ACBH Network Adequacy Certification Tool (NACT) Client Services Information (CSI) Assessment Record Data Documentation Training

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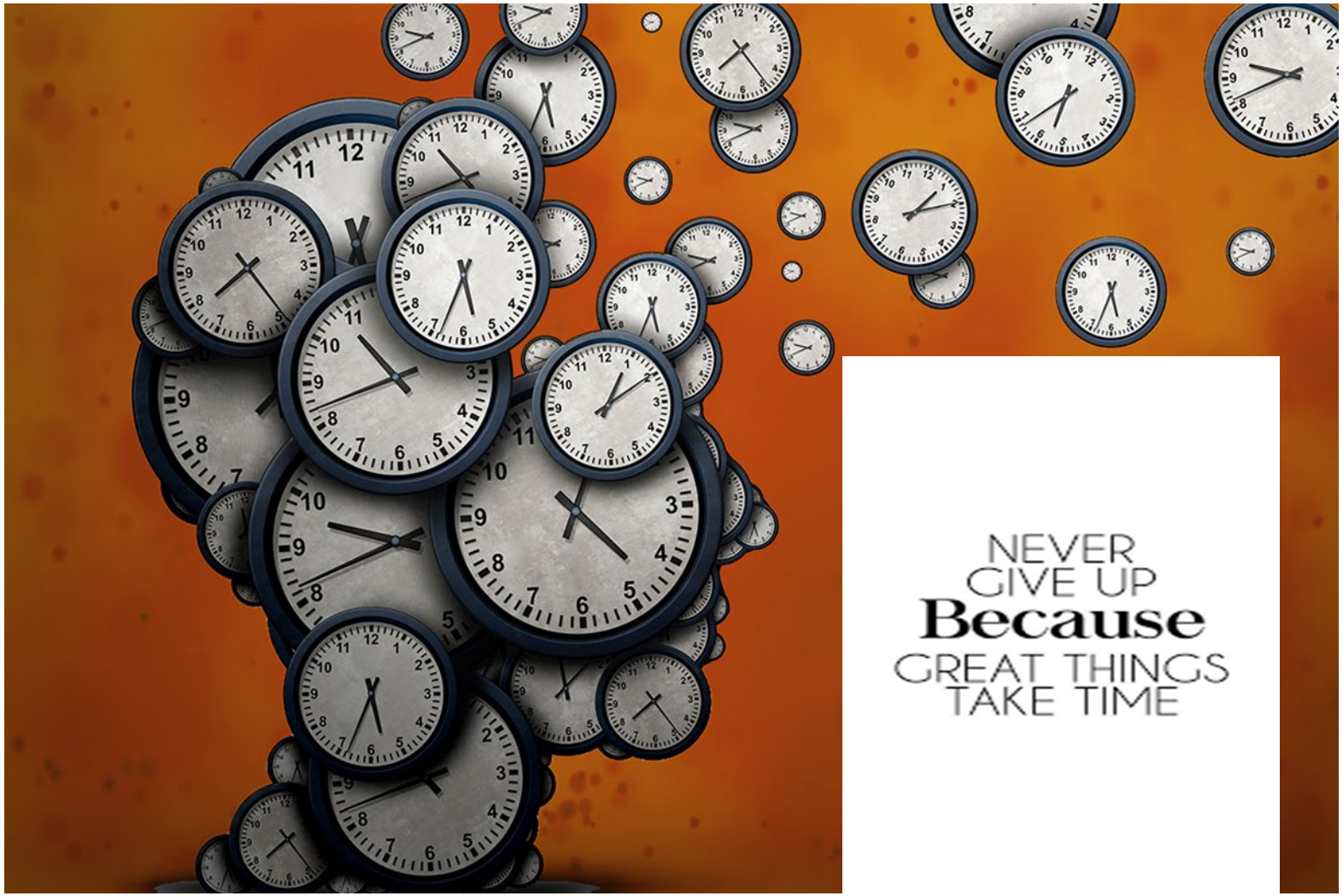
NOTE: This presentation was originally offered in April 2021. Slide 23 was updated by the QA team on 9/14/22 to reflect changes to the Data Collection process.



Alameda County Behavioral Health Care Services

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Agenda

- Introduction: The reason we are revisiting this topic
- Review the reports that agencies will receive
- Review definitions and forms
- Data Collection Forms
- Close with FAQs

Network Adequacy Certification Tool Information Notice

- Information Notice 18-011, dated February 13, 2018,establishes timely access to service standards and tracking requirements.

- MHPs are required to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

- Timely access standards refers to the number of business days in which a plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider on behalf of the beneficiary, requests medically necessary services.

NACT Timely Access Information notice

- Information Notice 19-020, dated March 22, 2019, notes the State must require each county Mental Health Plan to commit to having a system in place for tracking and measuring timeliness of care. This is in accordance with the Special Terms and Conditions from CMS pertaining to timeliness and the Medicaid Managed Care Final Rule pertaining to timely access standards.

- Monitor and ensure MHPs meet the timely access standards, DHCS is requiring MHPs to begin submitting new data elements to the BHIS-CSI System.

- Determine the number of days from a beneficiary's request for specialty mental health services to an initial assessment, and the number of days from the initial assessment to the first treatment appointment.

NACT Information Notice Summary

- DHCS wants to know: Does the MHP provide timely appointment offers, and ultimately timely access to assessment? And does the MHP provide timely access to treatment?

- DHCS wants to determine the number of days from a beneficiary's request for specialty mental health services to an initial assessment, and the number of days from the initial assessment to the first treatment appointment.

NACT Corrective Action Plan Requirements

As part of the Federal and State Network Adequacy Certification Tool (NACT) requirement, ACBH must submit Client Service Information (CSI) Timeliness data to the Department of Health Care Services (DHCS) by **January 2, 2021**. All providers, county and subcontractors, will be required to submit CSI timeliness data for reporting period September 1, 2020 through November 30, 2020.

- Priority should be given to providing missing CSI Assessment Record data from September 1, 2020 through November 30, 2020.

- ACBH provided reports will focus on requested services that began July 1, 2020 anticipating that closure dates would fall after September 1, 2020.

Who is responsible for collecting Data

- All outpatient ACBH county-run and subcontractor programs with ACBH who bill Medi-Cal for services.

Who does not need to report timeliness?

- Any providers not providing specialty mental health services and not claiming to Medi-Cal
  -Outreach programs

*once a client agrees to services-this is the “Date of Requested Services”

When do you have to track timely access?

1. New Client (Medi-Cal and Medi-Cal eligible)
   - New to the Mental Health Plan and not just new to your program

2. New Returning
   - Beneficiary that has not received outpatient services in the past 12 months in the MHP system

Ways to determine if a beneficiary is a new client or returning new client

- 1. A beneficiary is a new client if they do not have an INSYST client number

- 2. A beneficiary is a new returning client if InSyst or Clinician's Gateway Face sheet shows no services in the last 12 months.

*If a client has only received services that did not bill Medi-Cal they are still considered new (i.e. outreach teams, jail services, etc.)

Type of Service

- Psychiatry=Evaluation of the need for administration of and education about the risks and benefits associated with medication.

- Outpatient=Crisis Intervention, Crisis Stabilization, Mental Health Services, Targeted Case Management, Intensive Care Coordination, Medication Support Services.

- Outpatient Services-Prior Authorization=Intensive home-based services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, Therapeutic Foster Care.

Date of First Contact to Request Service

- When any new Medi-Cal eligible person calls ACCESS, walks in, interacts with crisis services etc.
- Even if you are unable to see that person and it results in a referral back to ACCESS it is the “Date of First Contact.”
- Service can only be requested by Client or Client’s legal guardian
- Medi-Cal eligible is defined as someone who has Medi-Cal insurance or may have Medi-Cal insurance retroactively applied.

Time Requirements

- Providers are required to offer an appointment from the date of the request.
- Psychiatry-15 business days
- Outpatient prior authorization not required- 10 days
- Outpatient prior authorization is required- 10 days
- Providers can provide "offered appointment" date/time over voicemail and request beneficiary call back by a certain date t confirm/decline appointment.

Urgent services

- A request for service shall be considered urgent when the enrollee's condition is such that the enrollee faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.
- Urgent services have different timeliness requirements based upon whether prior authorization is required.
  - Psychiatry- 48hours
  - Outpatient prior authorization is not required- 48 hours
  - Outpatient prior authorization is required- 96 hours

Assessment

- Any intervention in which the purpose is to gather information necessary to complete a client's Medi-Cal-compliant assessment document. This includes assessing the client for medical necessity for specialty mental health services.

Assessment Start Date

- The date of the first assessment appointment.
- This indicates that the beneficiary attended and completed the first assessment appointment.
- This can start on the phone.

Medical Necessity

- A service is medically necessary if it is needed to address a particular health condition and the following criteria are met: 1) the diagnosis is included/covered, 2) the condition results in a functional impairment, 3) the proposed intervention addresses the impairment, and 4) the condition would not be responsive to treatment by a physical health care provider. For Specialty Mental Health Services the beneficiary's impairments, as a result of their mental health condition, must fall in the moderate-to-severe range.

- A probability the child will not progress developmentally, as individually appropriate or children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated with mental health services.

Assessment End Date

- The date the Medi-Cal-compliant assessment document is completed and signed.

- **This must include an in-person visit to complete the mental status exam and the diagnosis section of the assessment**

Treatment Start Date

- Most times this will be after the treatment plan is completed and signed

- The first date an appointment is offered to a new or new returning client to provide Crisis Intervention, Crisis Stabilization, Mental Health Services, Targeted Case Management, Intensive Care Coordination, or Medication Support Services

- Treatment services do not include assessment or treatment planning interventions

*can be the same day as the assessment start date, and can be over the phone.

Unsuccessful Referrals

- A Request for Service with no Date of First Offer Assessment Appointment

- CSI Timeliness Record Data is Required for Unsuccessful Referrals
  - Standard (i.e. Non-Urgent) Appointments: Report CSI Timeliness Record Data sixty (60) days from Date of First Contact to Request Service
  - Urgent Appointments: Report CSI Timeliness Record Data seven (7) days (i.e. 168 hours) from Date of First Contact to Request Service.

Close Out Date

- When the beneficiary does not complete the assessment process and/or treatment and the case is closed.

*see the list on the data collection form

Note: Effective September 2022, ACBH has rolled out a new Timeliness Tracking Process in InSYST. As of that date, Fee for Service providers are the only ones who will continue using the eForm.

Data collection forms

1. Timeliness Reporting Data Collection (Interim)
2. Timeliness Data Collection Instructions (updating)
3. Timeliness Data Entry eForm (IS web portal)

https://eforms3.bhcs.internal/lincdoc/doc/run/alameda/CSI_Assessment_Non_P_RUs

- The Timeliness Data should be submitted when the assessment end date and treatment start date is successfully completed or when the client does not complete the assessment process and the case is closed
- Standard Appointments: Report CSI Timeliness Record Data sixty (60) days from Date of First Contact to Request Service.
- **Priority should be given to providing missing CSI Assessment Record data from September 1, 2020 through November 30, 2020.**

Notices Of Adverse Benefit Determination (NOABD)

A NOABD is written notification of when an adverse benefit determination is made, and the Behavioral Health Plan (BHP) is required to issue these to Medi-Cal beneficiaries.

Purpose: Provide Medicaid (Medi-Cal) beneficiaries timely and understandable written notification when an adverse benefit determination for specialty mental health (SMHS) or substance use disorder (SUD) services is made; notification inclusive of beneficiary rights, such as the right to appeal.

1. 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;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. **The failure to provide services in a timely manner;**
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

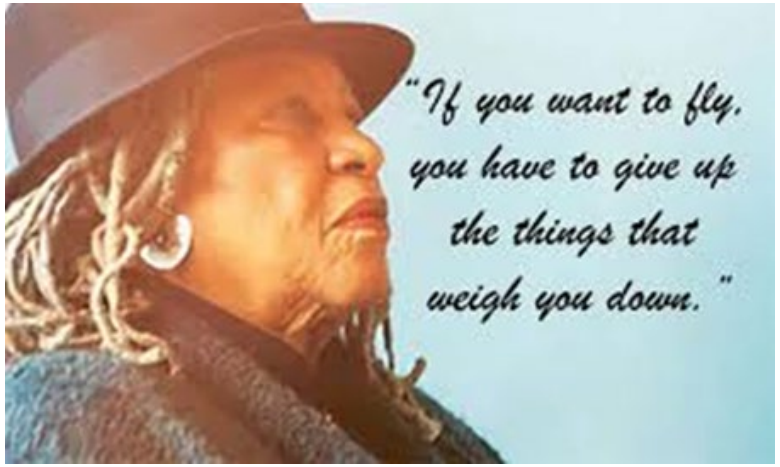
What to do with NOABD

- Send to Client or Client's Legal Guardian

- Submit to QA via fax 510-639-1346

Who to Contact with Questions

- For Reports: Martha.Diaz@acgov.org or Danielle.Benjamin@acgov.org
- Information Systems Support Desk 510-567-8181
- Access 800-491-9099
- Quality Assurance Office 510-567-8105



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