Alameda County acbh Behavioral Health Care Services MENTAL HEALTH & SUBSTANCE USE SERVICES	By: DocuSigned by: [signature] BA167CA0C0B444A... Karyn L. Tribble, PsyD, LCSW, Director
POLICY TITLE **Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services**	**Policy No: 1603-6** **Date of Original Approval**: 10/7/2022 **Date(s) of Revision(s):**

PURPOSE

This policy addresses the need for Crisis Residential Treatment (CRT) Services and Adult Residential Treatment (ART) Services to be concurrently reviewed, in accordance with Centers for Medicaid and Medicare (CMS) Final and Parity Rules and States policy.

BACKGROUND

On May 6, 2016, CMS published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. The Final Rule revised the regulations for Medicaid Managed Care in Part 438 of the Code of Federal Regulations (CFR). Mental Health Plans (MHPs) are classified as Prepaid Inpatient Health Plans (PIHPs), and therefore, must comply with applicable federal managed care requirements. The Final Rule stipulates requirements for coverage and authorization that became effective July 1, 2017.

On March 30, 2016, CMS issued the Parity Rule in the Federal Register to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule is intended to create consistency between the commercial and Medicaid markets. The key objective is to ensure that restrictions or limits are not more substantially applied on mental health and substance use disorder services as compared to medical surgical services.

On October 2, 2017, the Department of Health Care Services (DHCS) issued the Medicaid Mental Health Parity and Addiction Equity Act Compliance Plan, which details California's parity analysis, findings, and solutions. During its assessment of the State's authorization policies across delivery systems, DHCS identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi-Cal Managed Care Plans (MCPs).

On April 15, 2022, DHCS issued BHIN 22-016 Authorization of Outpatient Specialty Mental Health Services to address the aforementioned authorization inconsistencies by implementing policy changes to align the policies governing the MHPs with those governing the Managed Care Plans (MCPs). One of these policy changes requires MHPs to conduct concurrent review of CRT and ART services. The intent is to render timely coverage and beneficiary notification, especially in regards to appeal rights when services are denied, terminated, reduced or modified. Please note, BHIN 22-016 supercedes MHSUDS Information Notice 19-026.

AUTHORITY

- Centers for Medicaid and Medicare (CMS) Final Rule (2 81 CFR, §27497)
- CMS Parity Rule (81.Fed.Reg. 18390)
- DHCS BHIN: 22-016 Authorization of Outpatient Specialty Mental Health Services
- MHSUDS Information Notice: 18-010E Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates
- Title 42, Code of Federal Regulations (CFR) §438.210
- Title 9, California Code of Regulations (CCR) §531, §541
- Title 22, California Code of Regulations §85000-§85002

SCOPE

Alameda County Behavioral Health (ACBH) county and county-contracted CRT and ART programs, in addition to programs and individuals designated to conduct concurrent review and authorization for CRT and ART services.

POLICY

This policy establishes concurrent review and authorization procedures for CRT and ART services provided to ACBH beneficiaries.

PROCEDURE

CRISIS RESIDENTIAL TREATMENT (CRT) SERVICES

CRT Providers are responsible for:

I. Admission Notification to the Mental Health Plan (MHP)
   A. To implement the least restrictive access for beneficiaries, CRT Provider assesses and admits beneficiaries in accordance with clinical appropriateness and ACBH Crisis Residential Admission Criteria.
   B. If the beneficiary requests Specialty Mental Health Services (SMHS) through ACCESS and is determined to meet criteria for this level of care, ACCESS will refer the beneficiary via standardized referral letter to the CRT program for further assessment and admission.
   C. Within one (1) business day of admission, CRT Providers submit written admission notification and request for concurrent review to the MHP.

II. Data System Entry Completion
   A. CRT Provider completes necessary admission data system entry(s) prior to admission notification and request for concurrent review from the MHP.
   B. CRT Provider completes necessary discharge data system entry(s) within one (1) business day of the discharge date.

C. CRT Provider updates the ACBH bed tracking/availability application to provide up-to-date and live bed availability 24/7.

III. Concurrent Review
   A. CRT Provider has trained/designated/available staff to conduct concurrent review with the MHP, in accordance with ACBH policy and/or clinically indicated review frequency.
   B. CRT Provider has internal logging, tracking, monitoring mechanisms to ensure all admitted ACBH beneficiaries receive timely concurrent review and authorization.

IV. Deliverance/Assistance to Beneficiary if Notice of Adverse Benefit Determination Issued by MHP:
   A. CRT Provider delivers the Notice of Adverse Benefit Determination (NOABD) to a beneficiary when a CRT requested service is denied, terminated, reduced, or modified by the MHP.
   B. CRT Provider, as needed, is also to assist the beneficiary in clarification of the NOABD content, inclusive of informing the beneficiary of their rights.

The MHP is responsible for:

I. Upon Receipt of Admission Notification from CRT Provider
   A. MHP verifies beneficiary insurance status and residency.
   B. MHP assigns concurrent review to a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.

II. Concurrent Review
   A. MHP utilizes Admission, Continued Stay, and Discharge Criteria for determining CRT authorization requests. (Attachment A)

III. Authorization Notification to Providers and Beneficiaries
   A. *Provider Notification:* MHP communicates the authorization decision (i.e. approval, modification, denial) to CRT Provider within 24 hours of making the decision.
   B. *Beneficiary Notification:* MHP provides timely written beneficiary Notice of Adverse Benefit Determination (NOABD) when a CRT service is denied, terminated, reduced, or modified.
      1. If a CRT service request is denied/modified or if there is a MHP authorization delay, the MHP renders a written NOABD to the beneficiary within two (2) business days of the decision.
      2. If a previously authorized CRT service is terminated or reduced, the MHP must send a notice at least ten (10) days before the date of action, except as permitted under § 431.213 and § 431.214.

ADULT RESIDENTIAL TREATMENT (ART) SERVICES

ART PROVIDERS are responsible for:

I. Admission Notification to the Mental Health Plan (MHP)
   A. To implement the least restrictive access for beneficiaries, ART Provider assesses and admits beneficiaries in accordance with clinical appropriateness and ACBH Adult Residential Admission Criteria.
   B. If the beneficiary requests SMHS through ACCESS and is determined to meet criteria for this level of care, ACCESS will refer the beneficiary via standardized referral letter to the ART program for further assessment and admission.
   C. Within one (1) business day of admission, ART Providers submit written admission notification and request for concurrent review to the MHP.

II. Data System Entry Completion
   A. ART Provider completes necessary admission data system entry(s) prior to admission notification and request for concurrent review from the MHP.
   B. ART Provider completes necessary discharge data system entry(s) within one (1) business day of the discharge date.

III. Concurrent Review
   A. ART Provider has trained/designated/available staff to conduct concurrent review with the MHP, in accordance with the ACBH policy and/or clinically indicated review frequency.
   B. ART Provider has internal logging, tracking, monitoring mechanisms to ensure all admitted ACBH beneficiaries receive timely concurrent review and authorization.

IV. Deliverance/Assistance to Beneficiary if NOABD Issued by MHP:
   A. ART Provider delivers the NOABD to a beneficiary when an ART requested service is denied, terminated, reduced, or modified by the MHP.
   B. ART Provider is also to assist the beneficiary in clarification of the NOABD content, inclusive of informing the beneficiary of their rights.

The MHP is responsible for:

I. Upon Receipt of Admission Notification from CRT Provider
   A. MHP verifies beneficiary insurance status and residency.
   B. MHP assigns concurrent review to a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.

II. Concurrent Review
   A. MHP utilizes Admission, Continued Stay, and Discharge Criteria for determining ART authorization requests. (Attachment B)

III. Authorization Notification to Providers and Beneficiaries
   A. Provider Notification: MHP communicates the authorization decision (i.e. approval, modification, denial) to ART Provider within 24 hours of making the decision

B. Beneficiary Notification: MHP provides timely written beneficiary NOABD when an ART service is denied, terminated, reduced, delayed or modified.
    1. If an ART service request is denied/modified or if there is a MHP authorization delay, the MHP renders a written NOABD to the beneficiary within 2 (two) business days of the decision.
    2. If a previously authorized ART service is terminated or reduced, the MHP must send a notice at least (10) days before the date of action, except as permitted under 42 CFR §431.213 and §431.214

NON-COMPLIANCE

- Non-compliance is defined as the MHP and/or CRT/ART Providers not acting in accordance with the above procedures, to include notifications and timeliness standards.
- CRT/ART Providers may utilize the ACBH Provider Problem and Resolution and Appeals process.
- Staff shall not face retribution for filing a notice of non-compliance.
- Staff can notify their immediate supervisor about non-compliance, and the immediate supervisor can report the non-compliance to ACBH as soon as possible. Alternatively, staff can notify the appropriate ACBH staff directly.
- Communication that contains protected health information or otherwise confidential information shall be sent through secure methods such as email with secure encryption.

CONTACT

ACBH Office	Current Date	Email/Phone
Utilization Management Program (UM)	7/27/2022	um@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Karen Capece, LCSW; Deanna Kolda, LCSW
Original Date of Approval: 10/7/2022 by Karyn Tribble PsyD, LCSW, Behavioral Health Director
Date of Revision:

Revision Author	Reason for Revision	Date of Approval by (Name, Title)

DEFINITIONS

Term	Definition
Adult Residential Treatment (ART) Services	Adult Residential Treatment Services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and /or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services assist the beneficiary in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability of independent living upon discharge from the program. The program will also provide a therapeutic environment in which beneficiaries are supported in their efforts to acquire and apply interpersonal and independent living skills.
Concurrent Review	Concurrent review is a method of reviewing beneficiary care and services as they are being rendered to a beneficiary, to monitor appropriateness of the care, to include the level-of-care, and the progress of discharge and aftercare plans.
Crisis Residential Treatment (CRT) Services	Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical completions requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. The timing, frequency, and duration of the various types of services provided to each beneficiary receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each beneficiary. For example, a beneficiary newly admitted to a crisis residential treatment program would be more likely to receive crisis intervention or psychotherapy then the development of community support systems, which would be more appropriate as the beneficiary prepares for discharge from the program.
Notice Of Adverse Benefit Determination	Notice of Adverse Benefit Determination (NOABD) - A Notice of Adverse Benefit Determination informs a beneficiary of a denial or change to their SMHS services, and the beneficiary's right to request an appeal if the beneficiary does not agree with the decision made.

(NOABD)	
Mental Health Plan (MHP)	The department of Health Care Services (DHCS) is responsible for administering the Medi-Cal SMHS waiver program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet access criteria. Alameda County Behavioral Health (ACBH) is the Mental Health Plan for Alameda County.

APPENDICES

A. Admission, Continued Stay & Discharge Criteria

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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ADMISSION, CONTINUED STAY & DISCHARGE CRITERIA

Crisis Residential Treatment (CRT) Services

Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non-institutional residential setting. These services provide a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

The timing, frequency, and duration of the various types of services provided to each beneficiary receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each beneficiary. For example, a beneficiary newly admitted to a crisis residential treatment program would be more likely to receive crisis intervention or psychotherapy then the development of community support systems, which would be more appropriate as the beneficiary prepares for discharge from the program.

Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service.

In a crisis residential treatment facility, structured day and evening services are available seven days a week. Services include:

A. Individual and group counseling
B. Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the individual's usual coping mechanisms
C. Planned activities that develop and enhance skills directed towards achieving client plan goals
D. Family counseling with significant support persons directed at improving the beneficiary's functioning, when indicated in the client's treatment/rehabilitation plan or problem list
E. The development of community support systems for beneficiaries to maximize their utilization of non-mental health community resources
F. Counseling focused on reducing mental health symptoms and functional impairments to assist beneficiaries to maximize their ability to obtain and retain pre-vocational or vocational employment
G. Assisting beneficiaries to develop self-advocacy skills through observation, coaching, and modeling
H. An activity program that encourages socialization within the program and general community, and which links the beneficiary to resources which are available after leaving the program; and,
I. Use of the residential environment to assist beneficiaries in the acquisition, testing, and/or refinement of community living and interpersonal skills.

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This service includes one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- Crisis Intervention

Providers: Crisis residential treatment services may be provided within their scope of practice by a Physician, a Psychologist, a Waivered Psychologist, a Licensed Clinical Social Worker, a Waivered/Registered Clinical Social Worker, a Licensed Professional Clinical Counselor, a Waivered/Registered Professional Clinical Counselor, a Marriage and Family Therapist, a Waivered/Registered Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, Peer Support Specialist and Other Qualified Provider.

Limitations: Crisis residential treatment services are not reimbursable on days when the following services are reimbursed, except for day of admission to crisis residential treatment services: mental Health services, day treatment intensive, day rehabilitation, adult residential treatment services, crisis intervention, crisis stabilization, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services. Crisis residential treatment services are not provided in an institution for mental disease as defined in SSA sec. 1905(i) and CFR 435.1010.

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CRISIS RESIDENTIAL TREATMENT (CRT)		
Admission Criteria	**Continued Stay Criteria**	**Discharge Criteria**
All of the following criteria must be met: 1) Beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in an important area of life functioning. 2) Beneficiary's condition as described in paragraph (1) is due to either of the following: 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 and/or a suspected mental disorder that has not yet been diagnosed 3) Beneficiary experiencing an acute psychiatric episode or crisis: a) which requires a 24-hour structured setting and if not admitted will likely require acute psychiatric hospitalization b) which is expected that the proposed intervention will significantly diminish the impairment or prevent significant deterioration in an	**All of the following criteria must be met:** 1) Beneficiary continues to meet admission criteria; 2) A less restrictive level of care would not be adequate to safely and effectively treat the beneficiary's current condition; 3) Treatment is still necessary to reduce symptoms and improve functioning so beneficiary may be treated in a less restrictive level of care; 4) There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care; 5) Beneficiary progress is monitored regularly and the treatment plan or problem list modified, if the beneficiary is not making substantial progress toward a set of clearly defined and measurable goals; 6) Beneficiary is engaged in treatment and amenable to goals/interventions set forth by the treatment team; 7) Family/guardian/caregiver/significant others are participating in treatment as clinically indicated and appropriate or engagement is underway; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out; 9) There is evidence of coordination of care and active discharge planning for:	**Any one of the following criteria must be met:** 1) Beneficiary no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; **OR** 2) Beneficiary or parent/guardian withdraws consent for treatment and the beneficiary does not meet criteria for involuntary/mandated treatment; **OR** 3) Beneficiary does not appear to be participating in treatment; **OR** 4) Beneficiary is not making progress toward goals, nor is there expectation of any progress; **OR** 5) Beneficiary's individual treatment plan and goals have been met, and when indicated, beneficiary's support systems are in agreement with the aftercare treatment plan.

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important area of life functioning; c) with no imminent risk to self or others requiring a higher level of care (i.e. acute psychiatric hospitalization); d) cannot be safely treated in a less restrictive setting 4) Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care. 5) Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily.	a. transition of the beneficiary to a less intensive level of care; and, b. provider referral/linkage and teaching/coaching, with beneficiary active involvement, towards the development and connection to appropriate aftercare and non-mental health community supports, beginning from admission.	

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Exclusions

Any **one** of the following criteria is sufficient for exclusion from this level of care:

1. Beneficiary does not meet Medi-Cal Specialty Mental Health access criteria
2. Beneficiary has medical conditions that would prevent beneficial utilization of services; or
3. Beneficiary's psychiatric condition is of such severity that it can be safely treated only in an inpatient setting; or
4. Beneficiary does not voluntarily consent to admission or treatment; or
5. Beneficiary can be safely maintained and effectively treated in a less intensive level of care; or
6. Request for service is being pursued to address a primary issue of homelessness or lack of identified disposition.

Reference Sources

1) Medicaid State Plan No: 12-025
2) Title 9, California Code of Regulations (CCR), §531, 541.24, 1810.208, 1840.312, 1840.334, 1840.356
3) DHCS BHIN 21-073

Title 9, California Code of Regulations

§531. Program Standards and Requirements

(a) To be certified as a Short-Term Crisis Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (e) or (f) of section 541 as an alternate to hospitalization for individuals experiencing an acute psychiatric episode or crisis. The planned length of stay in the program shall be in accordance with the client's assessed needs, but not to exceed thirty (30) days, unless circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond thirty (30) days shall be documented in the client's case record. Under no circumstances may the length of stay exceed three (3) months.

(2) Scheduling of staff which provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the night time hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served.

§541. 24-Hour Services

(e) **Short-Term Crisis Residential Service (Less than 14 Days),** which means a licensed residential community care facility available for admissions 24-hours a day, 7 days a week, and staffed to provide crisis treatment as an alternative to hospitalization. Admissions are generally limited to a stay of less than 14 days for voluntary patients without medical complications requiring nursing care. Twenty-four-hour capability for prescribing and supervising medication must be available for patients requiring this level of care. The prescribing capability shall be provided by written agreement.

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(f) **Short-Term Crisis Residential Service (Less than 30 Days),** which means a licensed residential community care facility available for admissions 24-hours a day, 7 days a week, and staffed to provide treatment services for voluntary patients without medical complications requiring nursing care and who generally require an average stay of 14-30 days for crisis resolution or stabilization. Twenty-four-hour capability for prescribing and supervising medication must be available. The prescribing capability shall be provided by written agreement. Respite care, in accordance with Welfare and Institutions Code, Chapter 5, up to a maximum of 30 days, may be provided within this definition.

§1810.208. Crisis Residential Treatment Service

"Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

§1840.312. Non-Reimbursable Services-General

The following services are not eligible for FFP:

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

§1840.320. Claiming for Service Functions Based on Calendar Days

(a) The following services are reimbursed based on calendar days:
  (1) Adult Residential Treatment Services
  (2) Crisis Residential Treatment Services
  (3) Psychiatric Health Facility Services.

(b) The following requirements apply for claiming of services based on calendar days:
  (1) A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
  (2) Board and care costs are not included in the claiming rate.
  (3) The day of admission may be billed but not the day of discharge.

§1840.334. Crisis Residential Treatment Services Contact and Site Requirement

(a) Crisis Residential Treatment Services shall have a clearly established certified site for services although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis.

(c) In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services shall be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2,

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Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

§1840.356. Crisis Residential Treatment Services Staffing Requirements

(a) Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with Section 531(a).
(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Crisis Residential Treatment Services and function in other capacities.

§1840.364. Lockouts for Crisis Residential Treatment Services

Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services:

(a) Mental Health Services
(b) Day Treatment Intensive
(c) Day Rehabilitation
(d) Psychiatric Inpatient Hospital Services
(e) Psychiatric Health Facility Services
(f) Psychiatric Nursing Facility Services
(g) Adult Residential Treatment Services
(h) Crisis Intervention
(i) Crisis Stabilization

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Adult Residential Treatment (ART) Services

Adult Residential Treatment Services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and /or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

Adult residential treatment services assist the beneficiary in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability of independent living upon discharge from the program. The program will also provide a therapeutic environment in which beneficiaries are supported in their efforts to acquire and apply interpersonal and independent living skills.

Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site.

Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face mental health service provided to the beneficiary by a treatment staff person of the facility on the day of service.

In an adult residential treatment facility, structured day and evening services are available seven days a week. Services include:

A. Individual and group counseling;
B. Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the individual's usual coping mechanisms;
C. Family counseling with significant support persons, when indicated in the client's treatment/rehabilitation plan;
D. The development of community support systems for beneficiaries to maximize their utilization of non-mental health community resources;
E. Counseling focused on reducing mental health symptoms and functional impairments to assist beneficiaries to maximize their ability to obtain and retain pre-vocational or vocational employment;
F. Assisting beneficiaries to develop self-advocacy skills through observation, coaching, and modeling;
G. An activity program that encourages socialization within the program and general community, and which links the beneficiary to resources which are available after leaving the program; and,
H. Use of the residential environment to assist beneficiaries in the acquisition, testing, and/or refinement of community living and interpersonal skills.

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This service includes one or more of the following service components:

- Assessment
- Plan development
- Targeted Case Management
- Therapy
- Rehabilitation
- Collateral

Providers: Adult residential treatment services may be provided within their scope of practice by a Physician, a Psychologist, a Waivered Psychologist, a Licensed Clinical Social Worker, a Waivered/Registered Clinical Social Worker, a Licensed Professional Clinical Counselor, a Waivered/Registered Professional Clinical Counselor, a Marriage and Family Therapist, a Waivered/Registered Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, Peer Support Specialist, and Other Qualified Provider.

Limitations: Adult residential treatment services are not reimbursable on days when crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except on the day of admission.

Adult residential treatment services are not provided in an institution for mental disease as defined in SSA Sec. 1905(i) and 42 CFR 435.1010.

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ADULT RESIDENTIAL TREATMENT (ART)		
Admission Criteria	**Continued Stay Criteria**	**Discharge Criteria**
All of the following criteria must be met: 1) The beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in an important area of life functioning. 2) The beneficiary's condition as described in paragraph (1) is due to either of the following: 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 and/or a suspected mental health disorder that has not yet been diagnosed. 3) Beneficiary is not sufficiently stable to be treated outside of a highly structured 24-hour therapeutic setting, but does not require a crisis or emergency higher level of care; 4) Beneficiary's behavior or symptoms, as evidenced by initial screening and/or assessment are likely to respond to treatment; 5) Beneficiary has sufficient cognitive capacity to respond to active, intensive and time-limited behavioral health treatment and intervention;	**All of the following criteria must be met:** 1) Beneficiary continues to meet admission criteria; 2) A less restrictive level of care would not be adequate to safely and effectively treat the beneficiary's current condition; 3) Treatment is still necessary to reduce symptoms and improve functioning so beneficiary may be treated in a less restrictive level of care; 4) Beneficiary's behavior or symptoms, as evidenced by the initial assessment and treatment plan/problem list, are likely to respond to, or are responding to active treatment; 5) There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care; 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out; 7) Beneficiary evaluation by a physician occurs at least on a weekly basis; 8) Beneficiary progress is monitored regularly and the treatment plan/problem list modified, if the beneficiary is not making substantial progress toward a set of clearly defined and measurable goals;	**Any one of the following criteria must be met:** 1) Beneficiary no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR 2) Beneficiary or parent/guardian withdraws consent for treatment and the beneficiary does not meet criteria for involuntary/mandated treatment; OR 3) Beneficiary does not appear to be participating in treatment, OR 4) Beneficiary is not making progress toward goals, nor is there expectation of any progress, OR 5) Beneficiary's individual treatment goals have been met, and when indicated, beneficiary's support systems agree with the aftercare plan.

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6) Beneficiary has only poor-to-fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care; 7) Beneficiary requires a time-limited period for stabilization and lower-level-of care and community resource connection for successful community reintegration; 8) Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care. 9) Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily	9) Beneficiary is engaged in treatment and amenable to goals/interventions set forth by the treatment team; 10) Family/guardian/caregiver/ significant other is participating in treatment as clinically indicated and appropriate or engagement is underway; 11) Beginning at admission, there is evidence of coordination of care and active discharge planning for: a) transition the beneficiary to a less intensive level of care; and, b) provider referral/linkage and teaching/coaching, with beneficiary active involvement, towards the development and connection to appropriate aftercare and non-mental health community supports.	

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Exclusions

Any **one** of the following criteria is sufficient for exclusion from this level of care:

1. Beneficiary does not Specialty Mental Health Services access criteria; or
2. Beneficiary has medical conditions that would prevent beneficial utilization of services; or
3. Beneficiary's psychiatric condition is of such severity that it can be safely treated only in an inpatient setting; or
4. Beneficiary does not voluntarily consent to admission or treatment; or
5. Beneficiary can be safely maintained and effectively treated in a less intensive level of care; or
6. Request for service is being pursued to address a primary issue of homelessness or lack of identified disposition.

Reference Sources

1) Medicaid State Plan No: 12-025
2) Title 9, California Code of Regulations (CCR), §531
3) DHCS BHIN 21-073

Title 9, California Code of Regulations

§531. Program Standards and Requirements

(b) To be certified as a Transitional Residential Treatment Program, a program shall provide:

(1) Services as specified in subsection (H) or (i) of section 541 which shall provide a therapeutic environment in which clients are supported in their efforts to acquire and apply interpersonal and independent living skills. The program shall also assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability for independent living upon discharge from the program. The planned length of stay shall be in accordance with the client's assessed need, but not to exceed one (1) year; however, a length of stay not exceeding a maximum total of 18 months is permitted to ensure successful completion of the treatment plan and appropriate referral. The reasons for length of stay beyond one (1) year shall be documented in the client's case record.

(2) Greater number of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.

At least one staff member shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio.

§541. 24-Hour Services

(h) **Transitional Residential On-Site Service,** which means a licensed residential community care facility, designated to provide, for a 2-to-12-month period, a therapeutic residential community including a range of social rehabilitation activities for individuals who are in remission from an acute stage of illness, and interim support to facilitate movement towards

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the highest possible level of functioning. Individuals may receive day, outpatient and other treatment services outside the transitional residence.

§1810.203 Adult Residential Treatment Service

"Adult Residential Treatment Service" means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

§1840.312. Non-Reimbursable Services-General

The following services are not eligible for FFP:

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

§1840.320 Claiming for Service Functions Based on Calendar Days

(a) The following services are reimbursed based on calendar days:
  (1) Adult Residential Treatment Services
  (2) Crisis Residential Treatment Services
  (3) Psychiatric Health Facility Services.

(b) The following requirements apply for claiming of services based on calendar days:
  (1) A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
  (2) Board and care costs are not included in the claiming rate.
  (3) The day of admission may be billed but not the day of discharge.

§1840.332 Adult Residential Treatment Services Contact and Site Requirements

(a) Adult Residential Treatment Services shall have a clearly established certified site for services, although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs that provide Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program in accordance with Chapter 3, Division 1, of Title 9. Facility capacity must be limited to a maximum of 16 beds.

(c) In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

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§1840.354 Adult Residential Treatment Services Staffing Requirements

(a) Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Section 531(b), (c).

(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the personas who provide Adult Residential Treatment Services and function in other capacities.

§1840.362 Lockouts for Adult Residential Treatment Services

Adult Residential Treatment Services are not reimbursable under the following circumstances:

(a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.

(b) When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.

Medicaid State Plan No: 12-025 Supplement 3 to Attachment 3.1-A

DEFINITIONS:

"Assessment" means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

"Client Plan" means a documented plan for the provision of services to a beneficiary who meets medical necessity criteria; it contains specific observable and/or quantifiable goals and treatment objectives, proposed type(s) of intervention, and the proposed duration of the intervention(s). A client plan is consistent with the beneficiary's diagnosis or diagnoses. A client plan is signed by the person providing the service(s), or a person representing a team or program providing the service(s), or a person representing a team or program providing services, and must include documentation of the beneficiary's participation in, and agreement with, the client plan.

"Collateral" means a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity.

"Crisis Intervention" is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response then a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

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"Plan Development" means a service activity that consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a beneficiary's progress.

"Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

"Therapy" means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

Department of Health Care Services, Behavioral Health Information Notice 21-073

Medical Necessity:
Medical Necessity Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, 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.

For individuals 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 or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

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

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System:
For beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

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

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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

Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System:
For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.
OR
(2) The beneficiary meets both of the following requirements in a) and b), below:
   a. The beneficiary has at least one of the following:
      i. A significant impairment
      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 to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

Additional Coverage Requirements and Clarifications:

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This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

(1) Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
(2) The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
(3) The beneficiary has a co-occurring substance use disorder.

Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.