Behavioral Health and Recovery Services

Implementation Plan

2024-2025

Introduction and Purpose

The purpose of the Implementation Plan for psychiatric inpatient hospital services and outpatient specialty mental health services, is to describe the procedures to be followed in establishing the Stanislaus County Mental Health Plan (MHP), and in transitioning from a State administered Medi-Cal system to a system which is coordinated by the County. The Implementation Plan outlines the process of service delivery and utilization review by the MHP.

The Implementation Plan responds to the regulatory requirements found in Title 9, Chapter 11, Section 1810.310. Regulation citations are included at the beginning of each section of the Implementation Plan. This plan is a living document and may be updated if the Mental Health Plan (MHP) makes systemic changes. Per Title 9 regulations, all updates to the Implementation Plan will be submitted to Department of Health Care Services (DHCS) for approval.

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Point of Authorization - Inpatient Treatment Services

Title 9, Chapter 11, Section 1810.310 (a) (1)

The inpatient point of authorization is the function within the MHP which receives provider communications regarding requests for MHP payment authorization for psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facilities services.

The Inpatient Point of Authorization:

Electronic submission via web-enabled platform managed by Concurrent Review Contractor – Acentra Health

The Inpatient Point of Authorization's telephone number is:

(209) 525-5373

The Inpatient Point of Authorization's FAX number is:

(209) 554-0371

In order to be eligible to receive payment for psychiatric inpatient hospital services to a Medi-Cal beneficiary, all contract and provider hospitals must do the following:

- Within 24 hours of admission, the hospital or PHF shall provide the beneficiary's admission orders, initial plan of care, a request to authorize the beneficiary's treatment, and a completed face sheet;
- Within 14 days of the beneficiary's discharge, submit a ***Treatment Authorization Request (TAR)***

If, upon admission, a beneficiary is in a psychiatric emergency medical condition, as defined in Health & Safety Code section 1317.1(k), the time period for the hospital to request authorization shall begin when the beneficiary's condition is stabilized, as defined in Health & Safety Code section 1317.1(j).

Review of Initial Authorization Request

Concurrent Review Contractor shall decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF. For expedited authorization request, Concurrent Review Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for services.

Continued Stay Authorization

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay-authorization request for a specified number of days to the responsible county MHP.

Clinical Information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding

changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after MHP admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.
- MHP information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.
- Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested.

Administrative Day Criteria

In order to qualify for administrative days, the following criteria must be met:

- During the hospital stay, the beneficiary had previously met medical necessity criteria for reimbursement of acute psychiatric inpatient services for at least one day.
- There is no appropriate, non-acute residential treatment facility placement within a reasonable geographic area.
- For adults, the following types of non-acute treatment facility placements meet criteria:
  a. Skilled Nursing Facilities with a Psychiatric Component
  b. Institutes for Mental Diseases (IMDs)
  c. State Hospitals
- For children, the following types of non-acute treatment facility placements meet criteria and should be arranged through the authorized placement agency (e.g., Child Welfare or Probation):
  a. Community Treatment Facility (CTF) [i.e., licensed by Community Care Licensing as a combination of a Psychiatric Health Facility (PHF) and an RCL14 Group Home, with a portion of the facility being locked].
  b. Group Homes (i.e., RCL 9 Through 14 Facilities licensed by Community Care Licensing or Out-of-State facilities)
  c. Foster Homes
- The hospital or program staff must document contacts with a minimum of five appropriate, non-acute residential treatment facilities per week.
- If there are fewer than five appropriate, non-acute residential treatment facilities available as placement options, Concurrent Review Contractor may waive the requirement of five contacts per week. However, in no case shall there be less than one contact per week.

The documented contact with potential placements must include the following information:

- Status of the placement option;
- Date of the contact;
- Name and title of the person contacted;
- Signature and title of the person making the contact.

Examples of appropriate placement status options include, but may not be limited to, the following:

- The beneficiary's information packet is under review;
- An interview with the beneficiary has been scheduled for [date];
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a wait list;
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
- The patient has been rejected from a facility due to [reason]; and/or,
- A conservator deems the facility to be inappropriate for placement.

Point of Authorization - Outpatient Treatment Services

Title 9, Chapter 11, Section 1810.310(a)(1)

The outpatient point of authorization is the function within the MHP which receives provider communications, regarding requests for MHP authorization for outpatient specialty mental health services (SMHS).

The mailing address for the Outpatient Point of Authorization is:

Behavioral Health and Recovery Services
1130 12th St. Suite C
Modesto, CA 95354

The Outpatient Point of Authorization's telephone number is:

(209) 525-5373

The Outpatient Point of Authorization's FAX number is:

(209) 554-0371

MHP beneficiaries who wish to receive outpatient SMHS may arrange to do so by contacting one of the following:

- The Access Line
- Any MHP outpatient clinic or contract agency

BHRS outpatient clinics and contract agencies are authorized to provide outpatient services as clinically warranted. Services available at each location may vary depending upon the nature of the program; however, all outpatient SMHS are available through the MHP system of care. Each Medi-Cal certified service site has procedures to authorize treatment for beneficiaries; SB 785 authorizations will occur from the Service Authorization Request process.

BHRS has no Fee for Service (FSS) providers who furnish outpatient SMHS to Medi-Cal beneficiaries currently. If in the future, this were to change, providers will become a panel member of the MHP and will submit information to the MHP regarding the beneficiary. If the beneficiary is eligible to receive and requires specialty mental health services, the provider will be authorized to provide services. If the beneficiary does not appear to require this level of care, the beneficiary will be referred to the Managed Care Plan (MCP).

If outpatient FFS providers are utilized in the future, the providers will be required to submit authorization requests prior to providing treatment modalities, except for the initial clinical assessment.

Each outpatient FFS provider is permitted to provide one (1) initial assessment session without pre-authorization for a Medi-Cal beneficiary. All services after this initial visit must be preauthorized by the UM staff. The following Specialty Mental Health Services are provided through the MHP's FFS Provider network:

- Psychiatric Diagnostic Interview
- Pharmacologic Management (Medical Support Services)
- Individual Psychotherapy
- Group Psychotherapy
- Case Consultation

All services except for pharmacologic management (which is provided by psychiatrists only) are

provided by psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, and or licensed professional clinical counselor.

For standard authorization decisions, the MHP provides notice within five (5) business days following the completion and authorization of the comprehensive assessment or, when applicable, within fourteen (14) calendar days of an extension. The authorization is approved or denied only by licensed/waivered/registered mental health professionals of the MHP. A NOABD is given to beneficiaries at the time of denial for services.

Assessment and Coordination

Department of Health Care Services Behavioral Health Information Notice 21-073 (supersedes previous CCR Title 9 medical necessity regulations)

The goal of the MHP service delivery system is a seamless system of care which affords equal access to all eligible persons based on individual treatment needs. In order to assure this access for individuals, the MHP works closely with all providers at the different levels of care (e.g., Acute Psychiatric Inpatient Hospital Services and Coordinated Outpatient Mental Health Programs).

This collaboration is done at the individual treatment provider level, the specific agency level, and through more formal collaboration and arrangements. Collaborations serve to ensure beneficiaries are served in the most appropriate manner and encourage awareness of service options and support care transitions between MHP providers.

The criteria which must be met for a beneficiary aged 21+ years to begin receiving medically necessary SMHS are as follows:

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

The access criteria which must be met (either criteria 1 or criteria 2) for a beneficiary aged under 21 years to qualify for medically necessary SMHS are as follows:

(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:
   a. scoring in the high-risk range under a trauma screening tool approved by the Department of Health Care Services,
   b. involvement in the child welfare system,
   c. juvenile justice involvement, or
   d. experiencing homelessness.

OR

(2) The beneficiary meets **both of the following** requirements:
   a. The beneficiary has **at least one** of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for specialty mental health services, regardless of presence of 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 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 Statistical Classification of Diseases and Related Health Problems
    ii. A suspected mental health disorder that has not yet been diagnosed
    iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria for SMHS; it is not necessary to establish that the beneficiary meets the criteria in (2) above.

Medical Necessity is defined as follows:

For beneficiaries under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether such services are covered under the State Plan. Federal guidance from Centers for Medicare & Medicaid Services clarifies that mental health services need not be curative or restorative to ameliorate a mental health condition, only sustain, support, improve, or make more tolerable a mental health condition, and are covered as EPSDT services.

For beneficiaries age 21 and over, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

Access Line

The MHP's Access Unit is available to all beneficiaries and providers 24-hours a day, seven days per week, via the toll-free number: (**888) 376-6246**. The Access Unit provides all beneficiaries with referrals to specialty mental health services available within the MHP which meet the specific needs of the beneficiary.

When a beneficiary contacts the Access Unit with request for services, the Access Unit staff assesses the nature of the beneficiaries' request, cultural and linguistic needs, and links beneficiaries to specialty mental health services treatment providers. Crisis (emergent and/or urgent) calls are transferred to the Crisis Emergency Response Team (CERT) for crisis intervention via telephone as needed.

Crisis and Support Line

The Access Crisis and Support (ACS) line is available 24/7, to all beneficiaries whom may need crisis management or support to help them expediently manage a situation which may result in an escalated mental health crisis or avoid a crisis. Callers may be directed to a Mental Health Clinician who is available onsite with the ACS staff to help manage the crisis. The staff are also trained to provide community resources as needed.

Short Term Residential Therapeutic Program/Presumptive Transfer/Service Authorization

Minors with full-scope Medi-Cal residing outside Stanislaus County in a Short Term Residential Therapeutic Program (STRTP) and or resource home who meet medical necessity criteria should arrange for Specialty Mental Health Services following the individualized plan developed in the Child and Family Team, either through Waiver or the Presumptive Transfer (PT) process.

Minors with full-scope Medi-Cal residing outside of Stanislaus County that qualify for SB 785 status due to Adoption or Kin-Gap placement, who meet medical necessity criteria, should arrange for Specialty Mental Health Services through the Service Authorization (SAR) process.

CARE Court

The Adult System of Care recently launched the Community Assistance, Recovery, and Empowerment (CARE) Court Program to comply with the new state law aimed to support those living with untreated schizophrenia spectrum or other psychotic disorders by allowing a court to order individuals into behavioral health treatment in community- based settings.

CARE Court is intended to serve this population of adults with the goal of diverting individuals with schizophrenia spectrum or other psychotic disorders from more restrictive settings (such as conservatorship or incarceration) into the community with the support of an individualized CARE Agreement or CARE Plan.

Psychiatric Inpatient Hospital Services

Evaluation Process
During standard business hours, BHRS regional team members will evaluate the need for psychiatric inpatient hospital services for beneficiaries who are currently receiving services through one of the systems of care. CERT will complete the evaluation during standard business hours and after hours for those beneficiaries that are not currently receiving services and are uninsured.

Crisis Residential Unit

The Crisis Residential Unit (part of a regional contract with Merced Co, located in Merced) is a voluntary, 30-90-day adult treatment program for beneficiaries at risk of experiencing a mental health crisis without 24/7 treatment to help provide stabilization. The goal will be for the beneficiary to learn daily living skills to thrive independently upon discharge. The beneficiary is able participate in group therapy, individual counseling, medication evaluation and services. Crisis assessment are provided as needed in this setting. Case management, Rehabilitation and Recovery services, including SUD services are also included as part of the services.

Discharge and Referral Process

Adults:
Clients who are psychiatrically hospitalized and not currently open to BHRS outpatient services:
The BHRS Behavioral Health Outreach and Engagement team (BHOE) is a program designed to engage all Medical and Uninsured clients who fall in this category. The BHOE team focuses on engaging and linking clients to the needed resources and programs. They can assist clients in accessing and following up with outpatient services that include county mental health, substance use disorder services, mild to moderate metal health services (managed care), medication services, community resources, and placement needs (which can include respite, room and board, board and care etc.). The BHOE team is

also engaged in D/C planning, assess client needs, and participate in the inpatient treatment team meetings. Initially the BHOE team engages with and offers services to clients while they are admitted in the inpatient psychiatric hospital. If needed they will continue to engage, support, and link them to services after discharge.

Clients who are psychiatrically hospitalized and open to BHRS outpatient services:
Each Adult outpatient program has designated hospital liaisons who attend hospital treatment team meetings during the client's inpatient stay in order to provide continuity of care. Program hospital liaisons are also involved in discharge planning and assisting the client in accessing follow up mental health appointments, medication visits, and assisting with placement needs. The Liaison will also evaluate and assist with the client's service needs related to Substance Use Disorder (SUD) services. The Liaison can also help coordinate a SUD assessment for the client in order to expedite client's access to SUD services.

Children/Youth:

BHRS makes every attempt to support children and youth in remaining in the least restrictive environment possible when experiencing a crisis. If a minor in Stanislaus County does not meet criteria for psychiatric hospitalization but is experiencing a crisis the minor may be referred by the staff completing the crisis evaluation to the Crisis Stabilization Program for immediate support. This program offers all Medi-Cal beneficiaries and uninsured minors intensive mental health treatment services and referral to ongoing outpatient services. If a child or youth requires inpatient treatment to stabilize mental health symptoms, BHRS provides discharge planning for all who are uninsured residents of Stanislaus County or are Stanislaus County Medi-Cal beneficiaries, or are children or youth who have been presumptively transferred to Stanislaus County under AB 1299. This includes consultation with the inpatient hospital social worker or discharge planner regarding the needs of the minor, and referral and/or linkage to services for aftercare. This may include transportation assistance when needed. The goal is to assist in planning for the minor's return to the least restrictive environment in the community with necessary services and supports in place.

For minors who have existing services in place when they are admitted to an inpatient facility, the hospital liaison notifies the existing provider and there is collaboration regarding the potential need for intensive services (e.g. TBS, WRAP, and Full-Service Partnership). For minors who have no existing specialty mental health services at the time of admission to the inpatient facility, a referral is completed to the Crisis Stabilization Program (CSP) while the minor is inpatient. The CSP staff reaches out to the caregiver to arrange an intake and offer intensive services to be available upon hospital discharge. For a minor who has multiple inpatient admissions, the hospital liaison or other provider may refer for a collaborative planning meeting, including Planning Linking Conference (PLC), Interagency Resource Committee (IRC), System of Care (SOC) meeting, or Child and Family Team meeting to discuss complex needs, refer for additional supports, and increase engagement opportunities with the minor and family. The hospital liaison may also refer the caregivers to a Parent Partner to support the caregiver in navigating the crisis and transition to ongoing services.

For Dependents and Wards of the Court, there is collaborative discharge planning with the agency of responsibility (e.g. Adult, Child, and Family Services Agency or Probation). In most instances this is completed through the collaboration of the hospital, the placement agency, and the outpatient program intended to provide ongoing care; however, it is also feasible to include the BHRS Children's System of Care coordinating staff or hospital liaison to help facilitate this process. The hospital liaison may consult with the placing agency to support referral or linkage to services, or to support planning around Child and Family Team engagement or a Child and Family

Team meeting. For children or youth who have been presumptively transferred to Stanislaus County, the hospital liaison will conduct similar discharge planning to ensure appropriate linkage to services. The placing agency of responsibility may have contracts in place to offer services directly to these minors, so service referral is at their discretion.

For minors residing in Stanislaus County who have out of county Medi-Cal and meet eligibility criteria for services under SB785, they may be referred for aftercare services in the same manner as Stanislaus County beneficiaries.

For any of the above-described minors, with complex discharge needs (e.g. parents refusing to pick up a child) then the inpatient hospital may access additional help through the proper system of care to facilitate discharge plans.

Outpatient Specialty Mental Health Services

Screening and Assessment Process:

All entry points into the MHP system of care use the Adult and Youth Screening Tool for beneficiaries who contact the MHP and are not currently receiving mental health services. The tools are to be used to guide a referral by the MHP to the appropriate Medi-Cal mental health delivery system (i.e., MCP or MHP). The Adult and Youth Screening Tools identify initial indicators of beneficiary needs in order to make the best determination for referral to either the beneficiary's MCP for clinical assessment and medically necessary NSMHS or to the beneficiary's MHP for a clinical assessment and medically necessary SMHS.

After administration of the Adult or Youth Screening Tool, based on the score generated, the beneficiary is either referred to the MCP or scheduled for an Assessment with the MHP.
If at time of assessment, with the MHP, it is found that beneficiary does not meet medical necessity for specialty mental health services, then the appropriate Notice of Adverse Benefit Determination (NOABD) is provided and the beneficiary is referred to their Managed Care Plan (MCP) for beneficiaries with assigned Medi-Cal or the State Medi-Cal System for beneficiaries with unassigned Medi-Cal.

Beneficiaries may also present for services after contacting their Managed Care Plan (MCP). Stanislaus County MCPs screen beneficiaries who contact the MCP for services. The MCP screening may find that the beneficiary's impairments are severe and, in these cases, the MCP will initiate a referral to the MHP. The MHP processes these referrals and provides linkage to an appropriate care provider within the MHP system of care.

Discharge and Referral Process:

MHP providers conduct informal assessments of functional impairments and progress on goals at every encounter with a beneficiary. The process of discharge is clinically begun at the first session with a beneficiary, as the MHP providers work to support the beneficiary in gaining self-sustaining stability which allows them to transfer to natural supports. Once a beneficiary is determined to have consistent and sustained stability, the MHP provider will work with the beneficiary on a smooth care transition.

Specialty programs within the MHP, which target the most severe mental health impairments, will transition the beneficiary from the intensive specialty services to a traditional outpatient behavioral health clinic when clinically appropriate.

MHP will facilitate a warm hand off between the MHP provider and the MCP when a beneficiary no longer demonstrates medical necessity for specialty mental health services. MHP will maintain an

open case with the beneficiary until complete linkage to the MCP is accomplished, in order to avoid a lapse in care for the beneficiary.

Interagency Agreements and Collaborative Efforts

BHRS Adult System of Care have built several partnerships with the community and other local agencies to better collaborate and provide appropriate care for the clients that we serve. Some of these programs include: The LGBTQA Collaborative, The Assyrian Wellness Collaborative, The Stanislaus Asian American community resource (SAACR), Promotoras/Community Health Workers, Aging and Veteran Services, Community Based early intervention services, , Valley Mountain Regional Center (VMRC), Adult Protective Services and Ombudsman's Office, Managed Care providers, Doctor's Behavioral Health Center (DBHC) and Stanislaus County Psychiatric Health Facility (PHF), and Crisis Residential Unit (CRU).

BHRS Children System of Care has partnerships with various agencies or entities in the community. Some specific examples of these collaborations include: Child Abuse Prevention Council (CAPC), Juvenile Justice Coordinating Council, Center for Human Services, CAIRE Center, Stanislaus County Office of Education, Victor Community Support Services, Stanislaus SELPA, Modesto City Schools, Valley Mountain Regional Center, Child Welfare, LGBTQA Collaborative, Children's Crisis Center, Pathways, Youth Navigation Center, Aspiranet Drop-in Center/ILSP, homeless shelters, Modesto Junior College, After 18 (AB 12), and Juvenile Probation.

Access for Special Populations

Language

The MHP continues to have a range of providers with special language and cultural competencies available to assist beneficiaries. In those cases where MHP staff is not available with a language competence, arrangements are made to ensure that a qualified interpreter is present.

The beneficiary informing materials, however, that are developed by the MHP, e.g., Beneficiary Handbook and Provider Directory, will be available in English and Spanish. In addition, the beneficiary informing materials are available in large print and other formats, upon request.

Outreach and Access

CCR Title 9, Chapter 11, Section 1810.310 (a)(2)(B)

The MHP has distributed copies of its Mental Health Services Beneficiary Handbook and other beneficiary protection materials in both English and Spanish to psychiatric inpatient hospitals under contract with it and to all the BHRS and contract clinics. All service sites have been informed that beneficiaries must be offered a complete set of informational materials (Beneficiary Handbook, Notice of Privacy Practices, Advance Directive brochure, and Provider Directory) upon request or upon first accessing services. In addition, all service sites have been informed of the beneficiary protection materials and other items which must be available in the waiting room (grievance and appeal forms, envelopes addressed to BHRS Quality Services (QS) & Risk Management (RM) Department and form for requesting a change of provider). Written materials are also available in alternative formats (e.g., large print for those who are visually limited).

MHP ensures that the Department of Health Care Services (DHCS) issued Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT) brochure, which includes information about accessing Therapeutic Behavioral Services (TBS) is given to Medi-Cal beneficiaries under 21 years of age and their representative in the following circumstances: At the time of admission to a Skilled Nursing Facility (SNF) with a Specialized Treatment Program (STP) for the mentally disordered; at the time of admission to a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD); or at the time of placement in a Short Term Residential Therapeutic Program (STRTP).All contract hospitals have been informed via written notification and training sessions that all Medi-Cal beneficiaries under 21 years of age and admitted with an emergency psychiatric condition must be given notices regarding EPSDT and TBS at the time of admission. In addition, the Medi-Cal beneficiary's representative must also be given a copy of these notices at the time of admission.

The MHP also provides each beneficiary written notice of any significant changes in the information specified in Sections 438.10(g)(4) of Title 42 of the Code of Federal Regulations at least 30 days before the intended effective date of the change.

Coordination with Physical Health Care

Title 9, Chapter 11, Section 1810.310(a)(2)(D)

BHRS collaborates with open mental health clients' primary care practitioners (PCPs) to improve appropriate use of psychopharmacological medications, reduce incidents of adverse drug reactions and improve continuity of care. A custom database linked with the current BHRS client information system automates the process of providing and receiving information from a client's PCP to improve the rate at which providers of on-going services communicate with each client's PCPs. For this process, a letter is automatically generated to the client's PCP, which is completed by program staff, to provide the necessary information to the PCP to coordinate care. As a part of the process, a "bounce back" letter is included which allows for the PCP to provide information back to BHRS regarding the client's medical care. Additional letters can be generated as needed during the year to provide updated information to the PCP

In addition, BHRS service providers attempt to link clients without PCPs to physicians so that medical conditions can be addressed. BHRS will also arrange to provide individual consultation if a referral is made for psychiatric consult by any physician providing primary care in the community, if the client does not meet criteria to access this resource through their managed care plans.

BHRS has developed procedures that facilitate the coordination of care between the MHP and Managed Care Plans (MCP). BHRS has been diligently working on a memorandum of understandings with Health Plan of San Joaquin (HPSJ), Health Net Community Solutions (MHN), and Kaiser. Kaiser is a new MCP for BHRS and in partnership, continuous work is happening to finalize procedures on care coordination. BHRS holds, at minimum, quarterly coordination meetings with the MCPs.

HPSJ has a process in place in which they offer "curbside consultation" to Primary Care Physicians (PCP) willing to have peer to peer dialogue with a HPSJ psychiatrist/medical director, with the member's consent. The goal of the consultation is to get PCPs to a comfort level in terms of prescribing psychotropic medications and to answer any questions related to the members' mental health needs. This process provides support to ongoing access challenges in the area for psychiatrist services that is causing some wait times and helps prevent disruption in care.

If the member gives their consent for HPSJ to outreach to their PCP, a letter is faxed by a HPSJ care manager to the PCP explaining the consultation service and requesting that their office staff provide at least two dates and times that the PCP would be available. The HPSJ psychiatrist then calls the PCP at a mutually agreed upon time to review and discuss the member's current psychotropic medication regimen. The HPSJ psychiatrist can assist in the development of a treatment plan to address current behavioral symptoms.

MHN's process is that a PCP can call their clinical call center, in the same way that a member can call, and their staff will provide referrals to in-network psychiatrists. MHN has a policy stating they can routinely work with PCPs to offer referrals to MHN contracted psychiatrists who are able to assess the member and coordinate care with the PCPs, either to confirm the PCP's treatment plan is appropriate or to provide the ongoing medication monitoring service to the member and coordinate care with the physician. The choice of whether the member would like to continue with the MHN psychiatrist or get their medications from their PCP would be up to the member themselves. MHP psychiatrists are also available to provide clinical consultation to MCPs primary care physicians, as needed.

Problem Resolution

Title 9, Chapter 11, Section 1810.310(a)(3)

Grievance Procedure

Beneficiaries who are receiving SMHS through the MHP are entitled to file a grievance—either orally or in writing—about the services they have received. The grievance may be filed with the beneficiary's care provider, with the BHRS Risk Management (RM) Department, or with the Patients' Rights Office.

Beneficiaries have the right to have an authorized representative, acting on behalf of the beneficiary and with the beneficiary's written consent, act on his/her behalf during a grievance or appeal procedure. Beneficiaries may also identify a staff person or other individual to assist him/her with the grievance or notice of action adverse benefit determination (NOABD) appeal process (see next section).

Staff should make every effort to resolve grievances at the proper level. Resolution may be achieved through disclosures between the beneficiary and the therapist/case manager, clinic supervisor, program manager or the BHRS RM department. The Patient's Rights Office is also available as a resource.

If grievances cannot be resolved at the provider level, a grievance form may be completed by the beneficiary and sent to the BHRS RM department or the beneficiary may call the BHRS RM to attempt to resolve the issue. After receiving a verbal or written grievance, the BHRS RM department sends a resolution letter to the beneficiary acknowledging the grievance has been received. The BHRS RM department has 90 calendar days in which to assist in resolution of the issue. After resolution is achieved, the BHRS RM department sends a resolution letter to the beneficiary describing what has occurred. A 14-calendar day extension may be granted if the beneficiary requests the extension; or the MHP shows to the state, upon its request, that there is need for additional information and how this is in the best interest of the beneficiary. Grievances will be reviewed quarterly at the Quality Management Team meeting. An electronic grievance log is maintained by the BHRS RM Department in order to monitor the progress and resolution of each grievance.

Contacts for filing a grievance:

Stanislaus County Behavioral Health and Recovery Services
Quality Services Department
1130 12th St. Suite B - upstairs
Modesto, CA 95354

Phone - (209) 525-6043
FAX - (209) 558-4324

Stanislaus County Behavioral Health and Recovery Services
Patients' Rights Office
800 Scenic Dr. Bldg. A
Modesto, CA 95350

Phone - (209) 525-7423 or (800) 334-0352
FAX - (209) 558-4332

Notice of Action Adverse Benefit Determination (NOABD) Appeal Procedure

The following are procedures to be used when the beneficiary's dissatisfaction is the result of a NOABD which is defined to mean any of the following actions taken by the MHP:

- The denial or limited authorization of a requested service, including determinations based on the type or 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 payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the required timeframes for standard resolution of grievances and appeals; or
- The denial of a beneficiary's request to dispute financial liability

A NOABD for denial of specialty mental health services based on medical necessity will entail review of a provider's determination to deny, in whole or in part, a beneficiary's request for a covered specialty mental health service or for review of a determination by the MHP or its providers that the medical necessity criteria in Title 9 of the California Code of Regulations, Section 1830.205(b)(1), (b)(2), and (b)(3)(C) have not been met and the beneficiary is not entitled to any Specialty Mental Health Services from the MHP.

A beneficiary may complete a Grievance/Appeal/Expedited Appeal Form, which is to be forwarded to the BHRS Quality Services (QS) & Risk Management (RM) Department or may initiate a NOABD Appeal orally with the BHRS QS & RM department. Verbal appeals must be followed up in writing by the beneficiary within 30 calendar days of the date on which the verbal appeal was communicated.

The beneficiary and his or her authorized representative have the right—before and during the appeals process—to examine the beneficiary's case file, including medical records, and any other documents and records considered during the appeals process. The MHP shall provide the beneficiary and his or her authorized representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

A written acknowledgement of the NOABD Appeal is sent to the beneficiary. This acknowledgement also contains information on how the beneficiary may pursue subsequent requests for additional review. A written response to the appeal is made within 30 calendar days from the date of receipt of the form and is mailed to the beneficiary. A 14-calendar day extension may be granted if the beneficiary requests the extension; or the MHP shows to the state, upon its request, that there is need for additional information and how this is in the best interest of the beneficiary. Appeals will be reviewed quarterly at the Quality Management Team meeting. An electronic appeal log is maintained by the BHRS QS & RM Department in order to monitor the progress and resolution of each appeal.

Standard Appeal Procedure

Beneficiaries who are receiving SMHS through the MHP are entitled to file an appeal either orally or in writing when the MHP decides about their SMHS. If you submit your appeal orally, you must follow it up with a signed, written appeal. The beneficiary will have been notified of the decision through a NOABD. If the beneficiary did not receive a NOABD, they still have the right to file an appeal. The appeal may be filed with the beneficiary's care provider, with the BHRS Risk Management (RM) Department, or with the Patients' Rights Office.

The beneficiary and his or her authorized representative have the right—before and during the appeals process—to examine the beneficiary's case file, including medical records, and any other documents and records considered during the appeals process. The MHP shall provide the beneficiary and his or her authorized representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

A written acknowledgement of the Appeal is sent to the beneficiary. This acknowledgement also contains information on how the beneficiary may pursue subsequent requests for additional review. A written response to the appeal is made within 30 calendar days from the date of receipt of the form and is mailed to the beneficiary. A 14-calendar day extension may be granted if the beneficiary requests the extension; or the MHP shows to the state, upon its request, that there is need for additional information and how this is in the best interest of the beneficiary. Appeals will be reviewed quarterly at the Quality Management Team meeting. An electronic appeal log is maintained by the BHRS RM Department in order to monitor the progress and resolution of each appeal.

Expedited Appeal

An expedited review process for appeals occurs if the MHP determines that the time usually taken for a standard resolution would seriously jeopardize the beneficiary's life, health, or ability to function. Under the expedited process, the MHP notifies the parties no later than seventy-two (72) hours after the MHP has received the appeal. A 14-calendar day extension may be granted if the beneficiary requests the extension; or the MHP shows to the state, upon its request, that there is need for additional information and how this is in the best interest of the beneficiary. Expedited appeals will be reviewed quarterly at the Quality Management Team meeting. An electronic appeal log is maintained by the BHRS RM Department in order to monitor the progress and resolution of each expedited appeal.

The beneficiary and his or her authorized representative have the right—before and during the appeals process—to examine the beneficiary's case file, including medical records, and any other documents and records considered during the appeals process. The MHP shall provide the beneficiary and his or her authorized representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for expedited appeal resolutions.

State Fair Hearing Procedure

Beneficiaries who have received a NOABD may request a State Fair Hearing at any time before, during, or after the appeal process. If the appeal decision is not in favor of the beneficiary, the beneficiary may request a State Fair Hearing regarding the denial of service. The beneficiary must request a State Fair Hearing no later than 120 calendar days from the date of the MHP's notice of resolution. The beneficiary may also be eligible to continue receiving services pending the outcome of the State Fair Hearing if the request for a State Fair Hearing is made within 10 days of the date on which the NOABD was postmarked or was personally handed to the beneficiary or before the effective date of the change, whichever is later.

The fair hearing tracking log is maintained by the BHRS RM Department to monitor the progress and resolution of each request for a State Fair Hearing. Information regarding State Fair Hearings is forwarded to the BHRS Quality Services & Risk Management Department and reviewed quarterly in the Quality Management Team (QMT) committee. The BHRS RM department is responsible for coordination with the State Department of Social Services, State Department of Mental Health, providers, and beneficiaries regarding the State Fair Hearing process.

State Fair Hearing may be requested as stated below:

- On-line: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx
- By phone:
  - Call the State Hearings Division, toll free, at
    - (800) 743-8525 or
    - (855) 795-0634
  - Call the Public Inquiry and Response line, toll free, at
    - (800) 952-5253 or
    - TDD (800) 952-8349
- In writing:
  - Submitting your request to the county welfare department at the address shown on the Notice of Adverse Benefit Determination, or by fax or mail to:
    - **California Department of Social Services State Hearings Division**
      P.O. Box 944243, Mail Station 9-17-37
      Sacramento, CA 94244-2430
      Fax - (916) 651-5210 or (916) 651-2789

Provider Appeals Process

Providers may appeal a denied, terminated or reduced request for MHP payment authorization for psychiatric inpatient hospital services or for outpatient services. The procedures and timelines for the provider appeals process are outlined below.

- The provider must submit a written appeal to the MHP within 90 calendar days of the date of receipt of the MHP's non-approval of payment or within 90 days of the MHP's failure to act on the provider's request.
- The MHP has 60 calendar days from its receipt of the written appeal to inform the provider in writing of the decision. If the appeal is not granted in full, the provider is notified of any right to submit an appeal to the Department of Health Care Services (DHCS).
- If the MHP does not respond within 60 calendar days to the provider's appeal, the appeal is considered denied.
- The provider has 30 calendar days from receipt of the MHP's decision to approve the provider's payment authorization request to submit a revised request. In the case of psychiatric inpatient hospital services, the MHP has 14 calendar days from the date of receipt of the provider's revised request to submit the treatment authorization request to the fiscal intermediary for processing.
- When an appeal concerning the denial or modification of a payment authorization request for psychiatric inpatient hospital services in an emergency is denied in full or in part by the MHP on the basis that the provider did not comply with required timelines or did not supply documentation which established medical necessity, the provider may appeal to DHCS.
- Providers' appeals of an MHP's denial or modification of a payment authorization must be submitted in writing within 30 calendars day of the date of the MHP's written decision of denial.
- DHCS notifies the MHP and the provider of its receipt of a request for an appeal within seven calendar days.
- The MHP has 21 days in which to submit requested documentation to DHCS.
- DHCS has 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP of its decision, in writing.

- The provider has 30 calendar days from receipt of the DHCS decision in which to submit a revised request for MHP payment authorization, if applicable. The MHP has 14 calendar days from receipt of the provider's revised request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

The MHP contact information for provider appeals related to psychiatric inpatient hospital services:

Electronic submission directly to third-party contractor, Acentra Health

The MHP contact information for provider appeals related to outpatient services:

Behavioral Health and Recovery Services
Utilization Management
1130 12th St. Suite C
Modesto, CA 95354

Provider Selection

Title 9, Chapter 11, Section 1810.310(a)(4)

Hospitals

The MHP has, in accordance with Section 1810.430(a) of Title 9 of the California Code of Regulations, offered a contract to all hospitals which are either (1) Disproportionate Share Hospitals, and provide services to a disproportionate share of low-income individuals as determined annually by the Department of Health Services, or (2) Traditional hospitals which account for five (5) percent or $20,000, whichever is more, of the total psychiatric inpatient hospital payments for the MHP's beneficiaries. Contracts are now in place with hospitals interested in contracting.

Individual Providers

All applicants for panel membership as individual providers will be processed in a timely manner, according to uniform criteria. Applicants that are accepted for consideration for panel membership will be appropriately credentialed and approved according to BHRS Managed Care Services credentialing policies for individual practitioners. Applicants providing services to high-risk populations or specializing in conditions that require costly treatment will not be discriminated against. Providers, agencies, and facilities will be appropriately certified according to BHRS policy. (P&P 50.4.106 & 50.4.102)

All applicants for employment with BHRS will be processed in a timely manner, according to uniform criteria. Applicants that are accepted for consideration for employment will be appropriately credentialed and approved according to BHRS Human Resources credentialing policies for employment. Applicants providing services to high-risk populations or specializing in conditions that require costly treatment will not be discriminated against. Providers will be appropriately certified according to BHRS policy (P&P 60.2.129). All Organizational Contractor Providers ("Contractors") will also be processed according to uniform criteria as written in the contract between BHRS and the Contractor agency.

Network Adequacy

Title 9, Chapter 11, Section 1810.310(a)(5)(A)(B)

The Managed Care Final Rule requires each plan to submit to DHCS documentation on which the State bases its certification that the Plan has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in Title 42 C.F.R. Part 438.206. Each Plan shall complete the Network Adequacy Certification Tool (NACT) for all network providers at the organizational, site and rendering provider level of detail. The Managed Care Final Rule defines network providers as any provider, group of providers, or entity that has a network provider agreement with a Plan and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the State's contract with the Plan.

Stanislaus County BHRS conducts quarterly access studies for all portions of the MHP including adult and children's access. Included in the access studies are geographic maps which identify the population density of Stanislaus County residents, Medi-Cal beneficiaries and BHRS clients. BHRS utilizes the studies of the geographic regions of the county in order to compare the density of Medi-Cal beneficiaries with BHRS consumers and ensure that service delivery is located within those regions with the highest density of eligible beneficiaries.

Submission documentation includes the following:

- Network Adequacy Certification Tool (NACT) identifying both children/youth and adults for psychiatry and outpatient services.
    - Mental Health Plan NACT Attachment – A.1
        - Exhibit A-1 Organization – For the purposes of network adequacy, Plans must complete Exhibit A-1 in reference to the county and Plan's subcontracted organizations. Telehealth organizations must be included in this exhibit.
        - Exhibit A-2 Site – Include the physical location where the services are rendered to Medi-Cal Beneficiaries.
        - Exhibit A-3 Rendering Service Providers – Individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries.
        - Exhibit B-1: Field-Based Services – rendering providers who routinely travel to a satellite site or a fixed-location community setting to deliver services to beneficiaries in community-based setting (NOT including a beneficiary's home.)
        - Exhibit B-2: American Indian Health Facilities - Plans must complete Exhibit B-2 to demonstrate compliance with Federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR 438.14). American Indians and American Indian Health Facilities (IHF) are not required to maintain MHP affiliation; however, they retain the option to join an MHP at any time. In the exhibit, Plans must document all efforts to contract with American Indian Health Facilities in the Plan's service area.
        - Exhibit C-1 -Provider counts – enter the number of provider full-time equivalents (FTE) within the existing network, separated by provider type and the age group(s) served.

- DMC-ODS NACT Attachment – A.2
    - Exhibit A-1 Organization – For the purposes of network adequacy, Plans must complete Exhibit A-1 in reference to the county and Plan's subcontracted organizations. Telehealth organizations must be included in this exhibit.
    - Exhibit A-2 Site – Include the physical location where the services are rendered to Medi-Cal Beneficiaries.
    - Exhibit A-3 Rendering Service Provider – Individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries.
    - Exhibit B-1: Field-Based Services – rendering providers who routinely travel to a satellite site or a fixed-location community setting to deliver services to beneficiaries in community-based setting (NOT including a beneficiary's home.)
    - Exhibit B-2 American Indian Health Facilities – Plans must complete Exhibit B-2 to demonstrate compliance with Federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR 438.14). American Indians and American Indian Health Facilities (IHF) are not required to maintain DMC-ODS affiliation; however, they retain the option to join DMC-ODS at any time. In the exhibit, Plans must document all efforts to contract with American Indian Health Facilities in the Plan's service area.
    - DMC ODS Exhibit C-1 Expected Utilization – Actual and expected number of Medi-Cal Beneficiaries served for provided period. DMC-ODS providers should complete and submit Exhibit C-1. In the tables provided on Exhibit C-1, enter the actual number of Medi-Cal beneficiaries served this fiscal year (year-to-date) and the expected number of Medi-Cal beneficiaries to be served next fiscal year (next certification year), separated by service type/modality and age group(s) served.
- Language Line Encounters (Utilization) – Should be provided on Template G – Language Line Encounter Template separated by Encounters – 24/7 Access Line / Face to Face / Telehealth
- DMC-ODS provides:
    - Capacity and Composition Methodology
    - Timely Access Reporting Requirements
- MHP provides:
    - Inpatient Contract Reporting
    - Timely Access Urgent Psychiatric Reporting Requirements
- Timely Access Data Tool (TADT)
    - Attachment D.1 - (MHP) Non-Urgent / Psychiatry
    - Attachment D.2 - (DMC ODS) Outpatient / All Opioid

- Continuity of Care Report (COC) – Transition of Care Report Attachment F (MHP only) Title 42 of the Code of Federal Regulations, part 438.62 requires the State to have in effect a Continuity of care policy to ensure continued access to services during a beneficiary's transition from Medi-Cal fee-for-service (FFS) to a managed care program or transition from one managed care entity to another
    - Grievances and appeals related to availability of services and/or problems in obtaining services in a timely fashion, as well as the resolutions of such grievances and appeals
    - The results of beneficiary satisfaction surveys related to network adequacy or timely access for MHPs only
- All County Contracts will be requested by the DHCS County Liaison after the submission has been received via email.
- Network Provider Cover Sheets (CS) for MHP and DMC-ODS Contracts: (Attachment I) – MHP and DMC-ODS
    - Network Provider Contracts – Both Youth & Adults
        - MHP
            - Psychiatry
            - SMHS
            - ICC
            - IHBS
        - DMC-ODS
            - ODF
            - IOT
            - Residential
            - OTP
    - Reserve/Staffing Contracts
        - Telehealth (OP)Services Contracts
        - Inpatient Hospital Contracts (MHPs only)
            - Crisis residential treatment services
            - Adult residential treatment services
            - Psychiatric health facility services
            - Psychiatric inpatient hospital services
- Alternative Access Standard Request (Attachment C) only if requested by DHCS for both MHP and DMD-ODS
- Certification of Network Adequacy Data and Documentation (Attachment E) – all submitted items for each plan must be included in the Certificate and signed by Director or CFO for submission
- Attestations should be created with explanation and signed:
    - Psychiatry – we have used contracts to cover required FTE hours set by DHCS
    - Administrative Attestation – Letter of explanation when using additional contracts to cover FTE required hours

- Network Adequacy Annual Certification Inventory Form (applicable to all MHP & DMC-ODS Plans) Lists all documentation and required naming process to be followed. Follow Attachment G for naming sequence.

Age-Appropriate Services

Title 9, Chapter 11, Section 1810.310(a)(6)

Aging and Veteran Services

Through Prevention and Early Intervention (PEI), Aging and Veteran Services (AVS) provides mental health prevention and early intervention services for older adults who are primarily from culturally and geographically underserved communities. AVS implements the following services: Care coordination, brief intervention counseling, senior peer navigation, and friendly visitor program.

Older Adults

The older adult population is served throughout all Adult system of care programs. Services in all programs include case management, counseling, family education, medication and rehabilitation services. Clients are also provided Peer, Housing and Employment support services as needed. Support in ACT level programs is available to clients on a 24/7 basis. The teams work closely with family physicians. In addition, individuals are linked to community support groups and encouraged to develop their own peer support and recovery groups.

Children

Access for children occurs through BHRS outpatient clinics and contract agencies. A full continuum of care is available for youth from screening and early intervention to intensive services provided in the home and community or, if needed, within a residential setting. Local MHP community clinics provide a full array of outpatient services for children and families throughout the County. The MHP maintains its broad spectrum of County-wide children's services, including Wraparound Services, Therapeutic Behavioral Services (TBS), Crisis Stabilization Services, Short-Term Residential Therapeutic Program (STRTP) services, Full-Service Partnerships, Early Psychosis Services, Pathways to Wellbeing (Katie A), case management, and intensive outpatient services. The MHP has specialized services available that are co-located with Child Welfare and has representation in the juvenile hall reintegration meeting each week to receive referrals for youth transitioning out of custody back into the community. Service provision by the MHP includes Stanislaus County minors who are placed outside of this county when appropriate, and services to minors from other counties who are placed within Stanislaus County and are presumptively transferred to Stanislaus County for services.

Transitional Age Youth

The MHP has developed programs and services for other special populations, including programs designed to serve Transitional Age Youth (TAY). Telecare TAY Drop-In Center serves individuals age 18 to 25 experiencing mental health concerns who may not access traditional services. The drop in center is co-located with a Youth Navigation Center in the community, serves a diverse population and offers a wide array of services including educational opportunities, employment support, peer support groups, access to computers, crafts and recreational activities at the site and in the community, connection to physical health services, support in addressing housing or living situation needs, access to basic resources, and linkage and referral to other necessary services or supports. Co-located at this site are a low barrier shelter and transitional housing program for TAY that are operated by a local non-profit organization, Center for Human Services. These programs offer a continuum of care at one site, with all the programs emphasizing the youth's voice and choice. Telecare also operates a Behavioral Health Service Team (BHST) that provides assessment and treatment services, including medications when

needed, to individuals age 18 to 25. This includes assessment for substance use concerns and linkage to treatment if needed. The Telecare TAY team has a focus on reducing stigma, instilling hope, and increasing specialized services available to this population whose needs may not be otherwise met. Services are culturally and linguistically appropriate and sensitive to the needs of underserved populations in the community.

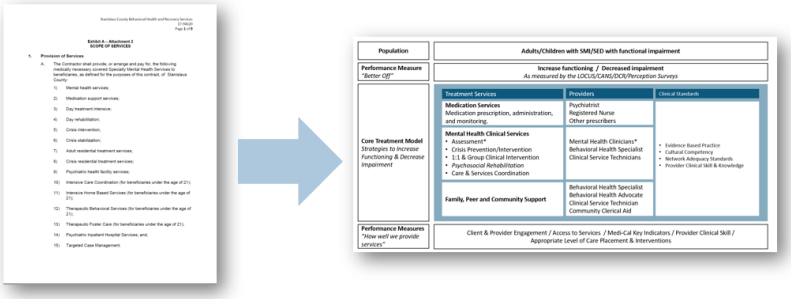
Cultural Competency

Title 9, Chapter 11, Section 1810.310(7)

Strategic Plan and Integrating Cultural Competency

Facing long-term systemic fiscal and community mental health need challenges and realizing the emerging opportunities with the implementation of CalAIM and other State historic behavioral health investments, BHRS developed a Strategic Plan that aligns program operations and services with sustainable funding. The Strategic Plan outlines BHRS's behavioral health services, organizational restructure, and fiscal resources to fulfill the mandated behavioral health plan role in the community of Stanislaus County. Mental health and substance use and addiction are central to the community's dialogue in addressing issues such as homelessness, crime, and the long-term impacts of COVID-19 on mental health.

Central to the Strategic Plan is the development of the Core Treatment Model (CTM) framework, which is a primary strategy to strengthen treatment capabilities as well as navigate the pathway to fiscal sustainability. The CTM clearly describes the population BHRS is mandated to serve and the expected outcomes as a result of treatment services. The CTM applies to both mental health and substance use disorders. By clearly identifying the mandated population, performance measures, and the treatment services that BHRS must provide as the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC ODS), the Department aims to improve both the efficiency and effectiveness of services. The CTM was developed using the Results-Based Accountability Framework (RBAF) and will integrate the treatment services specified to the MHP and DMC-OD.



Core Treatment Model = The population and core treatment services are defined in the Mental Health Plan and SUD ODS contracts with the State of California.

The BHRS Strategic Plan outlined actions to ensure core cultural competency initiatives, such as CLAS standards, cultural competency training, diverse workforce, etc., are integrated in the restructured systems of care. The Strategic Plan also outlines the role of the Behavioral Health Equity Committee (BHEC) in further developing the integration of the CLAS standards and strengthen our partnerships with diverse community collaboratives providing input and insight into how BHRS services diverse and ethnic communities.

The Department is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. The BHEC works to improve the quality of services and eliminate inequities and barriers to behavioral health care for marginalized cultural and ethnic communities. Based on established best practices, such as the Culturally and Linguistically Appropriate Services (CLAS) standards, BHEC developed applicable recommendations on strategies

to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Due to the implications of COVID-19, the initial recommendations put forth from the committee were identified as quick actions that can be implemented as part of the Strategic Plan.

The BHEC will also support the Department in the implementation of strategies that are responsive to the MHSA stakeholder priority that consumers are accessing and receiving behavioral health services and peer/community support in ways that are reflective and responsive to their cultures, languages, and worldviews." One of several key benchmarks will be the number of clinical providers that speak the County's Medi-Cal threshold language, Spanish.

The Department has also nurtured partnerships with diverse community stakeholders through the development of cultural collaborative partnerships with the Assyrian, faith-based organizations, Latino, National Association for the Advancement of Colored People (NAACP), Southeast Asian, Queer Lesbian Gay Bisexual Transgender Questioning Intersex Asexual and Two-Spirit (LGBTQIA+/2S) and other diverse communities. These partnerships, supported by the Prevention & Early Intervention Division, have continually provided overall community feedback to the Department on the further development of the local behavioral health system to meet the needs of Stanislaus County's diverse communities, and integrating community practice into current treatment programs

Our efforts to be culturally competent are also reflected in our updated Mental Health Services Act (MHSA) updated plan:

- Continued technical support and funding for the Promotora Program for Prevention and Early Intervention. The program works at the community level to provide social support and guidance for individuals who may be isolated or in need of services. Promotoras are trusted community members who can facilitate referrals to mental health services.

- The department expanded the Promotora model and approach by developing the Community Collaborative Plan that expands MHSA small/micro funding opportunities for diverse community partners to implement PEI strategies, such as Outreach for Increasing Recognition of Early Signs of Mental Illness and Access & Linkage to appropriate mental health services, that target Mental Health Services Act (MHSA) priority populations. These funding opportunities range from a $2,000 to $20,000. In addition, the department will work with key Community Collaborative partners to facilitate community conversations with peers/consumers and strengthening access to treatment services strategies.

In FY 2021-2022, the BHEC developed recommendations for the Principle CLAS Standard. As part of the planning process the BHEC was educated on the core treatment services outlined in the Mental Health Plan contract with the State of California. BHRS provided this education to ensure a shared understanding on what treatment entails so the BHEC could provide applicable recommendations on the Principle CLAS Standard. The education on the core treatment services and Principle Class Standard and subsequent brainstorming and discussion primarily unfolded before the COVID-19 emergency was declared. Given the Department did not have a projected timeline when the safety measures would be lifted, allowing for in-person gatherings, the BHEC decided to create a list of recommendations that could be implemented quickly. The BHEC realizes that the initial recommendations do not include strategies that address all the issues raised in the discussion. However, the committee developed these recommendations to provide the Department options for quick actions, even as the pandemic limited the ability for the committee to plan further.

The following recommendations were endorsed by BHEC in their meeting on September 13, 2020 and submitted to the BHRS Senior Leadership for implementation planning. These recommendations were included in the Strategic Plan and will be included in benchmarks for program development planning. The BHEC will play an active role in the implementation process as well.

How might we provide services and supports that are Equitable?

Equitable Themes

- Clients have a safe and supportive community and program space, accessible beyond regular business hours
- Client are provided a base level of care and appropriate level of care for all, making sure there's no partiality in treatment

Recommendations for Equitable Services

- Review SUD, LOCUS and CANS data for any disparity in the movement across levels of care.
- Review the informed consent documents for opportunities to improve for threshold language populations.
- Develop guidance for BHRS Senior Leadership on best practice for referrals and program transfers for diverse populations to reduce confusion for clients and timely continuity of care.
- Propose in the Mental Health Services Act Planning process that program expand their hours of operations to include weekends and evenings to meet the needs of diverse and hard to reach populations. Staff that work in the evenings should be able to meet the cultural and linguistic needs of the community as well.

How might we provide services and supports that are understandable?

Understandable Themes

- Client connection to treatment and supportive services is clear and simple to access
- Staff ensure clients understands the assessment and treatment process
- Referral information is accurate and up to date

Recommendations for Understandable Services

- Develop a standard program description template that describes the program and key points of information for clients both in Spanish and English
- Develop referral database that is updated regularly and tested for accuracy
- Develop Treatment Guidance on base standard of communication to the client about the assessment process, treatment planning, and supporting documents, fact sheets and videos. These videos could be viewed at clients wait for assessment.
- Develop Spanish language treatment summary as a proxy for a printed treatment plan.
- Develop target of the percentage of clients that will receive treatment services in their preferred language without interpreter.
- Define the number of staff that speak threshold language to meet the needs of our community.

How might we provide services and supports that are respectful?

Respectful Themes

- Staff talk to clients nicely with respect; show them that you are caring and happy to help the
- Programs environments are welcoming and reflect respect for clients
- Staff are trained and have concreate strategies/tools to engage culture

Recommendations for Respectful Services

- Develop guidance with concrete examples of best practice communication with diverse community populations that strengthen the clinical and client relationship
- Develop guidance on a standard program space decoration, marketing materials, and office setup that reflects the diversity of our community and clients.

Behavioral Health Equity Manager

The Behavioral Health Equity Manager (BHEM) is responsible for ensuring that their county meets cultural and linguistic competence standards in the delivery of community-based behavioral health services, including Medi-Cal Specialty Mental Health Services (SMHS), DMC-ODS substance use disorder (SUD) services, and MHSA services. The BHEM promotes and monitors quality and equitable care as it relates to diverse racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs.

The BHEM's priority for Fiscal Year 2023-2024 will be to develop a strategy to ensure all programs continue to fully implement the CLAS standards. The BHEC agenda will include education on CLAS, review of best practices, and presentations from programs on their CLAS standards program development activities and progress. The initial strategies will focus on ensuring program are adhering and further developing the initial recommendation CLAS standards.

Additionally, the BHEC and BHEM will support the Department's efforts to launch a Cultural Competency training. The training will introduce BHRS' commitment to cultural competency, including a discussion about CLAS Standards and the Cultural Competence Program for Stanislaus County – to include all policies and training requirements. In addition, the Department will work with local diverse PEI Community Collaboratives (PEICC) to further expand their scope of practice to include supporting the Department in community stakeholder participation that will inform the further development and strengthening of treatment services for diverse community populations. The Department will work with PEICC to develop and provide educational sessions for treatment providers on the local diverse community experience in accessing and receiving behavioral health treatment services. To develop these educational sessions, the Department will partner PEICC to convene learning sessions with BHRS clients and community members to learn and gain insight into diverse community member and client challenges and successes in accessing behavioral health services. The educational sessions will vary in topic and include information on local, natural community supports for clients and families, and how treatment providers can connect clients to these community supports. The PEICC includes but is not limited to:

- Stanislaus Asian America Community Resources
- LGBTQIA+/2S Collaborative
- NAACP
- Assyrian Wellness Collaborative
- Jakara Movement
- Peer Recovery Art Project
- Khmer Youth of Modesto
- Cricket's Hope
- MJC Latina + LGBTQ
- MoPRIDE
- Youth for Christ
- Promotores
- Youth Empowerment Program
- Community-based Continuum of Care Project
- LGBTQIA+/2S Collaborative Youth Support groups

The following is a highlight of some collaborations with the LGBTQIA+/2S collaborative, the Assyrian Wellness Collaborative (AWC), and the Stanislaus Asian American Community Resource (SAACR) committee.

The LGBTQIA+/2S Collaborative, supported by BHRS Prevention & Early Intervention service, is the collective efforts of agencies, organizations, and individuals dedicated to promoting well- being, support, and education to the LGBTQIA+/2S community and LGBTQIA+/2S allies and advocates in Stanislaus County. The collaborative mission is to promote the health and well-being of lesbian, gay, bisexual, transgender, questioning persons and their allies by uniting and cooperating with agencies, organizations, and groups of like purposes, helping to conserve and protect overall community health of the greater Stanislaus County area. Key strategies include mapping health supports, cultivating behavioral health leadership, advancing cultural competency, promoting awareness, and increasing community and peer support.

The Assyrian Wellness Collaborative (AWC) is a community-based collaborative developed in partnership with Stanislaus County Behavioral Health and Recovery Services: Faith/Spirituality Initiative. The AWC's mission is to increase knowledge and improvement of mental health, physical health, and overall wellness in the Assyrian Community by decreasing stigma and barriers currently keeping Assyrian's from receiving services. The collaborative strives to help decrease barriers by developing support networks in each distinct Assyrian community regardless of religious preference and beliefs. There is a strong emphasize to further promote understanding and awareness of behavioral health, emotional health, and wellness.

The Stanislaus Asian American community resource (SAACR) committee is part of the cross-cultural community capacity building project where Prevention & Early Intervention (PEI) plays a key role in helping the group develop their leadership as well as assist in developing a wellbeing plan for the group related to PEI areas (wellness, resiliency, strengthening protective factors etc.). SAACR holds community events to strengthen relationships related to the culture and increase awareness of their work related to their cultural protective factors and overall wellness.

Below are some current examples of Culturally Specific and age appropriate Programs provided by the MHP (through prevention, early intervention and treatment programs):

Promotoras/Community Health Workers (CHW) – (RAIZ) Mental Health Prevention Program:
Through PEI, the Promotoras program utilizes thirteen (13) full time Promotoras to promote community-based health education and prevention, particularly in communities historically underserved by the U.S. health care system. Promotoras and CHWs engage residents in activities that promote behavioral health and well-being to reduce the risk for developing a potentially serious mental health condition and to build protective factors. Promotoras and CHWs also represent a rich spectrum of characteristics that facilitate access and linkage for underserved individuals into needed mental health care services and/or natural communities of support. As non-clinical providers, Promotoras/CHWs are the bridge between health care institutions, professional providers, and community residents.

Aging and Veteran Services:
Through PEI, Aging and Veteran Services (AVS) provided mental health prevention and early intervention services for underserved/unserved older adults who are at risk of early onset of mental health conditions as well as from culturally and geographically underserved communities. AVS implements the following services: Care coordination, brief intervention counseling, and senior peer navigation and friendly visitor program.

Community Based Early Intervention Services:
BHRS contracts with various agencies to provide community-based early intervention and prevention services for children, adults, and older adults with emphasis on MHSA underserved and unserved populations. Local contracted agencies include Golden Valley, Catholic Charities, El Concilio, Parents United, Sierra Vista Child & Family Services, and Center for Human Services (CHS). Some of the areas of focus includes CHS which provides early intervention services at predominately Latino underserved schools in Tk-12, SVCFS's Life Path, an early psychosis program serving broad ages group of clients, engages Latino families experiencing psychosis of a family member or themselves, and lastly, the contract with Golden Valley Health Centers also outlines the delivery of the above-mentioned services through an integrated health care approach. These community-based programs have shown a strong ability to reach Latino communities.

Telecare TAY Behavioral Health Service Team and Drop in Center:
Telecare is contracted to operate a service team to provide young adults ages 18-25 years old with outpatient mental health services. Clients referred to the program must meet the SMI criteria for Medi-Cal medical necessity, moderate to severe symptomology. This team is co-located at a community-based Youth Navigation Center operated by a local non-profit, that also houses a low barrier shelter and transitional housing program for young adults. Telecare operates a drop-in center at the Youth Navigation Center, that is a membership-driven Transitional Age Youth Adults drop in center that provides support to TAYA youth seeking support for mental illness. Outreach to and participation from Lesbian Gay Bisexual Transgender Questioning Intersex Asexual and Two-Spirit (LGBTQIA+/2S) youth are included in the cultural sensitivity of services provided. Peer support groups are offered on site at the drop-in center. Both the Telecare Behavioral Health Services Team and the drop-in center seek to provide specialized support to young adults in more than one of the following areas: housing, health, work, education, relationships, mental health, substance issues, and domestic violence and/or trauma issues.

Admissions To Non-Contracted Hospitals

Title 9, Chapter 11, Section 1810.310(a)(8)

If a planned admission to a non-contract hospital is determined to be necessary by the MHP, the process to receive payment for psychiatric inpatient hospital services to a Medi-Cal beneficiary will be followed. The Utilization Management department with follow the appropriate review process, concurrent or retrospective review, in these cases. (See Point of Authorization – Inpatient Treatment Services, page 4 of this document).

Quality Improvement Program

Title 9, Chapter 11, Section 1810.310(a)(9)

The Stanislaus County MHP Quality Assessment & Performance Improvement Program (QAPI) is accountable to the Director of BHRS. The QAPI is overseen by the Quality Management Team (QMT) Committee, which meets monthly. The *Quality Improvement (QI) Program Description and Work Plan* is evaluated annually and updated as needed and meets the contractual requirements of the Mental Health Plan Contract with DHCS as well as additional areas of performance improvement as identified by California External Quality Review Organization (CalEQRO) and the BHRS Strategic Plan. Each Quality Improvement Council (QIC) develops an action plan, which supports the overall QI Program Description and Work Plan for BHRS. The QI Work Plan identifies quality improvement goals and objectives for the succeeding year, including a schedule of the specific quality improvement related activities and studies that are to occur. It is the responsibility of the BHRS Quality Services/Risk Manager (QS/RM) to assist QICs in developing action plans and to assist the Behavioral Health Plan Administration Chief in developing the overall BHRS QI work plan. The QI Work Plan is submitted to the QMT for approval. The QIC action plans identify the focus of improvement or monitoring for the year.

This QAPI is designed to ensure that any quality of care issue is identified and monitored and that appropriate corrective actions are taken. The QAPI is designed to pursue continuous quality improvement and to ensure that behavioral health services provided to members meet established quality of care standards.

Quality will be evaluated in the areas of access, satisfaction, continuity of care, coordination of care, and quality of care. Each area of BHRS has specific expectations for the delivery of behavioral health services, which will be identified and monitored through a continuous quality improvement work plan.

The QAPI is multi-disciplinary. Providers, consumers, family members and BHRS staff with direct responsibilities for care management, quality assurance and administration are involved. Consumer and family members, representing our diverse community and participating at all levels of the organization, are instrumental in helping us achieve our quality goals.

The QAPI of Stanislaus County BHRS operates using the following continuous process improvement principles as guidelines:

- Focus on the customer
- People orientation to problem solving (involve people closest to the problem)
- Process improvement principles
- Use of quantitative as well as qualitative methods
- Systematic approach

Committee Composition

Quality Management Team (QMT):
Provides direction, support and coaching to the various BHRS QICs. This may involve identification of key processes, especially cross-functional processes. The QMT reviews and evaluates each QIC activities. The QMT receives routine reports from the QICs, which delineate quality management activities, actions taken and reassessments to ensure there is continuous quality improvement. The QMT holds each QIC accountable for the quality activities in the respective divisions. In addition, the

QMT receives reports from the Medication Monitoring Committee. The QMT acts on recommendations from QICs and process improvement work groups that require Senior Leadership Team (SLT) review and approval. Membership includes all SLT members, QS/RM, chairs of division QICs, the QS Specialist and Mental Health Board members representing consumers and families. The QMT meets a minimum of ten (10) times each year, except in extreme circumstances (e.g., global pandemic).

Quality Improvement Councils (QIC):
Each division of BHRS participates on a QIC. The QICs oversee the overall program effectiveness and performance of their divisions. Each QIC also reviews and develops an annual action plan. The membership of most councils includes the Chief of the System of Care or Division (or designee), staff providers, consumers and family members of consumers. Consumer and family member participation is an expected and vital component of QIC. Each QIC meets at least ten (10) times each year, except in extreme circumstances (e.g., global pandemic).

Behavioral Health Equity Committee (formally known as Cultural Competency, Equity and Social Justice Committee (BHEC):
This committee is responsible for overseeing BHRS cultural competence initiatives to ensure effectiveness and promote transformation of the behavioral health system. This committee also monitors adherence to DHCS Cultural Competence Plan requirements. The membership includes Senior Leadership representatives, staff providers, partner agency staff, consumers and family members of consumers. Consumer and family member participation is an expected and vital component of BHEC. The Committee meets at least ten (10) times each year, except in extreme circumstances (e.g., global pandemic).

Process Improvement Project Work Groups (PIP):
PIP work groups are formed when functions and processes needing improvement cross divisions or County Departments. PIPs are to be time-limited and cross functional and focus on the processes in questions. These teams use continuous process improvement principles and tools and make recommendations to QMT. The contributions of consumers and family members to process improvement work groups are essential in achieving our goals and fulfilling our vision.

Medication Monitoring Committee:
This committee is responsible for the medication management functions of BHRS and reports to QMT. The committee is supervised by the Medical Director and the Behavioral Health Plan Administration Chief (or designee). The committee is chaired by a psychiatrist or pharmacist and is composed of psychiatrists, nurses and pharmacists. The committee meets at least once annually.

The MHP solicits information from diverse providers, beneficiaries and family members by means of questionnaires and satisfaction surveys (available in both English and Spanish) on a regular basis. The regularly scheduled tools are the California Consumer Perception Survey, Treatment Perception Survey, and annual CalEQRO focus groups. Additionally, questionnaires and surveys are administered on an as-needed basis throughout the year. A variety of outcomes measures implemented across our system also gather feedback directly from beneficiaries and family members in order to directly impact treatment planning. Examples include the Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC-35), Level of Care Utilization System (LOCUS), and Addiction Severity Index (ASI). The questionnaires include items concerning quality of care issues to determine consumer perceptions and levels of satisfaction with available services and suggestions for improvement. The MHP uses the results of these surveys to make improvements in the provision of services as appropriate so these groups have input into the continuous quality improvement processes.

Delegation

The MHP does not delegate any quality improvement activities to a separate entity.

Plan Submissions

The MHP submits the annual BHRS Quality Assessment & Performance Improvement (QAPI) Program: *Quality Improvement (QI) Program Description and Work Plan* as required.

Utilization Management Program

The primary responsibilities of the Utilization Management (UM) Program are:

- Pre-Authorization of Specialty Mental Health Services (SMHS)
- Monitoring of Concurrent Review Contractor
- UM Audit Reviews

Pre-authorization of services

Pre-authorization is required for the following services: Therapeutic Behavioral Services (TBS), Intensive Home-Based Services (IHBS), Day Treatment Services, Day Rehabilitation, and Therapeutic Foster Care (TFC).MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

Emergency psychiatric inpatient hospital services provided to Medi-Cal beneficiaries are not subject to prior authorization. No prior authorization shall be required for mental health assessment services, nor for outpatient services other than those services listed above.

Minor beneficiaries who have a County of Origin other than Stanislaus, must access services through the SB785 Service Authorization Request (SAR) Process (this applies only to KinGap and Adoptees). Minor beneficiaries who have Stanislaus County Medi-Cal, but who are being hosted in another county also access services in the host county through the SB 785 process. UM receives the SAR and authorizes services for the host county to provide SMHS for that beneficiary. Authorization not to exceed five (5) business days from the receipt of SAR documentation.

Emergency services provided to Medi-Cal beneficiaries do not require pre-authorization. Emergency services means inpatient and/or outpatient services that are as follows: 1) needed to evaluate or stabilize an emergency psychiatric condition; 2) furnished by a provider that is qualified to perform these services under his or her title. The crisis services that result in inpatient hospitalization will be subject to concurrent review by the Concurrent Review Contractor to ensure that emergency criteria were met. Concurrent Review Contractor shall review documentation utilizing Title 9 requirements and Department of Health Care Services (DHCS) training to determine authorization and payment of services to treat an emergency psychiatric condition. Concurrent Review Contractor must be notified of any psychiatric inpatient admission immediately for concurrent review to begin. Per BHIN 22-017, within 24 hours of admission of a Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital or PHF shall provide Concurrent Review Contractor the beneficiary's admission orders, initial plan of care, and a completed face sheet.

Concurrent Review

Concurrent review provides a means of monitoring for any admissions and is the primary method of review for medical necessity. Concurrent review is performed by the Concurrent Review Contractor, on inpatient admissions to acute, psychiatric facilities via a web-enabled utilization platform. Conduction of concurrent review of treatment authorizations following the first day of admission and for each day of continued stay. Concurrent review includes receiving information regarding continued medical necessity and/or discharge plans. For concurrent review, Concurrent Review Contractor staff utilizes medical necessity criteria established in CCR, Title 9, Chapter 11, Section 1820.205 and Informational Notice 22-017. Concurrent review is used to determine that medical necessity criteria is met for acute

days and administrative day criteria is met for administrative days claimed for reimbursement of Federal Financial Participation (FFP)and does not guarantee payment for inpatient services.

Retrospective Review

Retrospective Review may be conducted for retrospective authorization of SMHS under the following limited circumstances:

- Retroactive Medi-cal eligibility determinations
- Inaccuracies in the Medi-Cal Eligibility Data System
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries, and/or
- Beneficiary's failure to identify payer (e.g. for inpatient psychiatric hospital services.)

In cases where the review is retrospective, Concurrent Review Contractor's authorization decision shall be communicated to the provider in a manner that is consistent with state requirements. Additionally, if the Concurrent Review Contractor modifies or denies a retrospective authorization request, Contractor shall notify the beneficiary in writing via the appropriate NOABD.

Confidentiality/HIPAA/Security

Title 9, Chapter 11, Section 1810.310(a)(10)

The MHP has guidelines and standard operating policies and procedures designed to protect beneficiary confidentiality and privacy, all of which are in accordance with HIPAA requirements. Notice of Privacy Practices is provided to all beneficiaries to inform them about their rights.

A Code of Ethics policy (40.1.102) has been created to provide guidance to all members of the MHP workforce and contract agency staff to recognize and deal with ethical issues including areas of confidentiality.

The MHP has a Privacy Policy (30.2.136) that provides detailed information regarding use and disclosure of protected health information, client rights regarding their PHI, and safeguards for privacy protection.

The MHP has an Information Security Policy (30.2.107) that includes detailed information regarding the MHP's policies on meeting legal and best practice requirements for information security.

The MHP has a Confidentiality of Clinical Records (30.2.100) that describes the MHP's policy on how records are kept confidential when enforcing HIPAA and CFR 42 Part 2 laws.

The MHP also provides a Compliance Hotline (800-779-1907) which allows individuals to report any activity which may violate confidentiality rights of beneficiaries.

BHRS Compliance program conducts audits/reviews to ensure compliance with established Federal and State laws and regulations.