# BEHAVIORAL HEALTH READINESS CRITERIA

**DRAFT**

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| **STANDARD** |
| **Administration: Roles & Responsibilities** |
| 1. Health Plans (HP) will provide letters of support from county mental health and substance use departments(s) that describe their agreement to work in good faith to develop Memoranda of Understanding (MOUs) and enter into data sharing agreements by SPECIFIED DATE TDB. |
| 2. Health Plans (HP) will coordinate with County Department(s) to develop draft MOUs for shared accountability for behavioral health. If the county mental health and substance use departments are separate, there must be an MOU with each department. If the departments are unified, only one document is required, however separate MOUs for mental health services and substance use services are permissible at the discretion of the HP and the county department. Finally, MOUs will be executed by SPECIFIED DATE TBD.  These MOUs shall, at a minimum, address the following five core areas. Health plans are responsible for the creation and ongoing maintenance of the policies and procedures documents, and to ensure they are distributed to the county partners in a timely manner. Reviews and updates are expected to be done at least annually.  **2.1 Roles and Responsibilities:**   1. Clear delineation of financial responsibilities and provider contracting responsibilities 2. Criteria for identifying beneficiaries in need of various levels of MH and SUD care coordination, including identifying beneficiaries that may be in need of services provided by county mental health and/or substance use departments. 3. Referral processes that, at a minimum, include:  * How the county department will provide a referral to the HP when it determines that a beneficiary’s mental health or substance use conditions would be responsive to physical health care based treatment; and * How the HP will provide a referral when it determines specialty mental health services or county-based substance use services may be required.  1. Identified point of contact with the health plan and a corresponding clear point of contact with the county entity (ies). 2. A clear policy that describes the various communications processes to address issues related to coordination including, but not limited to, the availability of clinical consultation, and consultations on medications for beneficiaries who are receiving services by both the HP and the county department(s). 3. Process for resolving disagreements between the HP and the county department(s) related to clinical decision-making that ensures that beneficiaries receive, or continue to receive, medically necessary services, including specialty mental health services and medications, while the dispute is being resolved.  * When the dispute involves the HP continuing to provide services to a beneficiary that it believes requires specialty mental health services or substance use services from the county, the county shall identify and provide the HP with the name and telephone number of a psychiatrist, qualified licensed mental health professional, or other appropriate provider, available to provide clinical consultation, including consultation on medications to the HP provider responsible for the beneficiary's care.  1. Process for resolving disputes between the HP and the county department(s) related to provider relations and contracting   **2.2 Coordination of Care**:   1. An approach to screening, referral and linkages and coordination for mental health services with timelines specified. 2. An approach to screening, referral and linkages and coordination for substance use services with timelines specified. 3. Process for clinical consultation and coordination of care plans. 4. Process for notification of the interdisciplinary care team of hospital admission and coordinating a discharge plan linking the beneficiary to mental health and substance use services. 5. Procedures for direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary’s medical problems based on changes in the beneficiary’ mental health or medical condition. 6. Procedures for prescription drugs and laboratory services covered by the HP and prescribed through the county department that include:  * The county department’s obligation to provide the names and qualifications of the county department’s prescribing and dosing physicians to the HP. * The HP’s obligation to provide its procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the county department(s).  1. Procedures for providing services to treat the physical health care needs of beneficiaries who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission. 2. Process for conducting an annual review, analysis and evaluation of the effectiveness of the care management program description and processes and identify actions to be implemented to improve the quality of care and delivery of services. 3. Process for developing and implementing a Plan of Correction in response to the findings from the annual review, analysis and evaluation with timelines specified as when the out-of-compliance findings will be corrected and implemented then subsequently monitored for compliance. 4. Process for internal monitoring of compliance standards with Federal and State regulatory and contractual requirements with specified timelines for corrective actions and enforcement of standards.   **2.3 Information Exchange**:  a. Policies and procedures to be established by both the health plans and county agency(ies) to support the flow of information, including but not limited to, the exchange of protected medical, health, and personal information, clinical consultations, and referrals between the county departments and health plan that ensure that confidentiality of personal and medical records is maintained and that comply with HIPAA and other state and federal privacy laws.   1. Process for clinical consultation and training regarding mental health and substance use, including consultation and training on medications.   **2.4. Performance metrics**:   1. Agreed-upon metrics to to track performance over the three years of the demonstration. These measures may be process-oriented in the first and second years, but by the third year should be outcome-oriented based on baselines from prior years.   **2.5. Shared Financial Accountability Strategies:**  a. Specific description of how funds earned back through the quality withhold metric will be shared with the county mental health and substance use agencies. |
| 3. Health plans shall have and maintain data sharing agreements with the County mental health and substance use departments that ensure that the confidentiality of personal information and medical records is maintained in accordance with HIPAA and other state and federal privacy laws. |
| **Care Management/Coordination** |
| Health Plans will provide documentation that provides evidence of plans to implement and maintain:   1. A written description of the activities and responsibilities that are part of the care management process. 2. Procedures and quality of care criteria to monitor coordination of care among primary care providers, specialist(s), and county behavioral health providers. 3. A process for an annual review and evaluation of the care management program description and processes. 4. The health plan’s governing body approves the revised care management program description at least annually. 5. A standardized procedure/description/ methodology for identifying members for care management, including a process for self-referral. 6. A process and standards for oversight of care coordination activities delegated to a subcontractor or delegated medical group. 7. A contact person who is responsible for activities delegated to a subcontractor or delegated medical group 8. A process to ensure that the member and the member’s family are aware of community-based placement options. 9. A process for obtaining member input on satisfaction and identification of issues such as access, quality and delivery of services with care coordination processes. 10. A process for reviewing and responding to complaints to improve care coordination and quality of services with response and resolution timelines specified. |
| **Quality Improvement System** |
| Health Plans will provide documentation that provides evidence of:   1. A Quality Improvement and Quality Management system and written policies and procedures that demonstrate processes are in place and is updated annually. 2. A process for routine monitoring the service delivery system and identification of relevant clinical issues and practices, as well as interventions to address identified quality of care and noncompliance issues. |
| **Utilization Management** |
| Health Pans will provide documentation that provides evidence of policies and procedures showing how:   1. Authorized and non-authorized/denied/reduced services will be regularly evaluated for compliance with the contract requirements. 2. Authorization decisions are made and notice provided as expeditiously and timely as the beneficiary’s condition requires and notice provided to the beneficiary of the authorization decision. 3. Documentation of routine review of the Utilization Management program and outcomes including monitoring to ensure that the established standards for authorization decision making and action is taken to improve performance including a review of the consistency in the authorization process. 4. All Utilization Management activities are documented in accordance with established standards and criteria for authorization/ non-authorization and reduction of services specified and reviewed and approved in accordance with scope of practice requirements. 5. All authorization decisions resulting in adverse or reduction of services are based on standard authorization criteria with and reviewed by staff with appropriate licenses within their scope of practice. |
| **Provider Network & Relations** |
| 1. Health plan will provide documentation that provides evidence that:    1. An adequate provider network is established, maintained and monitored to provide access and services to the current and anticipated enrollment of and utilization of services.    2. The provider network provides for cultural and linguistic services (including alternative formats) to meet the needs of the current and anticipated enrollment and monitors the network to identify cultural and linguistic needs and issues of the population it serves.    3. There is access to cultural and linguistic providers (including alternative formats) within a geographical area that meets state guidelines and there are measures and criteria in place to monitor and identify the types of providers needed to serve the enrolled and anticipated enrollment. |
| **Access and Availability** |
| 1. Health plan will provide evidence of policies and procedures for each of the following: 2. Ensuring access to behavioral health services with specified timelines to obtain services from initial request of services by the enrollee to receipt of services. 3. Provision for emergency, urgent, and after-hours services and notification to enrollees of this process. 4. There is a 24/7 toll-free telephone line or web access that provides information and access to services for urgent and routine requests and information on member services including the complaint and grievance process and requests for change of providers. |
| **Stakeholder Process** |
| 1. Health plan will provide evidence for each of the following    1. Local stakeholders have been engaged in the planning process related to behavioral health coordination. Provide reviewer meeting agendas and summary of stakeholder participation leading up to the execution of the MOUs.    2. An advisory board has been established that includes consumers, family members, advocates, and providers (provide list with each member identified by category) that participates in and reviews the quality of care issues identified, utilization review issues, resolution of complaints and grievance outcomes and other quality indicators and makes recommendations.    3. The advisory board has scheduled at least one meeting before Dec. 31, 2012 and scheduled meetings quarterly thereafter. |
| **Education about Behavioral Health Service Options** |
| **1. Education of Members about Behavioral Health Service Options**  The health plan will provide documentation that it has an implementation plan to use and maintain the following mechanisms to educate members about the availability of behavioral services, including those coordinated with the county, including but not limited to, the following:   * 1. Member handbook updates   2. Website updates   3. Member newsletters in the threshold languages of the population served   4. Outreach activities that take into account the cultural and linguistic needs of the population served.   5. Engaging and consultation with primary care practitioners behavioral health treatment and services.   6. Educating case managers/coordinators regarding behavioral health treatment and services.   7. Information will be available in threshold languages and alternative formats for visually and hearing impaired. |
| **2. Education of Providers about behavioral health services:**  The health plan will provide documentation that it has an implementation plan to educate providers, including community physicians, about the availability of behavioral health services, including care coordination with county services, using the following mechanisms:  a. Initial and regularly scheduled provider trainings (at a minimum annually) that includes behavioral health education and culturally competency trainings.  b. Provider manual that includes information regarding access to services, the enrollee complaint and grievance process, authorization process, provider cultural and linguistic requirements (including alternative formats) and regulatory and contractual requirements.  d. Web site updates |
| **3. Education of Health Plan staff, including case managers, about behavioral health services:**  The health plan will provide documentation that it has an implementation plan to train health plan staff, including case managers, about behavioral health services available through the counties, as well as how to involve members and family members in decision-making, how to help members access services and how to identify behavioral health needs. The strategy includes the following mechanisms:  a. A plan to conduct initial and regularly scheduled trainings regarding behavioral health assessments, identifying behavioral health needs, development of behavioral health care plans and interventions and coordination and linkages to behavioral health resources.  b. Website updates.  c. Has developed Informational materials in the threshold languages of the population served and in alternative formats for the visually and hearing impaired.  d. Quality assurance/utilization review measures to monitor and assure staff meet established competency criteria measures in the areas of behavioral health such as assessment, care planning, authorization and other identified areas. |