Contra Costa Behavioral Health Services

Contra Costa Mental Health Plan

Provider Manual

1340 Arnold Drive, Suite 200
Martinez, CA 94553

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APPENDICES

WELCOME

Welcome to Contra Costa Mental Health Plan (CCMHP), a part of Contra Costa Behavioral Health Services Division.

We hope that you will find the Provider Manual to be a useful resource. In this manual, you will find information regarding the types of services provided within the county, how to get started working with Contra Costa County beneficiaries, documentation requirements, and links to resources to provide further assistance.

This manual has been developed as a resource for Providers within the CCMHP. It seeks to ensure that Providers meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services. As with any manual, updates will need to be made as policies and regulations change.

We look forward to working with you to ensure the delivery of quality Specialty Mental Health Services to Contra Costa County Medi-Cal beneficiaries.

Contra Costa Behavioral Health Services (CCBHS)

The Behavioral Health Services Division of Contra Costa Health Services brings together Mental Health and Alcohol and Other Drugs into a single system of care. With increasing challenges in serving complex populations with multiple needs, this integration is a response to the growing desire to have improved consumer outcomes through a systems approach that emphasizes "any door is the right door," and that provides enhanced coordination and collaboration when caring for the "whole" individual.

Contra Costa Mental Health Plan (CCMHP)

As a result of the Medi-Cal Specialty Mental Health Services Consolidation Phase II that took effect in Contra Costa County on April 1, 1998, all non-hospital Specialty Mental Health Services are administered and provided through the Contra Costa Mental Health Plan (CCMHP). Medi-Cal beneficiaries previously seen in the Short-Doyle/Medi-Cal system and those previously seen in the Fee-for-Services Medi-Cal system are served by CCMHP.

OUR MISSION

The mission of Contra Costa Behavioral Health Services, in partnership with consumers, families, staff, and community-based agencies, is to provide welcoming, integrated services for mental health, substance abuse, homelessness and other needs that promotes wellness, recovery, and resiliency while respecting the complexity and diversity of the people we serve.

OUR VISION

Contra Costa Behavioral Health Services (CCBHS) envisions a system of care that supports independence, hope, and healthy lives by making accessible behavioral health services that are responsive, integrated, compassionate, and respectful.

CCBHS strives to create an effective, high quality integrated system to meet the needs of all residents of Contra Costa County. We work together with those individuals with psychiatric conditions to provide:

Hope supports all human beings in becoming their unique and best selves.

Recovery empowers individuals to manage their symptoms and reclaim meaningful lives and relationships.

Partnership brings consumers, family, friends, and mental health professionals together in the hope-filled journey of recovery.

CCBHS provides an array of opportunities for partners to work together in the spirit of hope toward recovery. This includes programs and services for children, adolescents, young adults, adults, and older adults of Contra Costa County.

GUIDING PRINCIPLES

CCMHP is guided by the following principles that affect the implementation of all levels of beneficiary services:

1. Services are provided to beneficiaries with respect, dignity and their right to privacy regardless of race, religion, education, sex, cultural background, physical or mental handicaps, or financial status.
2. Services focus on consumers' strengths and not weaknesses.
3. Services are provided in an appropriate, accessible, culturally sensitive manner with beneficiary rights to interpreter services.
4. Services are delivered in an organized, coordinated, and cost-effective approach to care and treatment.
5. Services are beneficiary-driven, family focused and achieve positive mental health outcomes for culturally diverse populations across all age groups.
6. Services are delivered through a comprehensive, community-based coordinated system of care when serving adults with serious and persistent mental illnesses and children and adolescents with serious emotional disturbances.
7. Services are delivered with emphasis on problem-focused treatment at all levels when conditions are less serious and less enduring.

8. Services are provided in a "user-friendly" system with easy access for beneficiaries, and a "seamless" interface with the physical health, Alcohol & Other Drugs and Homeless services.
9. Services are delivered in an accountable system to quality assurance, standards of access, timeliness, quality and effectiveness.

Important Contacts

BENEFICIARY REFERRAL

Behavioral Health Access Line
Beneficiary screenings for mental health, psychiatry, and AOD services, and information about other programs; Therapeutic Behavioral Services (TBS) Referrals
Phone: 1 (888) 678-7277

ADMINISTRATIVE ASSISTANCE

Quality Improvement Coordinator
Phone: (925) 957-5160

Provider Services Unit
Site Certification, Credentialing, Recredentialing, Informing Materials and Posters
Website: https://cchealth.org/mentalhealth/provider/
Credentialing Email: Provider.Services@cchealth.org
Recredentialing Email: BHRecredentialing@cchealth.org
ShareCare Access and Training Request Email (CBOs only): Provider.Services2@cchealth.org
Phone: (925) 608-6790

Medi-Cal Provider Telephone Service Center
Phone: (800) 541-5555

Help Desk / ShareCare Assistance
Phone: (925) 957-7272

FOR COUNTY OWNED AND OPERATED CLINICS AND COMMUNITY-BASED ORGANIZATIONS (CBOs)

Utilization Review (UR)
Website: https://cchealth.org/mentalhealth/clinical-documentation/
Phone: (925) 608-6760
Fax: (925) 608-6791

FEE-FOR-SERVICE PROVIDERS

Care Management Unit (CMU)

Website: https://cchealth.org/mentalhealth/network-provider
Email: CMUProvider.Services@cchealth.org (DO NOT EMAIL ANY PHI)
Phone: (925) 372-4400
Fax: (925) 372-4410

Provider Portal Support (Fee-for-Service Providers only)

Email: BHS.Support@cchealth.org
Phone: (925) 957-7272

EMERGENCY SERVICES

Psychiatric Emergency Services

Phone: (925) 646-2800

Mobile Crisis Response Team

Adult Phone: (833) 443-2672

Contra Costa Crisis Center

Phone: 1 (800) 833-2900

Mobile Response Team

Phone: (510) 317-1444

CHAPTER 1. Categories of CCMHP Participating Providers/Covered Services/Practice Guidelines

1.1 TYPES OF PROVIDERS

The system of care utilizes a wide variety of professionals in order to service the needs of our beneficiaries. Each provider will be allowed to provide certain mental health services based on their scope of practice. Each site and its specific contract will dictate what type of provider is employed in each setting. Below are types of providers found in the various settings within Contra Costa County.

1.2 COUNTY OWNED AND OPERATED CLINICS AND COMMUNITY-BASED ORGANIZATIONS (CBOs)

County Owned and Operated Clinics and CBOs certified by Contra Costa Mental Health Plan (CCMHP) and Department of Health Care Services (DHCS) to deliver Short-Doyle Medi-Cal specialty mental health services may be staffed by licensed, license-eligible mental health professionals, registered interns, trainees under supervision by licensed staff, and other staff as approved by the Mental Health Director or designee. Services provided at each site are determined by each site's Medi-Cal certification.

1.3 FEE-FOR-SERVICE PROVIDERS

Fee-For-Service providers can hold any of the following credentials: Psychiatrist, Psychologist, Clinical Social Worker, and Marriage and Family Therapist who are licensed for independent practice. The fee-for-service network is comprised of both individual and group practice providers. Fee-for-service providers contract directly with the Care Management Unit, and the types of services they provide is based on the individual's credentials and contract.

1.4 TYPES OF SERVICES PROVIDED

Contra Costa County beneficiaries have access to a myriad of treatment options within the system of care. Depending on the beneficiaries' treatment needs, geographic location and functional impairment, services may be provided in a county owned and operated clinic, one of the county's contracted clinic partners or at a private practice location. Below you will find lists for the populations served in Contra Costa and the treatments available to them.

Services for Children & Families

CCMHP operates regional clinics as well as contracts with community-based organizations to offer home, school, and community-based services to meet the varied needs of children, youth, and their families.

Services:

- Psychiatric and medication assessments, consultation, and medication management
- Individual, family, and group outpatient therapy
- Case management to coordinate services
- Family Partners, with lived experience caring for family members with serious mental illness, support families of participants and help them navigate services and resources
- Wraparound services for children with serious emotional disturbances that involves each family's social network
- Evidence-based practices that are supported by research to be effective treatments
- CCMHP has implemented the Pathways to Wellbeing (Katie A Settlement Agreement) to serve children and youth who are eligible for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) services, including those who have been identified as Katie A subclass members. CCMHP provides ICC, IHBS and TFC under the Core Practice Model (CPM) for beneficiaries under the age of 21 who are eligible for full scope Medi-Cal, when medically necessary.
- Presumptive Transfer and Service Authorization Request (SAR) authorized providing specialty mental health services to children and youth who are placed outside of their home county.

Other Children/Adolescent Services

- Psychological evaluations to aid with placement planning and treatment of children in the child welfare system who have been removed from the home due to abuse or neglect
- First Hope, a prevention program that provides diagnostic and treatment services for adolescents and young adults who are at risk for psychosis
- Full-Service Partnership (FSP) for participants who may need 24-hour services, including crisis intervention and stabilization, treatment, family support, and family education services
- Mobile Response Team (MRT) travels to participants who are 18 and younger to provide immediate crisis intervention
- Multi-Dimensional Family Therapy (MDFT) is family-based treatment for substance-abusing adolescents, or those with co-occurring substance use and mental disorders
- Multi-Systemic Therapy (MST) is community-based, family-driven treatment for antisocial or delinquent behavior in youth
- Therapeutic Behavioral Services (TBS) for youth who are placed or being considered for placement in a high-level group home or locked treatment facilities for treatment

Evidence-Based Practices

Providers are encouraged to utilize treatment modalities that have been proven effective in treating various mental health symptoms. These interventions are targeted to specific populations. Evidence-based practices (EBP) require the treatment to be implemented correctly and consistently over the duration of treatment. These practices are routinely reviewed and assessed for appropriate usages to their target populations. Our system of care utilizes EBPs for services provided in both children and adult programs.

Evidence-Based Practice for Children Services

There are a wide variety of evidence-based practices (EBP) that are utilized in our system of care. Below are a few brief explanations of some of the EBPs being used.

Child Parent Psychotherapy

Per the Child Trauma Research Program at UCSF, Child Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and/or are experiencing mental health, attachment, and/or behavioral problems, including post-traumatic stress disorder (PTSD).

The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g. cultural norms and socioeconomic and immigration-related stressors).

Trauma Focused Cognitive Behavior Therapy

Trauma Focused Cognitive Behavior Therapy (TF-CBT) is the most researched model for treatment of trauma symptoms. The protocol is straight forward and child and family friendly. It involves teaching parents and their child what it means to experience trauma, develop the tools to cope with it, learn about safety planning, and bringing new meaning to their experiences and hopes for the future.

It is a model designed for children 8 - 18 years old that can be implemented in as few as 16-20 weeks. Parents or other significant care givers participate throughout the treatment with an emphasis on psychoeducation, supportive parenting, safety planning, and emotional support to the parent. The child learns healthy ways to cope with their thoughts and feelings, how to face their fears and worries, and developing trust and emotional connection by sharing their story with their provider and when appropriate

with their primary support person.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a cognitive behavioral treatment for suicidal and depressed adolescents (ages 14-18) as well as other conditions that result in symptoms of emotion dysregulation. When teens are showing signs of depression, suicidal feelings, have engaged in impulsive behaviors, and are having anger problems, they are experiencing a very serious level of emotional suffering. The primary focus of DBT is based on a hierarchy of safety first, skill development, and building a life worth living.

It is based on the premise of the bio-social theory that some of us are born with more emotional sensitivity than others, and that our society is often invalidating to teens who experience high levels of emotional sensitivity. By teaching teens, and at least one parent/guardian how to monitor and analyze their emotions and behaviors, along with helpful skills to address their symptoms, suffering is reduced, and functioning improves. Skills taught include Mindfulness, Interpersonal Effectiveness, Emotion Regulation, Middle Path and Distress Tolerance. The full DBT model involves a 20-week commitment to the multi-family skills group, concurrent weekly individual therapy, telephone coaching, and consultation team.

Family-Based Therapy for Eating Disorders

Eating disorders have historically been considered a chronic and intractable mental illness that is difficult to treat. Family-Based Therapy (FBT) is an evidence-based practice that has been found to be effective with children and adolescents, who have been ill for less than 3 years and are under age 18. Studies show between 50-70% of patients achieving recovery after a year of FBT treatment.

The treatment emphasizes empowering parents to manage their child's eating disorder through a firm, compassionate focus on re-nourishment and then transitioning control back to the adolescent. Helping both the beneficiary and parents recognize the eating disorder as a separate illness that is not part of the child's identity helps them align with each other against the disordered behaviors.

Functional Family Therapy (FFT)

Functional Family Therapy identifies specific phases of treatment that help to organize the interventions. This allows the provider to focus on the context of family and individual disruption. FFT focus on working with children and youth ages 10-18 and their families with problems ranging from acting out to conduct disorder to substance abuse. Each phase includes specific goals, assessment, and specific techniques of intervention. The specific interventions focus on engagement/motivation, behavior

change and generalization of new behaviors and skills.

Multidimensional Family Therapy (MDFT) Program

Multidimensional Family Therapy is an intensive in-home program that focuses on several core areas of the adolescent's life simultaneously (parents, schools, other family members and the community). The targeted age group is 11-18-year olds who have behavioral difficulties and serious substance abuse issues. MDFT focuses on helping the family understand the connections between drug use, criminal behavior and mental health.

Throughout the treatment, skills are taught to improve positive peer relations: healthy self-esteem; connection to school and community activities; increased autonomy; and emotional connection to family members. It is important for all members of the family to be involved so that they also learn skills to improve the relationship with the beneficiary; increase their knowledge of successful parenting techniques; and improve everyday communication.

Portland Identification and Early Referral (PIER)

Portland Identification and Early Referral is a specialized program that provides early identification and intensive interventions to young people from the of ages 12-25 years old showing early signs of psychosis. PIER focuses on educating the beneficiary and their families about early warning signs of psychosis. In addition, PIER provides treatment for the beneficiary through psychosocial and psychopharmacological interventions.

National Wraparound Initiative

The Wraparound Program is a strengths-based process, which engages family members to determine and prioritize their needs. The targeted age group is 5-18-year olds with significant mental health issues. Wraparound is described as a four-phase program (Engagement and team preparation, Initial plan development, Implementation, and Transition).

Wraparound aims to develop problem-solving skills, coping skills, and self-efficacy of the beneficiary and family members. There is an emphasis on integrating the beneficiary into the community and building the family's social support system. Throughout the Wraparound process, a team of people who are significant to the beneficiary's life collaboratively develop an individualized plan of care, implement this plan, monitor the efficacy of the plan, and work towards success over time.

Services for Adults

CCMHP operates regional adult and older adult mental health clinics as well as contracts with community-based organizations to support additional services throughout Contra Costa.

Services:

- Psychiatric and medication assessments, consultation, and medication management
- Individual, family, and group outpatient therapy
- Case management to coordinate services
- Community Support Workers are peer providers with experience as a mental health participant help navigate our services and resources
- Family Support Workers with experience caring for loved ones with serious mental illness, available to inform and support family members of participants on services and information needed to provide better care to their loved ones
- Wellness and prevention planning using the evidence-based Wellness Recovery Action Plan (WRAP) process
- Assistance planning and managing financial benefits and resources
- Crisis intervention, including psychiatric diagnostic assessment, medication, emergency treatment, screening for hospitalization and intake, discharge planning and placement, and referral services

Services for Older Adults

- Intensive Care Management (ICM) to support aging in place
- Improving Mood Providing Access to Collaborative Treatment (IMPACT) for those experiencing depression while receiving medical care
- Senior peer counseling

Other Adult Services

- Crisis, transitional, and supervised residential care
- First Hope, a prevention program that provides diagnostic and treatment services for adolescents and young adults aged 12-30 years old who are at risk for psychosis
- Community reintegration services for those with co-occurring mental health and substance related disorders who are transitioning from the justice system
- Full-Service Partnership (FSP) for participants who may need 24-hour services, including crisis intervention and stabilization, treatment, peer support, and family education services
- Short-term case management transition services for participants with severe and persistent mental illness, in order to engage them in mental health services and move into the appropriate environment
- Vocational services including job search preparation, referrals, coaching, and benefits management

- Assisted outpatient treatment for those with severe mental illness who may be a danger to themselves or others, and will not participate in treatment
- Evidence-based practices based on need

Evidence-Based Practice for Adult/ Older Adult Services

There are a wide variety of evidence-based practices (EBP) that are utilized in our system of care. Below are a few brief explanations of some of the EBPs being used.

Cognitive Behavioral Therapy - CBT

Cognitive behavioral therapy (CBT) is the one of the most commonly used evidence-based practices. This treatment approach can be used for a wide range of psychological symptoms in children, adolescents, and adults. Throughout treatment, the beneficiary is examining the relationship of emotions, behaviors, and thoughts. The model adheres to therapeutic strategies that change maladaptive cognitions and lead to a decrease in emotional distress and problematic behaviors.

Cognitive Behavioral Social Skills Training – CBSST

Building upon two strong and previously validated EBPs, CBSST combines cognitive behavioral therapy, CBT, and social skills training, SST, to target functional disability in schizophrenia. It is a manualized, but flexible, intervention that teaches cognitive skills, social skills, and problem-solving skills to help beneficiaries achieve their living, learning, socializing, and working goals.

CBSST targets the range of multidimensional deficits that can lead to functional disability in people with serious mental illness (SMI). The primary goal of CBSST training is to train providers to deliver CBT and SST interventions to systematically help people with SMI achieve their personal recovery goals. SST involves learning communication and social problem-solving skills, and CBT teaches individuals to learn how to catch, check and change unhelpful thoughts that interfere with successful goal-directed skill performance in the community.

Cognitive Behavioral Therapy for Psychosis – CBTp

CBTp is an evidence approach that can improve symptoms and functioning in those who are experiencing psychotic symptoms. The goal is to enhance functioning even though there are difficult symptoms such as delusion, hallucination, and thought disturbance. This method forms a collaborative alliance whereby the beneficiary and provider explore psychotic experiences and beliefs the beneficiary has formed about those experiences. The hope is to reduce the stress and disabling effects of these experiences. CBTp is a time limited, structured, and goal-oriented treatment. It can be

delivered in either a group or individual setting and has long lasting affects after termination of services.

Dialectical Behavior Therapy - DBT

DBT is an evidence-based practice utilizing a cognitive behavioral therapy approach combined with several critical and unique elements: 1) the biosocial theory with focus on emotions in treatment, 2) a consistent dialectical philosophy, 3) mindfulness and acceptance-oriented interventions, and 4) the five functions of treatment.

It has been found to be effective with parasuicidal women with Borderline Personality Disorder, BPD, but there have been promising findings for beneficiaries with BPD and substance use disorders, persons who meet criteria for binge eating disorder, and depressed elderly beneficiaries. DBT includes skills training for beneficiaries, usually in a group format; individual DBT psychotherapy to help beneficiaries identify and solve problems in changing their behavior; and treatment modalities to support generalization of the new skills beyond the treatment environment, most commonly by telephone coaching.

Improving Mood Providing Access to Collaborative Treatment- IMPACT

IMPACT is an EBP which provides depression treatment to individuals age 55 and over in a primary care setting. The IMPACT model prescribes short-term – 8 to 12 visits – Problem Solving Therapy and medication consultation with up to one-year follow-up as necessary. Services are provided by a treatment team consisting of licensed clinicians, psychiatrists, and primary care physicians in a primary care setting.

The target population of the IMPACT program is adults age 55 years and older who are receiving health care services at a federally qualified health center. The program focuses on treating older adults with late life depression and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. The primary goals of the IMPACT program are to prevent more severe psychiatric symptoms, assist beneficiaries in accessing community resources as needed, reducing stigma related to accessing mental health treatment and providing access to therapy to this underserved population.

Eye Movement Desensitization and Reprocessing Therapy -EMDR

EMDR is an evidence-based practice that can be used for a wide range of psychological issues that result from having overwhelming life experiences. In order to practice this technique, the provider must complete an extensive training program. EMDR is an eight-phase treatment, which include: identifying and addressing experiences that have overwhelmed the brain's natural resilience or coping capacity. Throughout the

treatment, the beneficiary reprocesses the traumatic information until it is no longer psychologically disruptive.

Wellness Recovery Action Plan (Wrap)

Wrap is an evidence-based practice which has shown positive outcomes in the categories of mental health, quality of life, social functioning, and treatment/recovery. There are five key recovery concepts for Wrap that include: Hope, Personal Responsibility, Education, Self-Advocacy, and Support. Wrap focuses on helping the beneficiary to identify upsetting events and early warning signs, then developing action plans for responding at these times.

Medication Support Services

This service is used exclusively by medical providers where it is within their scope of practice to provide such services. This service type may include:

- Detailed information about how medications work
- Different types of medications available and why they are used
- Anticipated outcomes of taking a medication
- Importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate)
- How the use of the medication may improve the effectiveness of other services a beneficiary is receiving (e.g., group or individual therapy)
- Possible side effects of medications and how to manage them
- Information about medication interactions or possible complications related to using medications with alcohol or other medications or substances
- Impact of choosing to not take medications

Medication Support Services support beneficiaries in taking an active role in making choices about their behavioral health care and help them make specific, deliberate, and informed decisions about their treatment options. CCMHP regularly analyzes data to ensure that State health measures are met or exceeded in an ongoing effort to improve the medication services provided.

Mental Health Crisis Services

Anyone living in Contra Costa County who experiences a mental or emotional crisis can get help. Mental Health Crisis Services are available in person or over the phone 24 hours a day, seven days a week at:

- Psychiatric Emergency Services
  Contra Costa Regional Medical Center (north side)
  2500 Alhambra Avenue
  Martinez, CA 94553
  (925) 646-2800
- For inquiries and referral information, call 1-888-678-7277 any time day or night. The call is free.
- The Mobile Crisis Response Team (MCRT) provides professional, same-day interventions for adults who are experiencing mental health crisis. Call 1-833-443-2672 if the behavior is escalating, but the person has not physically harmed or tried to harm anyone during the incident. If you are not sure what to do, call MCRT for advice.

Chapter 2. Service Provider Requirements

CCMHP requires all providers take initial steps in order to be connected to the Mental Health Plan prior to providing services to beneficiaries. All providers must successfully complete the credentialing process and clear all federal exclusion checks.

County Owned and Operated Clinic and Community Based Organization providers must complete these steps with the Provider Services Unit.

Fee-for-Service Providers must complete these steps with the Care Management Unit.

2.1 CREDENTIALING AND RECREDENTIALING

All providers must complete the Credentialing Application packet in order to receive a ShareCare Staff ID and be allowed to provide billable services. After successfully completing the initial credentialing process, all providers are required to be re-credentialed at least every three (3) years and must be re-credentialed sooner if they become eligible for a new credentialing category, or if they return to CCMHP after being inactive for more than thirty (30) days.

All applications for credentialing and re-credentialing must be submitted in writing and on forms approved by CCMHP.

County Owned and Operated Clinics and CBOs

Credentialing and Recredentialing forms and resources are available on the Provider Services website https://cchealth.org/mentalhealth/provider/

Initial Credentialing Application Requirements:

1. ShareCare ID Request Form (form MHA12).
2. Credentialing/Privileging Form (form MHA22).
3. Social Security Number for Provider Credentialing and Recredentialing (form MHA22c)
4. Verification of highest level of education attained (copy of degree or official transcript). Verification of highest level of education is not required for licensed and registered providers due to it being verified by the applicable licensing board.
5. A copy of current government-issued photo identification.
6. NPI registration with the correct taxonomy code.
7. A copy of their California professional license and /or board certification or registration (Must have no limitations in California or in other states).
8. DEA registration (required for MDs, DOs and NPs only).
9. CCMHP Peer Reference Form (MHA22g) (Required for MDs, DOs, and NPs only)

10. For MDs and DOs in County Owned and Operated Clinics and Psychiatric Emergency Services [PES] only. Approved Credentialing Application from the CCRMC Medical Staff Office in lieu of the Credentialing/Privileging Form (form MHA22.)
11. If the provider is a Psychiatrist or a Nurse Practitioner, they must be enrolled in Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal, have completed the Ordering/Referring/ Prescribing (ORP) application, and are enrolled in the Medi-Cal Rx portal.
12. If the provider is a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, and Licensed Psychologist, they must attest on the Credentialing/Privileging Form (form MHA11) that they are currently enrolled in Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal and have completed the Ordering/Referring/Prescribing (ORP) application.
13. If the provider is a trainee, they must also include the executed agreement or contract between the agency and school; field placement agreement signed by the student, individual supervisor and/or coordinator and school field placement liaison.
14. If the provider is requesting a PhD waiver, PsyD waiver or a Pre-Doctoral waiver, they must also include their official transcripts and curriculum vitae or resume.
15. If the provider is an unlicensed Therapeutic Behavioral Service (TBS) worker, they must attest on the Credentialing/Privileging Form (form MHA22) that they have received the required training in functional behavioral analysis with an emphasis on positive behavioral interventions prior to providing Specialty Mental Health Services.
16. If the provider is a Therapeutic Foster Care (TFC) parent, they must attest on the Credentialing/Privileging Form (form MHA22) that they have completed the forty (40) hours of initial TFC parent training that shall include a thorough understanding of the Therapeutic Foster Care (TFC) service model including an introduction to TFC and TFC service system, understanding child and adolescent development and appropriate interventions, working with children/youth using a trauma-informed approach, preventing and managing crises, communication with children/youth and families, cultural competency, client sensitivity, and parent self-care prior to providing Specialty Mental Health Services.

Recredentialing Application Requirements:

1. Re-credentialing Application (form MHA22b).
2. Social Security Number for Provider Credentialing and Recredentialing (form MHA22c)
3. Verification of highest level of education attained (if a new degree obtained since last credentialing). Verification of highest level of education is not required for licensed and registered providers due to it being verified by the applicable licensing board.
4. A copy of current government-issued photo identification.

5. NPI registration with the correct taxonomy code.
6. A copy of their California professional license and /or board certification or registration (Must have no limitations in California or in other states).
7. DEA registration (required for MDs, DOs and NPs only).
8. For MDs and DOs in County Owned and Operated Clinics and PES only. Approved Re-credentialing Application from the CCRMC Medical Staff Office in lieu of the Credentialing/Privileging Form (form MHA22.)
9. If the provider's license status changed since the previous credentialing and the provider is now a Psychiatrist or Nurse Practitioner, they must be enroll in Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal, have completed the Ordering/Referring/Prescribing (ORP) application, and are enrolled in the Medi-Cal Rx portal. If the provider's license status changed since the previous credentialing and the provider is now a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselors, or Licensed Psychologist, then they must attest on the Credentialing/Privileging Form (form MHA22b) that they are currently enrolled in Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal and have completed the Ordering/Referring/Prescribing (ORP) application.
10. If the provider is being recredentialed as a trainee, they must also include the executed agreement or contract between the agency and school; and the field placement agreement signed by the student, individual supervisor and/or coordinator and school field placement liaison.
11. If the provider is requesting a PhD waiver, PsyD waiver or Pre-Doctoral waiver, they must also include their official transcripts and curriculum vitae or resume.

Fee-For-Service Providers

All providers must complete the credentialing process and clear all exclusion checks (see next section for details) before they can provide billable services. Care Management Unit will assist with the completion of the credentialing and re-credentialing process for all Fee-For-Service Providers.

2.2 FEDERAL EXCLUSION CHECKS

CCMHP will not contract with any provider excluded from participating in a Federally funded health care program. In the event a current provider is found on an excluded list, at a minimum, CCMHP will stop claiming federal and state funding for that provider, may terminate their contract, and will promptly notify Department of Health Care Services (DHCS).

County Owned and Operated Clinics and CBOs

1. At initial credentialing and at recredentialing, the Provider Services Unit will run a search on each individual providing services for CCMHP using the following websites:
    - Department of Health Care Services (DHCS)
    - U.S. Department of Health & Human Services Office of Inspector General
    - System for Award Management
    - National Plan & Provider Enumeration System (NPPES)
    - Social Security Death Master File
    - National Practitioner Data Bank (NPDB)

2. On a monthly basis, the Provider Services Unit will run a search on all staff using the following websites:
    - Department of Health Care Services (DHCS)
    - U.S. Departments of Health & Human Services Office of Inspector General.
    - System for Award Management
    - National Plan & Provider Enumeration System (NPPES)

3. CBOs will run a search on these websites upon employment and monthly thereafter.
    - Department of Health Care Services (DHCS)
    - U.S. Dept. of Health & Human Services Office of Inspector General.
    - System for Award Management

In the event a current provider is on the excluded list, CBOs are required to notify the Provider Services Unit immediately and, at a minimum, stop claiming federal and state funding.

Fee-For-Service Providers

1. At initial credentialing and at recredentialing, the Provider Services Unit will run a search on each individual providing services for CCMHP using the following websites:
    - Department of Health Care Services (DHCS)
    - U.S. Department of Health & Human Services Office of Inspector General
    - System for Award Management
    - National Plan & Provider Enumeration System (NPPES)
    - Social Security Death Master File
    - National Practitioner Data Bank (NPDB)

2. On a monthly basis, the Provider Services Unit will run a search on all Fee-for-Service Providers using the following websites:
    - Department of Health Care Services (DHCS)
    - U.S. Departments of Health & Human Services Office of Inspector General
    - System for Award Management
    - National Plan & Provider Enumeration System (NPPES)

2.3 NETWORK ADEQUACY CERTIFICATION TOOL (NACT)

CCMHP must regularly submit the NACT to DHCS in order to demonstrate compliance with the network adequacy requirements. Some of these requirements are as follow:

Timely Access

CCMHP is required to meet time or distance standards as set by DHCS. To meet the standards, services must be within 15 miles or within a 30-minute drive from the beneficiary's residence.

Network Certification

CCMHP is required to:

- Offer an appropriate range of services that is adequate for the anticipated number of beneficiaries.

-AND-

- Maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

County Owned and Operated Clinics and CBOs this data is collected and reviewed twice a quarter by the Provider Services Unit.

Fee-For-Service Providers this data is collected by Care Management Unit and submitted to the Provider Services Unit for review.

Chapter 3. Site Requirements

All sites in which services are provided to CCMHP beneficiaries are required to be Medi-Cal certified through the Behavioral Health Provider Services Unit. County Owned and Operated Clinics, CBOs and Fee-for Service Providers are required to ensure that the physical space is safe for beneficiaries and staff, and all required Informing Materials are available and easily accessible by being displayed in the waiting area. Required policies and procedures must also be in writing and in place at every site.

The site review will also include an informal review of beneficiary charts for the purpose of assessing general compliance with Medi-Cal documentation requirements. However, no services will be recouped as a result of this type of review. For further details about what to expect during the site visit and the beneficiary informing materials, refer to the following:

County Owned and Operated Clinics and CBOs – Appendix B (Medi-Cal Certification and Site Visit Preparation Guide)

Fee-for-Service Providers – Appendix C (Site Review Preparation Guide for Individual Medi-Cal Providers)

These are also available on the Provider Services website at https://cchealth.org/mentalhealth/provider/

Timeframes:

- **County Owned and Operated Clinics and CBOs** will require the site review every three (3) years.
- **Fee-for-Service Providers** will require the site review every two (2) years.

3.1 BENEFICIARY INFORMING MATERIALS

This section will discuss the various CCMHP Beneficiary informing materials that must be displayed or provided upon request. The informing materials are comprised of the Beneficiary Handbook, Brochures and self-addressed envelopes, Provider Directory and Posters. Information about each piece is provided below.

Beneficiary Handbook

During the first session, the beneficiary must be offered a copy of the "Beneficiary Handbook-Specialty Mental Health Services". If the beneficiary (or Guardian) is Spanish speaking, the Handbook must be offered in the Spanish language: "Manual de beneficiario de plan de salud mental". The Handbook is also available in alternative formats such as large print, Braille and audio. The Handbook needs to be available to the beneficiaries upon their request and be in a location where the beneficiaries can easily take a copy (i.e. waiting room) anytime.

Brochures

During the first visit and upon request, the beneficiary must be offered or made aware of the various brochures explaining their rights and benefits along with self-addressed envelopes. The brochures and envelopes must be displayed in a conspicuous location that does not require the knowledge of the provider. These should be available to beneficiaries to pick up without having to make a verbal or written request to anyone. The following brochures must be displayed in both English and Spanish at all times:

- Appeal or Expedited Appeal Request
- Beneficiary Request for Change of Provider
- Beneficiary Suggestion
- Beneficiary Grievance Review Request
- Advance Directive
- Continuity of Care

The above brochures are also available in large print for those with visual impairments. These do not need to be displayed but retained by the provider and offered to those needing a larger font size. These are also available in Braille and audio format and may be requested by calling the Access Line at 1-888-678-7277 or the Provider Services Unit at 925-608-6790.

Provider Directory

A copy of the CCMHP Provider Directory must be available to the beneficiary at all times. This can be accomplished by either displaying the Directory for beneficiaries to look through or with a posted sign stating the Provider Directory is available upon request in both English and Spanish. The Provider Directory is also available on the Provider Services website at https://cchealth.org/mentalhealth/provider/.

Posters

The following posters must be displayed in both English and Spanish at all times in a conspicuous place for the beneficiaries to see and read (for example in the therapy room or waiting room):

- Informing Materials
- Grievance, Change of Provider, Appeal
- Consumer Rights

If more copies of the informing materials are needed, please contact the Provider Services Unit at (925) 608-6790.

Chapter 4. Portal Access

The type of provider you are will determine how you submit your billing. County Owned and Operated Clinics and CBOs bill through ShareCare and Fee-for-Service Providers bill through the Provider Portal managed by CMU.

4.1 COUNTY OWNED AND OPERATED CLINICS AND CBOs

Access to ShareCare (CBOs only)

Staff who are providing direct service to the beneficiaries are assigned a ShareCare Staff ID number upon the completion of the credentialing process. For staff who need access to ShareCare to enter billing, they must complete and submit the ShareCare Access and Training Request for CBOs form. The form is available on the Provider Services website at https://cchealth.org/mentalhealth/provider/.

A Supervisor must approve all ShareCare access requests prior to submission. Staff must complete ShareCare training before access can be granted. If report access is being requested, it will be granted to no more than three (3) people per facility.

For technical support, contact the Help Desk (925) 957-7272.

Access to CBO Portal

Select staff at each CBO will be granted access to the ccLink Provider Portal. This will allow the staff to view charts and referrals for the beneficiaries they serve. To request access, an authorized individual from the CBO will need to submit a ccLink Provider Portal Access Request Form to the Provider Services Unit. Along with the portal request, the staff person they are requesting access for must complete a required training and must sign and submit an attestation for that training.

4.2 FEE-FOR-SERVICE PROVIDERS

Provider Portal

The provider portal allows you to obtain information regarding the beneficiary and submission of claims. Please refer to the CMU Provider Portal Guide to Procedures for details, which is found on the following website: https://cchealth.org/mentalhealth/network-provider/#Materials

The Care Management "CMU Review" trainings are an opportunity for new Network Providers to learn the necessary procedures to obtain authorizations and submit claims. The trainings also cover the features and benefits of using the county Provider Portal. Seasoned Network Providers are welcome at any time for a refresher. Please go to CMU website for details. https://cchealth.org/mentalhealth/network-provider/#Training.

For technical support, contact the Provider Portal Support Help Desk (925) 957-7272.

Chapter 5. Beneficiary Access to Services

5.1 SCREENING AND REFERRAL

The 24-hour Behavioral Health Access Line 1-888-678-7277 must be the first point of access for requesting Medi-Cal specialty mental health services from CCMHP, as well as obtaining information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing process. The 24/7 Access Line provides initial screening to determine immediate beneficiary needs, referral to appropriate services, and coordination with community resources that provide substance abuse, educational, health, housing and vocational rehabilitation services.

The Behavioral Health Access Line offers the following:

- Information and referrals to Medi-Cal beneficiaries seeking specialty mental health services;
- Determination of appropriateness for specialty mental health services through the CCMHP based on medical necessity;
- Screening and triage of beneficiary calls to identify service needs;
- Crisis intervention;
- Connection to emergency services such as the Mobile Crisis Response Team and other urgent delivery service systems;
- Determination of programs currently providing services to a specific beneficiary;
- Referrals to County Owned and Operated Clinics, CBOs, and Fee-for-Service Providers;
- Direction for out-of-county providers to beneficiary enrollment and authorization services;
- Direction for out-of-county and out-of-state provider authorization requests to the appropriate resource;
- Information regarding linkage to community resources;
- Information and referrals for other non-related mental health services;
- Linkage and referral to services provided by the CCMHP;
- Information regarding beneficiary problem resolution processes; and
- Referral to the Patients' Rights Office and the Quality Improvement and Assurance unit.

Timeframes for Providing Initial Services

Emergency Services

If screening and/or triage indicates the potential beneficiary needs immediate services, the need must be addressed as soon as possible and, in all cases; the same day the

request is received. Access Line staff shall immediately refer the potential beneficiary to an appropriate provider.

Urgent Services

If screening and/or triage indicates a request for services is urgent, a referral must be made within 48 hours of the request.

Routine Services

If screening and/or triage indicates a request for services is appropriate for scheduling a routine appointment for intake, times, and dates for an initial clinical appointment shall be offered as close as possible to the date of the original initial request but no more than ten (10) business days from the date of the request for services.

Psychiatric Services

If at any time the beneficiary requests psychiatric services, an appointment shall be offered with a psychiatrist within fifteen (15) business days.

What to do when beneficiaries contact you directly requesting services

County Owned and Operated Clinics and CBOs

Beneficiaries should be encouraged to call the Behavioral Health Access Line directly at 1 (888) 678-7277. CBOs, who have been designated by CCMHP to assess beneficiaries and authorize services, are to follow all procedures set by CCMHP to ensure beneficiary access to services and protection of beneficiary rights.

Fee-for-Service Providers

Beneficiaries should be encouraged to call the Behavioral Health Access Line directly at 1 (888) 678-7277.

Chapter 6. Eligibility

All Contra Costa County Medi-Cal beneficiaries are eligible for membership in CCMHP. A Contra Costa Medi-Cal beneficiary is any person certified as eligible for services under the Medi-Cal Program according to Section 51001, Title 22, Code of California Regulations, whose beneficiary identification information includes Contra Costa Code Number 07.

For children/ adolescent beneficiaries who do not have the Contra Costa Code Number 07, but have certain special aid codes assigned to them, they still may be eligible to receive services in Contra Costa County, per the guidelines of the program's contract with Contra Costa County.

County Owned and Operated Clinics, CBOs and Fee-for Services Providers are responsible for monitoring their beneficiaries' eligibility throughout the duration of services. It is expected that eligibility will be checked, at minimum, at the beginning of the month and it is strongly encouraged to check again mid-month.

6.1 COUNTY OWNED AND OPERATED CLINICS AND CBOs

Please contact the assigned UR clerk to your clinic.

6.2 FEE-FOR-SERVICE PROVIDERS

Through Provider Portal, providers can check Medi-Cal eligibility at any time. Please refer to the CMU Provider Portal Guide to Procedures for details.

If not using Provider Portal, providers must call the AEVS (Medi-Cal Automated Eligibility Verification System) phone line to verify beneficiary eligibility at the beginning of each month.

The AEVS phone number is 1-800-456-2387.

- You will be asked to select English or Spanish as your language
- You will be asked to enter your Provider Identification Number. Individual Providers will be given this number on the CCMHP Welcome Letter
- Select the option for eligibility verification (Option 1)
- You will then be asked for the subscriber's ID number = State CIN.
    - ✓ To enter the letter at the end of the CIN, select the "star key," then enter the number on the key pad that corresponds to the letter, then enter 1, 2, or 3, depending on the position of the letter on the number key. For instance, to enter the letter "C", press the star key, then the number 2, then the number 3 (because "C" is the third letter associated with the number 2)
    - ✓ Instructions on how to enter the letter are also available when calling the AEVS line.
- Enter birth month/year (01/1965 = 011965)
- Enter service date (06/01/2018 = 06012018)

- Listen for the system to verify the county code as "07" Medi-Cal = Contra Cost Medi-Cal
- Continue listening to the entire message for additional eligibility information, such as Medicare.
- Document the eligibility response verification number.

6.3 CONTINUITY OF CARE

All eligible Medi-Cal beneficiaries who meet medical necessity criteria for Specialty Mental Health Services have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to CCMHP shall be given the options to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or terminated network provider, necessary to complete a course of treatment and to arrange for safe transfer to another provider.

In order to determine if the beneficiary meets these requirements, please have the beneficiary contact the Access Line 1-888-678-7277.

6.4 MEDICARE

Some beneficiaries, mostly in the adult population may receive both Medi-Cal and Medicare coverage. These beneficiaries are referred to as "Medi-Medi." Medicare providers include Physicians, Nurse Practitioners, Licensed Clinical Social Workers, and Psychologists. Depending upon the organization, those providers listed above may be required to complete the Medicare enrollment. Please refer to your Clinic Manager or Clinical Supervisor for further details.

Chapter 7. Consent and Protected Health Information

7.1 INFORMED DECISION-MAKING

We strive to provide excellent quality care to every beneficiary who receives services from CCMHP. We aim to involve the beneficiary and/or the family in treatment in order to provide services that are meaningful to them and will help them thrive. We must include the beneficiary/family in the treatment process at the onset of services. It is our responsibility to ensure that every beneficiary and/or family is treated with respect and that every person is informed about what services are offered from CCMHP, we provide information on treatment options in the community in a way that helps support the beneficiary in making an informed decision about whether the services offered through CCMHP are right for them or for their child. All CCMHP providers are expected to discuss issues related to individual's treatment along with the risks and benefits associated with these treatments in order to support the beneficiary/family in making an informed decision about their treatment. Equally as important is to have ongoing communication with every beneficiary/family about the treatment process and discharge planning.

Confidentiality

The confidentiality of medical, psychiatric, and substance abuse information is protected by State and Federal statutes, rules and regulations. The statues, rules, and regulations require that we protect the beneficiary's personal health information (PHI) and that we obtain informed consent from the beneficiary or beneficiary's parents in the case of a minor, in order to disclose any PHI information, prior to doing so, except under specific conditions as indicated by law. Only staff members who are directly involved in the beneficiary's treatment may access the health record for treatment purposes. It is never okay for staff members to access a beneficiary's health record to satisfy a curiosity for their own purpose, even when the beneficiary is related to the staff member. The electronic medical record stores information on who has accessed the medical record as part of the audit trail. The audit record is necessary to make efforts to safeguard the beneficiary's confidentiality as well as to provide an "account of disclosure" if requested by the beneficiary or legal entities via subpoena.

A beneficiary or authorized representative who consents to release of any and/or specific information about their health record must appropriate documentation that allows the release of medical records and/or the exchange of information. The Authorization, once obtained, may be valid for a designated period of time or on an event. A beneficiary may decide to revoke the Authorization, at any time. The Authorization will at that time be revoked, making it invalid. If the beneficiary, at a later time, decides to reactivate the Authorization, a new Authorization must be completed as indicated above.

Note: Any subpoenas regarding requests for medical records should be directed to the Quality Improvement office.

Informed Consent

Beneficiaries should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in beneficiary preferences and encourage shared decision making.

Adults, including those receiving mental health services, have the right to give or refuse consent to medical, diagnostic or treatment procedures. California Health and Safety Code § 7185.5(a) states that "the legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care..." California Code of Regulations, Title22 § 70707(b)(6) provides that a beneficiary has a right to "participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment." The range of services provided shall be discussed prior to admission with the prospective beneficiary or an authorized representative so that the program's services are clearly understood.

CCMHP has an obligation to inform beneficiaries of the risks and benefits of treatment. At the onset of services, we must ensure that beneficiaries understand the content of not only the Informed Consent form but of all the onset of services documentation prior to the beneficiary agreeing to services and signing these forms. This includes ensuring that minors who are able to consent for their own services without a parent are fully educated about the similarities and differences in the types of services they can receive. In addition, although we do not need to have beneficiaries re-sign Informed Consent forms when they transfer from program-to-program, it is important we inform them of the specific risks and benefits of each particular service when they initially transfer.

An important part of informed consent is the person’s capacity to consent. A person is deemed to have legal capacity to consent to treatment if he/she has the ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks and alternatives (including doing nothing), and can make and communicate a health care decision. A person's lack of mental capacity to consent to medical care may be temporary or it may be permanent, and the provider should determine capacity on a case-by-case basis whenever consent is sought. For example, a beneficiary who is clearly under the influence of drugs or alcohol may lack capacity temporarily, but could provide consent at a later time, when not so impaired. If you have any questions regarding a beneficiary’s ability to consent, please consult with your supervisor and Quality Improvement Unit.

7.2 SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI)

CCMHP, its offices, programs and facilities have policies and procedures in place for appropriate administrative, technical and physical safeguards to reasonably protect health information from intentional or unintentional unauthorized use or disclosure. This applies to protected health information (PHI) held in any medium including paper, electronic, oral, or visual.

Safeguarding PHI Stored in paper format

- Paper files and documents must be stored in locked desks, rooms, or storage systems.
- Where desks, file rooms, or open area storage systems are not lockable, reasonable efforts must be implemented to safeguard PHI.
- Each workplace will ensure that files and documents awaiting disposal or destruction in desk-site containers, storage rooms or centralized waste/shred bins, are appropriately labeled, are disposed of on a regular basis, and that all reasonable measures are taken to minimize access.

Safeguarding information on health system identification cards

- Health System Identification Cards contain the beneficiary's name, date of birth, medical record number, phone number, the abbreviated name of the clinic where they receive services, and the name of their health provider. This information is considered to be "confidential information" and is therefore subject to the same protections under Federal and State law as other health information.
- Workforce members must take precautions to prevent the unauthorized access, use, or disclosure of the Health System Identification Card itself, any document embossed with this information or any document with this information written on any part of it.
- Staff must be very careful to give the correct health system identification cards and paperwork to the proper beneficiary.

Safeguarding oral PHI

Workforce members must take reasonable steps (e.g., lowering voices, moving to a more protected area, etc.) to protect the privacy of all verbal exchanges or discussions of confidential information, regardless of where the discussion occurs, and should be aware of risk levels.

- Low risk: interview rooms, enclosed offices and conference rooms.
- Medium risk: employee only areas, telephone, and individual cubicles.
- High risk: public areas, reception areas and shared cubicles housing multiple staff where beneficiaries are routinely present.

Safeguarding visual PHI

Workforce members will ensure that observable confidential information is adequately shielded from unauthorized use and disclosure.

- Suggested means of safeguarding computer screens include: use of polarized screens or other overlay devices that shield information on the screen from persons not authorized to view; placement of computers out of the visual range of persons not authorized; clearing information from the screen when not actually being used; locking-down computer work stations when not in use; and, other effective means as available.
- Suggested means of safeguarding paper documents: placing paper or charts face down or in a location where unauthorized disclosure is avoided; locating fax machines, photocopiers, printers, etc., in areas not accessible by the general public.

Safeguarding electronic PHI held in computerized systems

Role-Based Access

Roles will be created and defined for each workforce member based on their need for the minimum necessary computerized information to perform their job. Their role will be the basis for establishing access to the computerized information systems used by CCMHP.

- CCMHP managers and supervisors will determine the role and request appropriate access for each of their workforce members based on the work member's job function.
- Each computerized information system holding protected health information has a defined data "owner" who is the manager responsible for its contents. Each owner will review and approve all access requests based on roles, as defined above.

Refer to Appendix A, Contra Costa Health Services Policy PCC 504, Safeguarding Protected Health Information, for additional detail on the policies and procedures to ensure beneficiary confidentiality.

Chapter 8. Beneficiary Rights

As the provider, it is important to understand the beneficiary rights. The information below can also be found in the Beneficiary Handbook.

As a person eligible for Medi-Cal, the beneficiary has a right to receive medically necessary specialty mental health services from the CCMHP. When accessing these services, the beneficiary has the right to:

1. Be treated with personal respect and respect for their dignity and privacy.
2. Receive information on available treatment choices and have them explained in a manner you can understand.
3. Take part in decisions regarding their mental health care, including the right to refuse treatment.
4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment, or retaliation about the use of restraints and seclusion.
5. Ask for and get a copy of their medical records, and request that they be changed or corrected, if needed.
6. Beneficiaries also have the right to receive information provided to them by the MHP in a form that is easy to understand.
7. Get specialty mental health services from an MHP that follows its contract with the state for availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. The MHP is required to:
    - Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible beneficiaries who qualify for specialty mental health services can receive them in a timely manner.
    - Cover medically necessary services out-of-network for you in a timely manner, if the MHP does not have an employee or contract provider who can deliver the services. “Out-of-network provider” means a provider who is not on the MHP’s list of providers.
    - The MHP must make sure the beneficiary does not pay anything extra for seeing an out-of-network provider.
    - Make sure providers are trained to deliver the specialty mental health services that the providers agree to cover.
    - Make sure that the specialty mental health services the MHP covers are enough in amount, length of time, and scope to meet the needs of Medi Cal eligible beneficiaries. This includes making sure the MHP’s system for approving payment for services is based on medical necessity and makes sure the medical necessity criteria is fairly used.

- Make sure that its providers do adequate assessments of people who may receive services and that they work with people who will receive services to put together a treatment plan that includes the goals for the treatment and services that will be given
- Provide for a second opinion from a qualified health care professional within the MHP's network, or one outside the network, at no additional cost to the beneficiary if they request it.
- Coordinate the services it provides with services being provided to the beneficiary through a Medi Cal managed care health plan or with their primary care provider, if necessary, and make sure their privacy is protected as specified in federal rules on the privacy of health information.
- Provide timely access to care, including making services available 24 hours a day, seven days a week, when medically necessary to treat an emergency psychiatric condition or an urgent or crisis condition.
- Participate in the state's efforts to encourage the delivery of services in a culturally competent manner to all people, including those with limited English proficiency and varied cultural and ethnic backgrounds.

8. CCMHP must make sure the beneficiary's treatment is not changed in a harmful way as a result of them expressing their rights. MHP is required to follow other applicable federal and state laws (such as: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act); Section 1557 of the Patient Protection and Affordable Care Act; as well as the rights described here.
9. Beneficiaries may have additional rights under state laws about mental health treatment. If they wish to contact their county's Patients' Rights Advocate, they can do so by calling (925) 293-4942 or (844) 666-0472. Collect calls are accepted.

Chapter 9. Medical Necessity

Medi-Cal requires specific standards to be met by all providers. Refer to current CCMHP policies and DHCS Information Notices for up-to-date standards. In order to obtain reimbursement for services, the beneficiary must meet Medical Necessity requirements.

Criteria for Beneficiaries to Access Specialty Mental Health Services for Adults:

For beneficiaries 21 years of age or older who meet **both of the following** criteria, (1) and (2) below:

(1) The beneficiary has **one or both** of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities

AND/OR

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. To obtain the current version of the Included Diagnosis, please go to the following website: https://cchealth.org/mentalhealth/clinical-documentation/#Documents

OR

b. A suspected mental disorder that has not yet been diagnosed.

Criteria for Beneficiaries to Access Specialty Mental Health Services for Beneficiaries under Age 21:

For enrolled beneficiaries under 21 years of age who meet **either of the following** criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department,

involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The beneficiary meets **both of the following** requirements in a) and b), below:

(a) The beneficiary has **at least one** of the following:

i. A significant impairment

AND/OR

ii. A reasonable probability of significant deterioration in an important area of life functioning

AND/OR

iii. A reasonable probability of not progressing developmentally as appropriate

AND/OR

iv. A need for specialty mental health services, regardless of presence impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in a subparagraph (2) above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statical Classification of diseases and Related Health Problems. To obtain the current version of the Included Diagnosis, please go to the following website: https://cchealth.org/mentalhealth/clinical-documentation/#Documents

OR

ii. A suspected mental health disorder that has not yet been diagnosed.

AND/OR

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Definitions:

Involvement in child welfare: The beneficiary has an open child welfare services case, or the beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both courtordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Homelessness: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii)

Juvenile justice involvement: The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

9.1 COUNTY OWNED AND OPERATED CLINICS AND CBOs

All information regarding these standards is available through the Utilization Review Unit. Please refer to Utilization Review Documentation Manual for further details. The manual is available through the following link:

https://cchealth.org/mentalhealth/clinical-documentation/#Documents

9.2 FEE-FOR-SERVICE PROVIDERS

All information regarding these standards is available through Care Management Unit. Please refer to Care Management Unit Network Provider Training Manual for further details. The manual is available through the following link

https://cchealth.org/mentalhealth/network-provider/#Materials

Chapter 10. Documentation

A key component for the reimbursement of services is proper documentation by the provider. CCMHP establishes documentation standards in order to help realize the commitment to clinical and service excellence. In addition, accurate and complete documentation protects providers from risk in legal proceedings, helps maintain compliance with all regulatory requirements when claiming for services, and enables professionals to discharge their legal and ethical duties.

CCMHP submits a claim for each covered service provided by each service provider. All services are documented using Medi-Cal Specialty Mental Health documentation rules, regardless of beneficiary status.

Throughout the documentation the golden thread must be found. The golden thread begins with the assessment (identified needs), then pulls through the treatment plan (interventions and goals) to ongoing progress notes (client efforts, services provided, progress made).

It is golden because, if accurately followed through, the documentation that supports each decision, intervention, or client progress note contributes to a complete record of client care that is error-free and ready for reimbursement.

Each piece of documentation must flow logically from one to another so that someone reviewing the record can see the logic.

10.1 COUNTY OWNED AND OPERATED CLINICS AND CBOs

Please refer to Utilization Review Unit documentation manual for more details regarding Medi-Cal Specialty Mental Health documentation standards.

Website: https://cchealth.org/mentalhealth/clinical-documentation/#Documents

10.2 FEE-FOR-SERVICE PROVIDERS

Please refer to Care Management Unit documentation manual for more details regarding Medi-Cal Specialty Mental Health documentation standards.

Website: https://cchealth.org/mentalhealth/network-provider/#Materials

10.3 FORMS

County Owned and Operated Clinics, CBOs and Fee-for Service Providers should only use CCMHP "approved" forms or templates. If a provider chooses to use their own forms or templates, they must obtain approval from CCMHP before using them.

Please ensure that you are using the "most current" approved version of the form. Recycle older versions.

Current forms can be found here:

- **County Owned and Operated Clinics** should only use ccLink for documentation and billing forms
- **CBOs:** http://cchealth.org/mentalhealth/clinical-documentation/
- **Fee-for-Service Providers:** https://cchealth.org/mentalhealth/network-provider/#Materials

Chapter 11. Authorization

CCMHP created the process of authorization in order to maintain the timeliness of Assessment and Partnership Plans. The Utilization Review Unit is responsible for the completion of all authorization for County Owned and Operated Clinics and CBOs. Care Management Unit is responsible for the completion of all authorization for Fee-for-Service Providers. If any provider is unable to meet the requirements for authorization, they may receive a Notice of Adverse Benefit Determination.

11.1 NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

A Notice of Adverse Benefit Determination (NOABD) is a form given to the beneficiary which advises them of a determination that has taken place regarding their case. This form also advises the beneficiary about their right to appeal the determination, including their right to request a State Hearing.

What is a NOABD and what is its primary purpose?

- To inform Beneficiaries of their rights, including their ability to appeal the adverse benefit determination.

NOABD are issued for the following actions:

- Denial or limited authorization of a requested service including determinations based on type/level of service, medical necessity appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of a payment for a service
- The failure to provide services in a timely manner
- The Denial of a beneficiary's request to dispute financial liability.

Beneficiaries must receive a written notice when a NOABD is issued.

What are the NOABD Requirements and Timeframes?

- A description of the criteria used to make the determination
- Beneficiary's rights to be provided upon request free of charge all documents, records and other info relevant to the beneficiary's adverse benefit determination.
- Initial communication is to be made within 24 hours to the Provider. This communication can be via phone, followed in writing.
- Termination, suspension or reduction of a previously authorized service, at least 10 days before the date of action, except as permitted under 42 CFR pt 431.213 and 431.214

- For decisions resulting in denial, delay or modification of all or part of the requested specialty mental health or substance abuse services within 2 business days of the decision. (These are issued by Utilization Review Unit/Care Management Unit)

For notifications resulting from the failure to provide access to services within standards or failure to adhere to required timeframes for appeals, expedited appeals or grievances on or before the last date of compliance.

11.2 MEDI-CAL REVIEWS/AUDITS

To ensure compliance with all documentation requirements, any Medi-Cal beneficiary's chart can be audited at any time. The purpose of these audits is to ensure CCMHP meets state standards of compliance.

As a Medi-Cal Mental Health Service Provider, your records can be reviewed by:

- State Department of Health Care Services
- CCMHP Centralized UR
- Provider Services Unit for Questionable Medi-Cal Billing

If any documentation fails to meet all required documentation standards, it will be subjected to current CCMHP policies.

Chapter 12. Trainings and Meetings

CCMHP makes various trainings and meetings available to County Owned and Operated Clinics, CBOs and Fee-for-Service Providers. Please refer below to obtain more information about the specific training or meeting offered.

12.1 COUNTY OWNED AND OPERATED CLINICS AND CBOs

Trainings

1. **Documentation Training** is provided by the Utilization Review Unit on an ongoing basis. It addresses common problems with proper Medi-Cal documentation. It provides training and tools to improve current documentation skills for licensed and non-licensed mental health providers. If you have questions or would like to be added to the training distribution list, please email CCMH.Training@cchealth.org.
2. **System of Care Utilization Review Memo** is released on a regular basis. The purpose of the memo is to update and inform providers of any upcoming changes related to UR that will impact the authorization process, audit reviews, and compliance requirement. If you have any questions regarding a memo, please email Utilization Review at BHSUtilizationReview@cchealth.org.
3. CANS is now a requirement, as part of a statewide implementation of a standardized functional assessment tool that allows providers to better meeting the needs of children, youth and families. In order to conduct CANS, you must be certified on a yearly basis. To register for the **CANS training,** please go to https://cchealth.org/mentalhealth/outcome-measures.php If you have any questions regarding CANS, please email canspc@cchealth.org.
4. **Beneficiary Protection Training** must be completed at the time of initial credentialing and again every three (3) years at recredentialing. It is offered periodically at the Provider Services Quarterly Meeting and is also available on the Provider Services website https://cchealth.org/mentalhealth/provider/
5. **NACT Training** provides guidance on how to complete the tool. It is offered periodically at the Provider Services Quarterly Meeting and is also available on the Provider Services website https://cchealth.org/mentalhealth/provider/
6. **ShareCare Training** may be requested by completing the ShareCare Access and Training Request for CBOs form. You can access the form on the Provider Services website at https://cchealth.org/mentalhealth/provider/
7. **ccLink training** may be requested by completing the training request form. You can access the training request form in several ways:

- from your "MY APPLICATIONS" menu in iSITE,
- from the link in the Recommended section on the iSITE homepage, or
- from the ccLink training website in SharePoint.

The training administrator will provide confirmation once the request form has been received.

Meetings

1. **Clerical Operation Group (COG) Meetings** are held every other month. These meetings provide support regarding but not limited to billing related issues.
2. **Provider Services Quarterly Meetings** are held once per quarter. These meetings provide County Owned and Operated Clinics and CBOs the opportunity to learn and discuss many different topics including Credentialing/Recredentialing, NACT, Medi-Cal Certification, Staff Verification, Service Verification Calls and updates on Informing Materials.
3. **Contractor Meetings** occurs every other month on the third Tuesday of the month from12:30pm to 2:00pm at 2425 Bisso Lane, Concord, CA 94520 in the Large Conference Room. These meetings encompass updates from CCBHS and programs (Child/Adolescent and Adults/Older Adults), UR, Provider Services, IT/ShareCare, CCLink/CBO Portal, CANS, ANSA, regulatory information, and any other pertinent information and/or resources.

12.2 FEE-FOR-SERVICE PROVIDERS

Documentation Training

The "Clinical Documentation and Audit Preparation" training is an opportunity for all Network Providers to review best practices in clinical documentation, how to effectively chart to Medical and Service Necessity, and create appropriate Partnership Plans. Attendance at this training will assist providers in maintaining their documentation, keeping up-to-date on any recent changes to Medi-Cal requirements, and having the opportunity to ask questions regarding any of the Medi-Cal requirements. The trainings are held at 30 Douglas Drive, Martinez, CA 94553.

To register, please contact CMU Provider Services at 925-372-4400, option 6 for Provider Services

Newsletters

CMU sends out Newsletters on a regular basis to keep the Fee-for-Service Providers updated on any upcoming changes. To access the newsletters, please go to Network Provider Resources at https://cchealth.org/mentalhealth/network-provider/#Newsletters