needs of the referral agencies.

ii. Monthly DSH reports are reviewed. These facilitate analysis of distribution of workload and allow meaningful assignment of cases to clinical staff.

iii. Monthly meetings are held with contract providers to monitor the utilization of clinical staff and distribution of services to mandated populations.

iv. Monthly meetings are held with CYBH Service Chiefs to review workflow issues and clinic capacity to serve more clients.

c. Drug Medi-Cal-Organized Delivery System for CYBH and AOABH

i. AQIS maintains responsibility to coordinate access to Substance use Disorder (SUD) services to Persons With Disabilities (PWD). The SUD support team manager is the designated County Access Coordinator (CAC). The AOABH Program Manager for Outpatient Operations is designated to conduct an annual assessment of the County's capacity to deliver services to this population and to maintain a strategic plan to do so. The County's plan includes estimates of the need for SUD services across the County, both by the general population and by PWD. An assessment of the County's access to SUD by PWD is conducted annually and reported at the CQIC. The annual assessment this Fiscal Year will occur in November of 2019.

ii. As the DMC-ODS continues to be implemented during this Fiscal Year, further assessment of capacity needs across the County will be evaluated to develop strategies to ensure proper access.

iii. The expected utilization of DMC-ODS services during the initial implementation year was 7556 beneficiaries. Several new providers were added to the network during last Fiscal

Year. There are still currently various Requests for Proposals (RFP) posted to the public to accommodate the expected increase in service need as the system matures.

Quality Improvement Work Plan

The goal of the quality improvement work plan is to monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. As part of the Quality Management program for both MHP and DMC-ODS, a Community Quality Improvement Committee has been in operation.

The Community Quality Improvement Committee (CQIC) consists of senior managers from across the Mental Health Plan and DMC-ODS, clients/beneficiaries and family members, community providers/contract organization providers and Mental Health Board and Alcohol and Drug Advisory Board (ADAB) Members. This committee recommends policy decisions; reviews and evaluates the results of QI activities, including performance improvement projects; institutes needed QI actions; ensures follow-up of QI processes; and documents QI Committee meeting minutes regarding decisions and actions taken.

The Community Quality Improvement Committee Advisory Group (CQIC-AG) is a working and study group of BHS clients and family members. This group provides an opportunity to engage clients/beneficiaries and family members in more depth than occurs at the CQIC. It was developed at the recommendation of the clients/family members on the CQIC several years ago. It allows for extended time for questions from members, special presentations to keep them informed, time to propose, consider and discuss recommendations for QI actions that the CQIC then takes under advisement for decisions.

During this Fiscal Year, it will be evaluated if the CQIC-AG can be combined with the existing Community Action Committee (CAC), which serves a similar purpose for Mental Health Services Act (MHSA) programs. The benefit of a combined advisory group would be a wider behavioral health services system perspective and greater community participation.

QI Activities

A. Reviewing of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review.

The monitoring activities related to these issues are described in the QM Work Plan. The results from that monitoring are presented to the Community Quality Improvement Committee at least annually for review, discussion and recommendations.

B. Performance Improvement Projects (PIPs) –

MHP - Children and Youth Behavioral Health Services (CYBH)

CYBH is conducting a multi-year Performance Improvement Project (PIP) with the goal of improving engagement rates for beneficiaries who have five (5) or more services in CYBH county-operated regional clinics. The goal is to improve retention rates at the CYBH county-operated regional clinics from 64.9% (FY17/18) to 80.0% by the end of Year 3 of the PIP.

Fiscal Year 2019/20 is the 2nd year of this project. As of the first year of the intervention, engagement rates improved to 68.4% in the first 6 months when measuring new episodes of care where five (5) billable services were provided. When measuring five (5) or more SMHS visits, the engagement rate improved from 72.7% to 77%. The rates also increased, from 71.2% to 75.5% when measuring five (5) or more visits during a new episode of care. This PIP will continue through the end of FY 2020/21.

MHP – Adult and Older Adult Behavioral Health (AOABH)

Step-Down Project: This project was implemented during last fiscal year with a focus on increasing rates of step-down to outpatient services following inpatient discharge among adult clients. Peers are utilized to provide support to clients during the transition from inpatient discharge to Recovery Open Access, which is a program that has been set up in part to assist clients with linkage to ongoing care following hospital discharge. The peers then continue to provide support to the clients once they are enrolled with Recovery Open Access through to linkage with ongoing outpatient care.

This first year of this project includes clients being discharged from Royale Santa Ana hospital. Some preliminary data has found that the intervention is effective; however, the number of beneficiaries who are offered the intervention has needed improvement. Several strategies have been implemented in an attempt to reach more beneficiaries who are eligible for the intervention. Over this and subsequent years of this project, lessons learned from implementing the intervention during the first year will continue to be used to modify the intervention, and any modifications will be implemented across other hospitals in the county. The expected project outcomes include increasing the percentage of clients who are discharged from the inpatient setting who then attend Recovery Open Access, and increasing the percentage of clients who link to ongoing outpatient services from Recovery Open Access.

It is also expected that this strategy will result in a decreased in re-hospitalization and intervention will be evaluated for future system wide implementation with the goal of reducing preventable hospitalizations.

DMC-ODS – Adult and Older Adult Behavioral Health (AOABH)

The DMC-ODS identified the problem of a 50% no show rate to scheduled appointments by beneficiaries at Adults/Older Adults Behavioral Health (AOABH) county operated outpatient clinics. As a non-clinical PIP, the system has begun the implementation of a motivational interviewing intervention to 1) decrease no-shows for intake/assessment; 2) decrease no shows for all scheduled appointments and 3) increase initiation and engagement for new clients as evidenced by a beneficiary attending four (4) appointments within six (6) weeks. This PIP is being implemented at AOABD County operated outpatient programs, starting with the Santa Ana and Aliso Viejo locations. Ongoing training and data tracking will continue during the fiscal year.

The system has also identified a 36% rate of co-occurrence of Post-Traumatic Stress Disorder (PTSD) symptoms among SUD clients in the AOABH outpatient clinics. The literature suggests that this is a significant risk factor for SUD participants discontinuing treatment and/or relapsing. As a clinical PIP, the "Seeking Safety" program has started to be implemented within the AOABH County operated outpatient programs with the objectives of 1) decreasing PTSD symptoms and 2) improving treatment completion rates for beneficiaries with co-occurring PTSD symptoms. The first site to implement the intervention will be the AOABH Westminster location. Ongoing training and data tracking will continue during the fiscal year.

C. Welcoming Policy Drop In Visits –

Members of the CQIC and CQIC-AG/CAC will continue to visit various clinics on a drop in basis. They fill out a short questionnaire on the facilities and whether they experienced a welcoming environment. This information is then reported to the CQIC and managers are asked to discuss and respond for QI opportunities. The results are also reviewed and discussed in the CQIC.

D. Linkage to physical health care –

The MHP and DMC-ODS will continue to review the chart documentation of clients in Adult Mental Health and Drug Medi-Cal, Organized Delivery Services to see if there is evidence of linkage to physical health care. The MHP and DMC-

ODS will engage in Interdisciplinary Care Team (ICT) meetings with the Managed Care Plan – Cal Optima (MCP). MHP and DMC-ODS staff will participate in coordination meetings with the MCP and on the MCP Quality Improvement Committee.

E. Consumer Perception Survey (CPS) data collection for MHP

Section 3530.40 of Title 9 of CCR requires that semi-annual surveys be conducted to collect data for reporting on the federally determined National Outcome Measures (NOMs). During this Fiscal Year, AQIS will coordinate the distribution and collection of all surveys for submission to DHCS as required.

F. Treatment Perception Surveys (TPS) for Drug Medi-Cal, Organized Delivery System –

Annual submission of client satisfaction survey data is required in the State/County Contract and the Code of Federal Regulations Title 42 §438.66. During this Fiscal Year, AQIS staff will coordinate the distribution and collection and submission of the TPS developed by the University of California, Los Angeles (UCLA) as part of the evaluation of the DMC-ODS Waiver demonstration required by the Centers of Medicaid and Medical (CMS). The TPS period will occur during October 7-11, 2019, for both for the youth version (ages 12-17) and for the adult version of the survey.