COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES SYSTEM OF CARE

Organizational Provider Operations Handbook (OPOH)

Adult/Older Adult

Children, Youth & Families

System of Care (SOC)

Note:

- The Pro Forma and Statement of Work for each Program take precedence over the OPOH. If providers find any elements of their contract to be inconsistent with the OPOH, contact your COR.

- All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules. Information about the final rule can be found at the following link: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html

- For the next five (5) years the County of San Diego will be identified as a managed care delivery system under the Federal Regulation waiver authority Section 1915b.

- All Forms and Manuals referenced in the OPOH can be found on the Optum Website https://www.Optumsandiego.com

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Q. Quick Reference

A. System of Care (SOC)

This provider manual describes a framework of standards that involve member services, clinical and business processes, and pertains to all providers within the County of San Diego Medi-Cal System of Care. In outlining these minimum expectations, this provider manual establishes an infrastructure of qualify for Specialty Mental Health treatment throughout San Diego County

County of San Diego Behavioral Health Plan

Between 1995 and 1998, the State consolidated Fee-for-Service (FFS) and Short-Doyle/Medi-Cal programs into one specialty mental health managed care program, and under the system all Medi-Cal specialty mental health services were "carved out" of Medi-Cal and became the Counties' responsibility. Medi-Cal member access to specialty mental health services became available through County Behavioral Health Plans. One of the Agency's departmental excellence goals is to become a trauma informed system of care.

The County has been working hand-in-hand with four current Medi-Cal approved Health Plans (Blue Shield California Promise Health Plan, Community Health Group, Kaiser Permanente, and Molina Healthcare) through the local Healthy San Diego model to develop communication and strategies to implement the Medi-Cal Transformation initiative. San Diego County Behavioral Health Services (SDCBHS) continues to work closely with the Managed Care Plans (MCPs) to ensure impacts and changes are communicated to the system of behavioral health providers and information is used to support the members they serve.

Overall, SDCBHS provides a continuum of trauma informed, culturally competent mental health and substance use disorder services to children, youth, families, adults, and older adults. The SDCBHS department promotes recovery and well-being through prevention, treatment, and intervention, as well as integrated services for members experiencing co-occurring mental illness and substance use issues. It employs an Administrative Services Organization (ASO) to fulfill specific management functions using managed care technology and expertise.

Harm Reduction

Harm reduction is a set of strategies aimed at reducing negative consequences associated with drug use and incorporates a spectrum of tactics to meet people who use drugs "where they are" and address conditions of use along with the use itself (National Coalition for Harm Reduction). Reflective of these principles, harm related to substance use are concerns of overall health and well-being, and stigma should not be allowed to impede access to services. Harm reduction strives to respect all people who

use drugs, as well as their families and communities. It is built on multidisciplinary evidence base and over a decade of foundational work of local and regional stakeholders.

Elements of these practices may be used in any type of service setting and must be performed by trained providers within their scope of practice. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of Motivational Interviewing and Relapse Prevention is a contract requirement and is monitored through the contract compliance monitoring process.

The guiding principles of the harm reduction approach in San Diego County are:

- Human Rights and Dignity: Substance Use and Harm Reduction approaches in San Diego County respect all human beings, meeting them “where they’re at” without judgment and aim to reduce the stigma of people who use drugs (PWUD).

- Diversity and Social Inclusivity: The County of San Diego strives to respect all PWUD, as well as their families and communities, regardless of gender, race, age, sexual orientation, ethnicity, culture, spirituality, health, or socioeconomic status.

- Health and Well-Being Promotion: Harm reduction efforts are oriented toward improving the health, safety, and capacity to thrive for all PWUD.

- Partnerships & Collaborations: Harm reduction approaches are informed by and carried out through partnerships and collaborations across all sectors in the community. Partnerships are built upon the foundation of shared goals and trust in the interest of serving our community.

- Participation (“Nothing about us without us”): The County of San Diego recognizes the right of PWUD to be involved in the efforts to reduce the debilitating impact of drug use in their communities.

- Accountability and Improvement: The County of San Diego is committed to continuous improvement in the quality of its harm reduction efforts and intends to use data, community feedback, and input to continually assess current and future individual and community needs.

The Countywide Comprehensive Harm Reduction Strategy was initiated in January of 2021 and aims to utilize evidence-based approaches to address substance use and overdose deaths in San Diego County. A proven strategy to prevent overdose deaths is widespread naloxone distribution within the community.

Naloxone is a medication which reverses the effects of an opioid overdose and its broad distribution in the community is aimed at providing a safety net so that its life saving capabilities are present when and where an opioid overdose occurs. Please see the following tools and resources to aid County staff in learning how to administer naloxone, how to distribute to community members, and how to collect and record data of these efforts:

- BHS - Naloxone
- Harm Reduction Services
- Harm Reduction Interactive Maps

Removal of Harm Reduction Training Requirement

As of 07/30/26- Behavioral Health Services (BHS) has removed the County's supplemental harm reduction training requirement previously outlined in an April 14, 2022 information notice. This change is intended to reduce administrative burden and avoid duplicative training requirements for clinicians. Training is still strongly encouraged for any staff who have not already received education on harm reduction principles and practices as part of standard clinical care.

Promoting harm reduction practices should continue to be an important component of service delivery. This includes evidence-based practices such as naloxone distribution for overdose prevention, consistent with guidance from the American Society of Addiction Medicine (ASAM). Harm reduction, overdose prevention, and naloxone practices remain guided by the Organizational Provider Operations Handbook (OPOH).

Behavioral Health Plan Principles

The County of San Diego Behavioral Health Plan (BHP) is built on the principle that all people, regardless of physical and mental abilities have dignity and worth, dreams and aspirations, and are part of the communities in which they live. Biopsychosocial treatment programs provided by the County and contracted mental health providers will make available mental health and rehabilitation treatment services without stigma or discrimination and with respect for the personal privacy, diversity, and dignity of persons with mental illness.

Behavioral Health Plan Philosophy

The BHP philosophy is that mental health care is consumer- and family-centered, safe, clinically effective, rehabilitation and recovery focused, trauma informed, outcomes driven, and culturally competent. It is our intent to provide our members and families with comprehensive, preventive, rehabilitative, and therapeutic mental health care delivered in the least restrictive environment and in the most effective mode. This will be accomplished in a manner that ensures access to and satisfaction with services

(consumer-centered), appropriateness of services (trauma informed, clinically effective, and culturally competent), and desirable outcomes (outcomes driven). The BHP's philosophy further appreciates and understands that trauma and complex stress are pervasive among those we serve and those we work with. This approach helps understand all people served and seen, and all staff. We must also accept that everyone does not respond to the same experiences in the same way—it is not a "one size fits all" approach. The quality of the BHP's care and services delivery system will be ensured by continually assessing important aspects of care and services, using reliable and valid measures.

Behavioral Health Plan Program Goal and Objectives

The BHP's goal is two-fold: to improve the health and well-being of our members, and to provide the highest quality and most cost effective managed, recovery-oriented and trauma informed mental health care and administrative services available. Accordingly, the BHP is designed to promote the continuous improvement of specialty mental health and supportive services provided to members; increase the effectiveness of care management and coordination of care with providers and referral sources; and advance the scope and efficiency of administrative services provided to stakeholders. The BHP is committed to becoming and remaining a Trauma Informed System, which draws upon and reflects the diversity in the experiences and needs of our community as seen in our members, staff and provider networks

System Scope of Services and Activities

The BHP utilizes a multidisciplinary network of providers to deliver a comprehensive continuum of mental health services that are trauma informed. These include, but are not limited to:

- Access and Crisis Line (ACL)
- Behavioral Health Court Services
- BH-CONNECT Evidence-Based Practices
    - Assertive Community Treatment (ACT)
    - Clubhouse Services
    - Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
    - Enhanced Community Health Worker Services (E-CHWs)
    - Forensic ACT (FACT)
    - Functional Family Therapy (FFT)
    - High Fidelity Wraparound (HFW)
    - Individual Placement and Support Supported Employment (IPS)
    - Multisystemic Therapy (MST)
    - Parent-Child Interaction Therapy (PCIT)
    - Peer Support Specialists with Forensic Specialization
- CARE Court
- Case Management (CM)
- Crisis Intervention (CIS)

- Crisis Residential Programs (CRTP)
- Crisis Stabilization Services (CSS)
- Day Treatment Intensive Services (DTI)
- Early Intervention Programs (EIP)
- Emergency Services
- Forensic Services
- Homeless Outreach Services
- Housing Services
- Innovation Programs (INN)
- Inpatient Services (IP)
- Intensive Care Coordination (ICC)
- Intensive Outpatient Services (IOP)
- Intensive Home-Based Services (IHBS)
- Justice Involved BH Linkage Services
- Justice-Involved Re-entry
- Long-Term Care (LTC)
- Mobile Crisis Response (MCR)
- Outpatient Services (OP)
- Outreach and Engagement (O&E)
- Partial Hospitalization Program (PHP)
- Peer Support Services (PSS)
- Prevention and Early Intervention (PEI) Programs
- Psychiatric Health Facility Services (PHF)
- Rehabilitation and Recovery Services
- Residential Treatment Programs (RTP)
- Supported Employment
- Supportive Housing
- Short-Term Residential Therapeutic Programs (STRTP)
- Therapeutic Behavioral Services (TBS)
- Therapeutic Foster Care (TFC)
- Wraparound Services

The above services and programs are described in more detail in OPOH *Section B*.

Customer Service

San Diego County Behavioral Health Services (SDCBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat members, families and other consumers with respect, dignity and courtesy. They should be treated *without* regard to race, religion, creed, color, gender, economic status, sexual orientation, age, source of income or any other non-treatment or non-service-related characteristics. Members and their families expect high-quality customer service as well as fast, efficient, caring and professional treatment.

Exceptional customer service includes:

- Treating members with courtesy, respect, professionalism and a positive attitude
- Responding to members in a timely manner whether in person, by phone, in writing or via e-mail
- Awareness of cultural diversity and focusing on understanding member differences
- Providing complete, accurate and reliable information and feedback

County and contracted organizational providers are expected to have a "customer-first" attitude instilled throughout their operations. Systems should be in place so that customers are able to voice issues or complaints anonymously. The recommended way to receive feedback from members is to have user friendly suggestion / comment cards available on site. Input should be listened to and acted upon. Programs can utilize feedback to improve upon current systems. The methods your program or legal entity use may be informal (i.e. via conversations), or more formal (i.e. individual interviews, focus groups, surveys, and suggestion/comment cards or forms).

The following are the basic expectations that COSD BHS has for all County and contracted programs:

1. Establish Customer Service Standards. For example, the County of San Diego Customer
2. Experience Initiative has set a standard of using a positive approach to provide customers with a positive experience. This commitment is summarized in the acronym **HEART**:
    - **H**elpfulness: going out of our way to find answers
    - **E**xpertise: being knowledgeable
    - **A**ttentiveness: being ready to meet customer needs
    - **R**espect: Treating customers with dignity and courtesy
    - **T**imeliness: being efficient with customer time
3. Ensure that all staff members are aware of these standards and are clear that adhering to Customer Service Standards is an expectation of the program.
4. Ensure members and families that no form of retaliation will come from any grievances or suggestions for improvement made to the program.
5. Enhance program services based on input received from customers to demonstrate receiving and accepting feedback from customers.

6. Make Customer Service Standards training available to all staff.

Medi-Cal Transformation

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery systems, programs and payment reform across the Medi-Cal program called *Medi-Cal Transformation*. The vision of Medi-Cal Transformation is that individuals should have longer, healthier, and happier lives via a whole system, person centered approach to health and social care via an integrated wellness system, aiming to support and anticipate health needs, prevent illness, and reduce the impact of poor health. It leverages Medicaid as a tool to help address challenges faced by California residents such as homelessness, behavioral health care access, complex medical conditions, justice-involvement and the aging population.

Medi-Cal Transformation includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including: updates to the criteria to access Specialty Mental Health Services (SMHS), implementation of standardized statewide screening and transition tools, payment reform, documentation requirements and other changes summarized in the Medi-Cal Transformation proposal and behavioral health information notices (BHINs).

Medi-Cal Transformation has three (3) primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.

2. Moving Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

3. Improving quality outcomes, reducing health disparities, and driving delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

For more information, please visit: CalAIM: Transforming Medi-Cal

Co-Occurring Populations

Co-occurring disorders (COD) refer to the presence of both a mental health condition and a substance use disorder (SUD). These conditions are common and, when not appropriately addressed, may be associated with poorer health outcomes and increased costs of care. San Diego County Behavioral Health Services (BHS) recognizes that individuals with co-occurring mental health and substance use needs are present throughout all levels of the behavioral health system of care. Accordingly, all programs are expected to provide a welcoming, inclusive, and supportive environment

for individuals with co-occurring needs. This approach is consistent with the intent of the Behavioral Health Services Act (BHSA), which identifies its target population as *eligible adults and children with, or at risk of, the most serious mental health conditions and substance use disorders*. By recognizing both mental health and substance use needs within the broader behavioral health system, the BHSA reinforces the importance of coordinated and integrated approaches to care.

Research supports addressing co-occurring conditions simultaneously. Consistent with this evidence, the Behavioral Health Plan (BHP) promotes an integrated treatment and recovery philosophy that addresses the whole person by coordinating mental health and substance use interventions within a primary treatment relationship or service setting. Whenever possible, integrated care should be provided within the program by staff who have the appropriate training, competencies, and scope of practice to deliver these services.

In alignment with the No Wrong Door policy, all programs are expected to be, at minimum, Co-Occurring Capable. This means programs must welcome and engage individuals with co-occurring conditions, conduct assessments that consider both mental health and substance use needs, and address substance use concerns within the context of the individual's mental health treatment. Consistent with Medi-Cal requirements, Behavioral Health Plans (BHPs) must not deny or disallow reimbursement for Specialty Mental Health Services (SMHS) provided to a member who meets SMHS medical necessity criteria solely because the member also has a co-occurring SUD, provided all other applicable Medi-Cal and service requirements are met.

When a program is unable to provide the level or type of substance use disorder services an individual needs, the program is still responsible for continuing to provide services within its scope of practice while coordinating an appropriate referral and warm handoff to additional or specialized substance use treatment services. The presence of a co-occurring condition should not, by itself, create a barrier to accessing or continuing medically necessary mental health services.

For additional information, refer to: BHIN 22-011 No Wrong Door for Mental Health Services Policy

Trauma Informed Facilities

Environments that are trauma informed and developmentally appropriate have been shown to benefit individuals seeking services. All providers are encouraged to utilize the *Trauma-Informed Care Code of Conduct*. This document was created by young adults with lived experience and is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings for staff, and to be offered to members to outline the commitment of the program to follow trauma informed principles. Providers shall demonstrate family partnership in the development and provision of service delivery. Providers shall also demonstrate organizational

advancement of family partnership in the areas of program design, development, policies, and procedures, etc.

Please see the following resource for best practices in creating a trauma informed environment: Creating Trauma- Informed Services: Tips for Creating a Welcoming Environment.

System of Care for Adults and Older Adult Populations

The System of Care for Adults and Older Adults has a mission and vision to make people's lives healthier, safer, and more self-sufficient by delivering essential services and providing recovery and wellness services to adults and older adults in the behavioral health system to be healthier and more independent. The San Diego County Adult & Older Adult System of Care provides recovery-oriented services to promote both clinical improvement and self-sufficiency. Members eligible for our specialty Behavioral Health

System services are individuals who cannot be appropriately treated within a primary care environment, or by a primary care physician. Every effort will be made to serve members within the recovery-oriented Behavioral Health System until they are either stabilized (i.e. able to function safely without Behavioral Health resources), or until they no longer require complex biopsychosocial services to maintain stability.

Older adults living with mental illness comprise a segment of the population whose co-occurring health and social problems present ongoing challenges and opportunities for providers of adult mental health services. Compounding effects of untreated mental illness (i.e. increased risk for institutionalization, hospitalization and medical services, increased mortality and social isolation and untreated medical illnesses) are some of the barriers that prevent older adults from accessing mental health services. Providers will participate in ongoing training focused on meeting the unique needs of older adult members. In addition, providers will participate in networking efforts with providers of collateral services for older adults, to continue to develop the system-wide capacity and expertise.

For additional information, please refer to: DHCS -Master Plan for Aging and AIS Aging Roadmap.

System of Care Goals

The specialty Behavioral Health System will provide expedited evaluation and/or access for members maintained in the community with other resources, at such times as their condition destabilizes and they meet one of the criteria for inclusion. They will also provide support for those members referred to primary care for maintenance. To

accomplish these goals, the specialty Mental Health System will make every effort to provide:

- Crisis screening services for individuals with acute symptoms,
- Triage to appropriate services within the Specialty Mental Health System, when needed.
- Psychiatric consultation, as needed, to primary care providers for members referred to primary care for chronic disease management after treatment in the Mental Health System.

Psychosocial Rehabilitation and Recovery

The San Diego County System of Care for Adult and Older Adult population provides recovery-oriented services to promote both clinical improvement and self-sufficiency. It focuses on normalization and recovery, with the person at the center of the care planning process. It emphasizes that personal empowerment, the ability to manage one's
disorder and move toward mastery of one's personal environment is the path to recovery. The psychosocial rehabilitation and recovery approach includes a variety and continuum of interventions and models, including, but not limited to, peer education, family education, clubhouses, skills development, resource development, housing support, job support, money management, and relapse prevention.

Psychosocial rehabilitation in a recovery-oriented system helps people with mental health disabilities:

1. Learn to manage the symptoms of their disorder(s).
2. Acquire and maintain the skills and resources needed to live successfully in the community.
3. Pursue their personal goals, recognize and celebrate their individual strengths.

Target Population for Adults and Older Adult Programs

The target population is defined as individuals with a serious psychiatric illness that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment. These individuals have serious, persistent psychiatric illness who, to sustain illness stabilization, require complex psychosocial services, case management and / or unusually complex medication regimens. Required psychosocial services may include illness management or skill development to sustain housing, social, vocational, and educational goals.

Members of this target population shall meet Access Criteria for Members 21 Years of Age or Older to Access the Specialty Mental Health Services Delivery System as described in BHIN 26-002.

The target population also includes:

- Medi-Cal eligible adults aged eighteen to fifty-nine (18-59) and older adults aged sixty (60) and older
- Transitional Age Youth (TAY) eighteen to twenty- five (18-25) and transitioning from the children's behavioral health system into the adult behavioral health system
- Members with co-occurring mental health and substance use disorders
- Indigent individuals
- Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.

Other individuals we may serve, (to the extent resources allow), but who otherwise may be referred to other medical providers, include:

- Individuals with serious psychiatric illness that may be adequately addressed in a primary care practice (either by a primary care practitioner or an affiliated mental health professional) when: the acute symptoms do not place the individual at risk of danger to self or others, do not threaten the individual's ability to sustain independent functioning and/or housing within the community.
- Individuals with lesser psychiatric illness, such as adjustment disorders, anxiety and depressive disorders that do not cause significant, functional impairment and could be addressed within the context of a primary care setting or other community resources.

Such individuals may also have their needs addressed, either alone or in combination with medication prescribed via their primary care physician and/or community support, such as therapeutic services, peer services, support groups, self-help groups and/or educational groups. When appropriate, co-occurring disorder programs might also serve an alternative resource.

Target Population for Transitional Age Youth Programs

When youth are between ages eighteen to twenty- five (18-25), and the most appropriate level of care is being determined, the following shall be considered:

- System of care target population with individual needs being considered
- Youth's goals and preference
- Youth's functional level
- Youth need for shorter term or longer-term service
- Youth's relationship with current provider and impact of consistency based on youth's history

System of Care (SOC) for Children and Youth Populations

The *System of Care Principles* (May 2005) refers to guidance issued by SAMHSA/CMHS as part of the national System of Care framework for children, youth, and families. These Principles shall be demonstrated by ongoing member and parent/caregiver participation and influence in the development of the program's policy, program design, and practice demonstrated by:

- Individualized services that are responsive to the diverse populations served,
- Integration of mental health and substance abuse into a behavioral health system,
- Integration of physical health for the overall advancement of health and wellness
- Underscoring the importance of natural community resources,
- Valuing the complexity of cultural diversity, AND
- Strengthening our commitment to youth and families.

Programs shall provide developmentally appropriate clinical services described herein to accomplish the following goals:

- Maintain members' safety in their school and home environment
- Reduce recidivism related to criminal habits and activities
- Increase school attendance and performance resulting in a higher rate of successful completion of their educational program (with high school diploma or equivalent)

- Improve members' mental health functioning at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the member and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and supports

Values of the SOC for Children, Youth and Families

1. **Collaboration of four sectors:** Coordination and shared responsibility between child/youth/family, public agencies, private organizations, and education.
2. **Integrated:** Services and supports are coordinated, comprehensive, accessible, and efficient.
3. **Child, youth, and family guided:** Child, youth, and family voice, choice, and lived experience are sought, valued, and prioritized in service delivery, program design and policy development**.**
4. **Individualized:** Services and supports are customized to fit the unique strengths and needs of children, youth, and families.
5. **Strength-based:** Services and supports identify and utilize knowledge, skills, and assets of children, youth, families, and their community.
6. **Community-based**: Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.
7. **Outcome driven**: Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.
8. **Culturally Competent:** Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.
9. **Trauma Informed:** Service and supports recognize the impact of trauma and chronic stress, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care, resiliency, and safety.
10. **Persistence:** Goals are achieved through action, coordination, and perseverance regardless of challenges and barriers.

Target Population for Children and Youth Programs

The priority population for Children's Behavioral Health Services is seriously emotionally disturbed (SED) children and youth. These children or adolescents are defined as individuals who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Services are provided to members with co-occurring mental health and substance use, Medi-Cal eligible members that meet criteria for access to SMHS criteria, Indigent individuals and/or low income/underinsured individuals. All specialty mental health providers will evaluate and assess the treatment needs of the member.

Programs for Children, Youth and Families serve a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County, regardless of funding source. An array of services is provided through Organizational Providers, Fee-For-Service Providers, and Juvenile Forensic Providers. Children, Youth and Families San Diego is a "System of Care" County. The System of Care is based on Child and Adolescent Service System Program (CASSP) System of Care principles and the Wraparound Initiative of the State of California (All County Information Notice 1/28/99; and SB163, Wraparound Pilot Project).

Members of this target population shall meet Access Criteria for Members under Age 21 to Access the Specialty Mental Health Services Delivery System BHIN 26-002. Treatment will encourage and involve the active participation of the member's significant others such as the parent/caregiver, family members, friends and/or advocates selected by the adult member. Orientation and education of significant others include discussion of what services are available, treatment goals, role of the provider, and expectations of the member and provider. It also includes legal limits around confidentiality.

Family & Youth Partnerships

Family Youth Professional Partnership embodies a set of values, principles, and practices critical to achieving optimal outcomes for children, youth and their families served in the Behavioral Health Services (BHS) Children, Youth & Families SOC. The concept and role of Youth and Family Support Partners (Y/FSP) was developed through a community process. In various settings, families and youth serve as members of advisory groups, make presentations, act as trainers, and provide direct, billable service to families and youth within the Children, Youth & Families SOC. In addition, Youth/Family Partners (Y/FSP) advise Behavioral Health Administration and other agencies' leadership teams regarding policy and programmatic issues and work with Children, Youth & Families providers. These efforts result in improved responsiveness to family and youth and increased awareness of agency, family, and youth cultures as well as family's sense of ownership of their child's treatment plans.

B. Providing Specialty Mental Health Services

Behavioral Health Plan Program Goal and Objectives

The BHP's goal is twofold: to improve the health and wellbeing of our members, and to provide the highest quality and most cost effective managed, recovery-oriented and trauma-informed mental health care and administrative services available. Accordingly, the BHP is designed to promote the continuous improvement of specialty mental health and supportive services provided to members; increase the effectiveness of care management and coordination of care with providers and referral sources; and advance the scope and efficiency of administrative services provided to stakeholders. The BHP is committed to becoming, and remaining, a Trauma- Informed System, which draws upon and reflects the diversity in the experiences and needs of our community as seen in our members, staff and provider networks.

System Scope of Services and Activities

The BHP utilizes a multidisciplinary network of providers to deliver a comprehens ive continuum of mental health services that are trauma informed. These service lines are described below:

Access and Crisis Line (ACL)

A statewide, toll-free telephone service (1-888-724-7240), staffed by master's level (MA) and licensed clinicians twenty- four (24) hours/day, seven (7) days/week. The ACL provides information, referrals, and crisis intervention for children/youth, families, adults, and older adults seeking behavioral health services as well as after-hours authorization for inpatient services.

For more information, please reference: Optum San Diego - Access & Crisis Line & The San Diego Access & Crisis Line (ACL): 888-724-7240.

Assertive Community Treatment (ACT) - BH- CONNECT

A community-based, team-based service to support members living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT assists members to cope with the symptoms of their mental health condition and acquire the skills necessary to function and be integrated in the community. Optum San Diego serves as the single point of access for *Assertive Community Treatment (ACT)* referrals.

For more information, please reference: Single Point of Access-ACT, FACT & ICM, Adult Evidence-Based Practices | DHCS & EBP Policy Guide

Housing Quality Checklist

The purpose of the Housing Checklist is to ensure that participants who are receiving ACT or ICM services and housing are connected to safe and quality housing placements. The checklist is an evaluation tool that ensures all housing is equally assessed using the same standards. If the placement process indicates the presence of any health and safety issues, the home/unit should be removed from consideration and member should not be placed in the home/unit.

For more information, please reference: Housing Quality Checklist located on the Optum San Diego Website > MH *Resources* Tab.

Behavioral Health Court Services

An eighteen (18) month, court-ordered treatment program for adults with serious mental illness (SMI) in the criminal justice system, blending the collaborative court model with assertive community treatment (ACT) services.

For more information, please reference: San Diego BHC - Behavioral Health Court

CARE Court

The County Operated Community Assistance, Recovery and Empowerment (CARE) Court program creates a pathway to deliver mental health and substance use services to individuals who are diagnosed with psychotic disorders and are not engaged in treatment. The CARE Team coordinates care and submits status reports to the court for ongoing judicial oversight and evaluation of the individuals' needs.

For more information, please reference: CARE Act | Superior Court of California - County of San Diego & CARE Act Program.

Case Management (CM): Augmented Services Program

Designated case management providers may refer to Augmented Services Program (ASP) to enhance and improve member functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific residential care facilities with which the county has an ASP contract. Emphasis is on developing member strengths, symptom management, and member self-sufficiency.

For more information, please reference: Augmented services program (ASP) handbook

Case Management (CM): Institutional Case Management (Inst. CM)

Services provided to members who reside in a State Hospital, out-of-county/ in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF).

Case Management (CM): Intensive Care Coordination (ICC)

A targeted case management service that facilitates assessment of care planning for and coordination of services to members under age twenty-one (21). ICC service components include assessing; service planning and implementation; monitoring and adapting; and transition. The BHP is obligated to provide ICC to all children and youth under the age of twenty-one (21) eligible for full scope Medi-Cal and who meet access criteria for these specialty mental health services.

For more information, please reference: The Medi-Cal Manual for ICC, IHBS, and TFC Services.

Case Management (CM): Intensive Case Management (ICM)

A Level 1 Full-Service Partnership care model, for adults / older adults with significant behavioral health needs who do not meet Assertive Community Treatment (ACT) criteria. Optum San Diego serves as the single point of access for *Assertive Community Treatment (ACT)* referrals.

For more information, please reference: Single Point of Access-ACT, FACT & ICM

Case Management (CM): Targeted Case Management (TCM)

Services that assist members with accessing needed medical, educational, social, prevocational, vocational, rehabilitative or other community services.

Case Management (CM): Transitional Case Management

Services provided via short-term case management services (up to ninety (90) days) for unconnected members with SMI and are discharged from Acute Care with the goal to connect them to outpatient and/or ACT services.

Clubhouse Services - BH- CONNECT

Clubhouse Services use a social practice model in which members voluntarily participate in Clubhouse activities and duties alongside providers in a work-ordered day. Services provide opportunities for employment, socialization, education, and skill development to improve members' physical and mental health and overall quality of life and wellbeing.

For more information, please reference: BHS Supportive Services Website & DHCS EBP Policy Guide

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) – BH CONNECT

A person-centered, team-based service that helps members cope with the symptoms of their mental health condition and to function and remain integrated in the community by providing timely and integrated support during the critical initial stages of psychosis.

For more information, please reference: Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) - BH COE Resource Hub & DHCS EBP Policy Guide

Crisis Intervention Services (CIS)

Unplanned, expedited services with the intent of stabilizing an immediate crisis within a community or clinical treatment setting; this includes mobile crisis intervention services such as the Mobile Crisis Response Team (MCRT).

For more information, please reference: COSD Crisis Services & BHIN 23-025

Crisis Stabilization Services (CSS)

A service lasting less than twenty- four (24) hours (23.59 hours), provided to or on behalf of a member for a condition that requires a more timely response than a regularly scheduled visit. Crisis Stabilization shall be provided on site at a licensed twenty- four (24) hour health care facility or hospital-based outpatient program or a provider site certified by the Department or a Behavioral Health Plan (BHP) to perform crisis stabilization. (CCR, Title 9 1840.338) Discharge occurs when members no longer meet criteria for danger to others, danger to self and grave disability and crisis stabilization services are no longer medically necessary.

For more information, please reference: COSD CSU

Crisis Residential Services

Therapeutic or rehabilitative services in a non-institutional residential setting which provide structured, short-term (three (3) months or less) treatment as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis. The service is available twenty/four (24) hours per day / seven (7) days per week. Referrals for services require initial and continued authorization from Optum based on the need for services at 1-800-798-2254.

For more information, please reference: COSD Mental Health Crisis Residential Services

Day Treatment Intensive Services (DTI)

Structured, multi-disciplinary programs which may be an alternative to placement in a more restrictive setting. Services are available at least three (3) hours per day and less than twenty-four (24) hours per day. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and coordination of care. Prior authorization & re-authorization is required for all day services. An Ancillary Service Request Form must be submitted if a member is going to receive Outpatient services in addition to the Day Intensive services.

For more information, please reference: DHCS Day Treatment Intensive Service Components , DHCS Informational Notice No. 19-026 & Optum Website > *UCRM* tab> *Prior Authorization Day Services Request* (DSR)

Enhanced Community Health Workers (E-CHW) – BH CONNECT

Preventative services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and behavioral health. CHW services may assist with a variety of concerns impacting MCP members, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services.

For more information, please reference: Community Health Workers | DHCS

Emergency Services

Services provided in a hospital emergency department. Prior authorization is not required. The provider shall not require hospitals or MCPs to utilize Contractor's in-network or preferred psychiatric inpatient facilities until the member's condition is determined to be stable.

For more information, please reference: BHIN 22-017 & BHIN 22-011

Full-Service Partnership (FSP) Programs

Programs which offer integrated and coordinated services with an emphasis on whole person wellness and promote access to medical, social, rehabilitative, and other community services / supports as needed. An FSP program provides all necessary services and supports to help members achieve their behavioral health goals. Members can access designated staff twenty- four (24) hours a day, seven (7) days a week. FSP

services comprehensively address member and family needs with a “do whatever it takes” approach.

For more information, please reference: MHSA Components | DHCS

Homeless Outreach Services

Programs and services focused on the prevention, reduction, and elimination of homelessness through evidence driven approaches that leverage existing regional partnerships and work with cross-sector community stakeholders to ensure person-centered services and data driven homeless solutions.

For more information, please reference: OHS- Program Dashboard & COSD Office of Homeless Solutions

Housing Services

Services that provide housing resources for vulnerable populations, develop affordable and supportive housing, and help achieve stability and self-sufficiency for families.

For more information, please reference: COSD- Housing & Community Development Services & Housing and Community Development.

Inpatient Services

Inpatient services for Specialty Mental Health Services (SMHS) are twenty-four (24) hour, intensive, hospital-based or licensed facility treatments designed to evaluate, stabilize, and manage acute psychiatric conditions or severe mental disorders that cannot be safely or effectively treated at a lower level of care. Within San Diego County, inpatient services include emergency services, acute inpatient services for Medi-Cal clients, and acute and long-term residential services for Medi-Cal and Realignment funded members.

For more information, please reference: Optum Website> Manuals> *Inpatient Operations Handbook*

Intensive Home-Based Services (IHBS)

Individualized, strength-based interventions designed to address behavioral health conditions that interfere with a child or youth’s functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community. A Child and Family Team must be identified to provide IHBS. Services may include but are not limited to assessment, plan development, therapy,

rehabilitation, and coordination of care services. Per BHIN 26-030, prior authorization is no longer required for Intensive Home- Based Services.

For more information, please reference: The Medi-Cal Manual for ICC, IHBS, and TFC Services.

Forensic ACT (FACT) – BH CONNECT

FACT builds upon the ACT model to address the complex needs of members living with significant behavioral health needs who are also involved with the criminal justice system. FACT includes the same covered service components as ACT; however, FACT teams complete additional training, include practitioners with lived experience in the criminal justice system, and serve a population of members with high risk or history of criminal justice system involvement. Optum San Diego serves as the single point of access for *Forensic Assertive Community Treatment (FACT)* referrals.

For more information, please reference: Single Point of Access-ACT, FACT & ICM & DHCS EBP Policy Guide

Functional Family Therapy (FFT) – BH CONNECT

An intensive, short-term, family-based counseling service designed for youth from early to late adolescence who are at risk of developing, or who are already experiencing, moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use, and criminogenic behavior.

For more information, please reference: Functional Family Therapy (FFT) - Behavioral Health Centers of Excellence (COEs) Resource Hub & DHCS EBP Policy Guide

High Fidelity Wraparound – BH CONNECT

A team-based “anything necessary” approach to care for youth and families with the most intensive mental or behavioral health challenges. CA HFW model aligns with the national evidence-based practice model for HFW that provides a comprehensive, holistic, youth and family-driven way of responding when youth experience significant mental health challenges, in addition to other identified needs, often involving multiple child-serving systems.

For more information, please reference: High Fidelity Wraparound (HFW) - Behavioral Health Centers of Excellence (COEs) Resource Hub & Medi-Cal HFW Concept Paper & HFW Policy Manual & DHCS EBP Policy Guide

Individual Placement and Support (IPS) Supported Employment – BH CONNECT

A community-based intervention that supports members living with significant behavioral health needs to find and maintain competitive employment. A team of employment specialists collaborates with each client to help them in their initial job search and with ongoing follow-along supports once they secure employment.

For more information, please reference: DHCS EBP Policy Guide & The IPS Employment Center

Intensive Outpatient Services (IOP)/ Day Intensive Half (DIH)

IOP providers serve adults and youth in an outpatient, time limited structured program typically offered three (3) days a week for three (3) to four (4) hours a day. The design calls for needed ancillary Outpatient Specialty Mental Health Services (SMHS) inclusive of medication monitoring which is offered outside of the Day Treatment program hours. Referrals to IOP typically come through an outpatient service provider and/or emergency screening/crisis stabilization unit when it is determined that intensive services are needed or as a step-down service from an acute setting. A prior authorization is required for Medi-Cal members members receiving these services.

For more information, please reference: Day Treatment Intensive And Day Rehabilitation Service Components & Clarification Of Medi- Cal Day Treatment Intensive And Day Rehabilitation Program Requirements

Justice Involved Behavioral Health Linkage Services

Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they are incarcerated and who wish to continue to receive these services from SMHS, DMC, and/or DMC-ODS in the community. Behavioral health links are also for individuals who receive medication treatment for SUD, including through the MCP provider network. Correctional Facilities and County Behavioral Health Agencies will work in partnership to facilitate professional-to professional clinical handoffs to post-release providers and share information with the member's health plan or the provider who will prescribe the medication for substance use disorder.

For more information, please reference: CalAIM Justice Involved Policy & Operations Guide

Justice-Involved Re-entry

The Justice-Involved Reentry Initiative allows eligible Californians who are incarcerated to enroll in Medi-Cal and receive a targeted set of services in the ninety (90) days before their release. This initiative aims to ensure continuity of health care coverage and services between the time they are incarcerated and when they are released. It also provides people who are reentering the community with the prescribed medications and durable medical equipment (DME) they need, and access to programs and services to support this important transition.

For more information, please reference: CalAIM Justice Involved Policy & Operations

Long-Term Care

Residential and long-term services offer twenty- four (24) hour support for people with mental health and substance use conditions. An array of services are available to people who are Medi-Cal eligible and who need more help than a nursing home but less than a hospital. Services in this category include residential treatment, community-based care, and skilled nursing and care in a secure setting.

For more information, please reference: Optum San Diego Long Term Care

Mobile Crisis Response Team (MCRT)

A non-law enforcement program responding to behavioral health crises comprised of teams of trained clinicians, case managers, and peer support specialists that can be deployed through the Access and Crisis Line, mobilized via emergency services, or contacted directly. Services operate twenty-four (24) hours a day, seven (7) days a week, and three-hundred and sixty-five (365) days a year. MCRTs assess the individual and their needs and provide crisis intervention, either stabilizing in the field where the individual is able to remain safely in the community or transporting voluntary or involuntary clients on to an appropriate level of care for additional crisis stabilization or connection to other support services.

For more information, please reference: BHS COSD MCRT & Mobile Crisis Services | DHCS & BHIN 23-025 Medi-Cal Mobile Crisis Service Benefit Implementation

Outpatient Services

Programs providing treatment, rehabilitation, and recovery care for Medi-Cal/ Medi-Cal eligible individuals of all ages managing an ongoing mental health condition which may also include substance use conditions. Services are tailored to the unique needs of each person.
For more information, please reference: Mental Health Outpatient Services

Multisystemic Therapy (MST) – BH CONNECT

An intensive, family-based intervention for youth at risk of severe negative consequences within their family, school or community due to serious externalizing, anti-social, and/or challenging behaviors. MST may be appropriate for youth who are involved in the juvenile justice system and/or at risk of out-of-home placement due to a history of criminogenic behavior.

For more information, please reference: DHCS EBP Policy Guide

Peer Support Services

Certified Peer Support Specialists is provide services using their "lived experience" to establish mutuality and build resiliency and recovery. Peer support services are recovery-oriented and resiliency-focused services for those managing behavioral health challenges as well as the parents, family members, and caregivers that support them. Peer Support Services may be delivered and claimed as a standalone service or provided in conjunction with other SMHS services and in numerous environments including inpatient facilities, residential services, outpatient clinics, case management programs and clubhouses.

For more information, please reference: Medi-Cal Peer Support Services | DHCS

Peer Support Specialists with Forensic Specialization – BH CONNECT

A forensic peer support specialist provides recovery-oriented support to justice-involved individuals using lived experience to guide, mentor, and advocate for clients navigating mental health, substance use, and criminal justice systems. Forensic peer support specialists (FPSS) are individuals with **lived experience in mental health or substance use recovery** who have also interacted with the criminal justice system. They use their personal recovery journey to **assist and inspire justice-involved clients**, helping them navigate community resources, develop self-advocacy skills, and plan for reentry and recovery

For more information, please reference: Medi-Cal Peer Support Services | DHCS

Parent-Child Interaction Therapy (PCIT) – BH CONNECT

A specialized behavior management intervention for young children with oppositional or defiant behavior, aggression, frequent or severe tantrums, or symptoms related to behavioral health conditions such as attention-deficit/hyperactivity disorder, anxiety, and trauma.

For more information, please reference: DHCS EBP Policy Guide & Parent-Child Interaction Therapy (PCIT) - COE Resource Hub

Partial Hospitalization Program (PHP)/ Day Intensive Full (DIF)

PHP offers outpatient specialty mental health services to children and youth as well as adult members. Program services are offered at minimum five (5) days a week for more than four (4) hours a day. Ancillary Services are available via additional authorization as needed. Referrals to PHP typically come from the emergency screening/crisis stabilization unit to prevent an escaladed need for inpatient psychiatric care, from intensive hospital teams as a step down from an acute setting and/or from an Intensive Outpatient Program who determine a higher level of care is needed. Prior authorization is required for Medi-Cal members receiving DIF.

For more information, please reference: IOP and PHP Prior Authorization Day Services Request Explanation Sheet 9.16.26.pdf

Prevention & Early Intervention Programs (PEIP)

Programs designed to prevent mental illnesses from becoming severe and disabling and to reduce disparities in behavioral health. Under BHSA, each county must establish and administer an Early Intervention program (WIC section 5890, subdivision (a)(3)) that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health. Includes Coordinated Specialty Care for First Episode Psychosis, and other allowable costs that meet the categorical requirements.

For more information, please reference: BHSA Components and Requirements | BHSA County Policy Manual

Psychiatric Health Facility Services (PHF)

Services provided in a psychiatric health facility licensed by DHCS to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Services are provided in a psychiatric health facility under a multidisciplinary model. Services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Residential Treatment Programs

Residential programs are twenty-four/ seven (24/7), structured treatment programs that may provide individual, group, family therapy and other treatment modalities as appropriate.

Short-Term Residential Therapeutic Programs (STRTP)

A Short-Term Residential Therapeutic Program (STRTP) provides intensive, short-term, twenty- four (24) hour care, supervision, treatment, and support for children, youth, and non-minor dependents (NMDs) whose needs cannot be safely met in a family-based setting but who do not require inpatient care. Services include a comprehensive range of Specialty Mental Health Services (SMHS), such as assessment, therapy, rehabilitation, case management, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and crisis intervention. Some programs also offer day services. Treatment is individualized and intensive, with the goal of stabilizing the individual's needs and supporting a successful transition to a less restrictive, community-based or family setting through aftercare services.

For more information, please reference: BHIN No: 20-005. & Day Treatment Intensive and Day Rehabilitation Service Components - Attachment A

IPC and CFT Meeting

Prior to placement in an STRTP, all children and youth shall participate in a Child and Family Team meeting and be evaluated by the Interagency Placement Committee (IPC) to ensure that the youth's needs cannot be met in a less restrictive environment and that they meet the criteria listed in All County Letter No. 17-22

The IPC consists of representatives from Child and Family Well-Being (CFWB), Probation, and Behavioral Health Services as well as representatives from Public Health, and Educational sectors. Interagency Placement Committee meetings are held weekly by both Probation and CFWB. For children 6-12 years old, placement in an STRTP shall not exceed six (6) months. For children aged 13 and up, placed under supervision of CFWB, the placement shall not exceed six (6) months. For children aged 13 and up, placed under supervision of Probation, the placement in an STRTP shall not exceed twelve (12) months.

Family First Prevention and Services Act

The Family First Prevention Services Act (FFPSA), signed into law on February 9, 2018, aims to strengthen family-based support services, prevent unnecessary congregate care placements, and establish additional oversight and requirements for residential placements. Under BHIN 21-060, a Qualified Individual (QI) must conduct an independent assessment and determine whether an STRTP or out-of-state residential placement is appropriate before placement occurs. The assessment must include engagement with the child and family team and, when applicable, the child's tribe. For emergency placements, the assessment must be completed within thirty (30) days of placement.

FFPSA also requires STRTPs to provide at least six (6) months of aftercare services following discharge to support the youth's transition to a family-based setting. This includes discharge planning and coordination with wraparound services. STRTPs may directly refer youth to BHS-contracted wraparound programs, and wraparound providers may begin services up to three months before the anticipated discharge date to facilitate a coordinated transition. Recommendations and planning for wraparound services should be routinely discussed during Child and Family Team (CFT) meetings. Overall goal: Reduce reliance on congregate care and promote successful transitions to safe, stable, family-based settings through appropriate assessment, coordinated discharge planning, and sustained aftercare support.

Supportive Housing

BHS provides short term, transitional, and permanent supportive housing to persons who are enrolled in the BHP and are experiencing homelessness or at risk of homelessness. Linkage to housing is provided by the program in coordination with numerous partners, to include housing entities, landlords, board and care facilities, and Independent Living Homes (ILHs).
For more information, please reference

Therapeutic Behavioral Services (TBS)

An intensive, individualized, one-to one behavioral coaching program that is offered through a county contract. A multi-disciplinary team headed by the Specialty Mental Health Provider (SMHP) is convened with the child/youth and family as the core drivers for treatment plan development. All direct services are offered in the home or child's/youth's natural environment, such as school. A TBS Case Manager acts as the care coordinator. Prior authorization through Optum is required. Members are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. Authorization forms are located on the Optum Website > *MH Resources* tab. Authorization requests are screened and assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Brochure

In accordance to CCR, Title 9, Chapter 1, Section 1810.310 (a)(1), providers are to provide the DHCS issued *Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT)* brochures, which include information about accessing Therapeutic Behavioral Services (TBS) to children and young adults (under age 21) who qualify for Medi-Cal EPSDT services and their caregivers or guardians at the time of admission to any of the following facilities: Specialized Treatment Program (STP), Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution of Mental Diseases (IMD), Rate Classification Level (RCL) 13-14 Foster Care Group Home, Short Term Residential Therapeutic

Program (STRTP) or RCL 12 Foster Care Group Home. Providers shall document in the member chart that brochure was provided to the member/family/caregiver.

See the link to the EPSDT brochures: Medi-Cal for Kids and Teens Resources

Therapeutic Foster Care (TFC)

Therapeutic Foster Care (TFC) provides short-term, intensive, individualized, trauma-informed, and coordinated Specialty Mental Health Services (SMHS) to children and youth up to age 21 with complex emotional and behavioral needs. Services are delivered in a family-based setting by specially trained, supervised, and supported TFC parents. TFC serves as a home-based alternative to higher levels of institutional care, including group homes and potentially STRTPs, while providing eligible services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Prior authorization through Optum is required before TFC services can begin.

For more information, please reference: The Medi-Cal Manual for ICC, IHBS, and TFC Services & Optum Website> *MH Resources*.

Wraparound Services

Intensive, non-traditional mental health services designed to support children and families with complex needs by using a team-based, strength-focused, and family-driven approach inclusive of a full range of specialty mental health treatment options. Services are delivered through a collaborative planning process that includes the youth, family, natural supports, and professionals, focusing on long-term success by improving stability, functioning, and empowerment of families. Fidelity to the HFW model is monitored annually to ensure services are delivered according to established California state wraparound standards and principles that supports adherence to the integrity and effectiveness of the model across all contracted programs.

Service Elements Specific to Children & Youth Programs

All authorization requirements in this section must be completed for all members even if the services will be funded by a source other than Medi-Cal, including Behavioral Health Services Act (BHSA), formerly MHSA. Department of Health Care Services (DHCS) BHIN 22-016 outlines authorization requirements for Specialty Mental health Services (SMHS). It emphasizes that all medically necessary covered SMHS must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR). The information notice specifies that for outpatient services prior authorization is required for Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. Prior authorization may not be required for Crisis Intervention, Crisis Stabilization, Metal Health Services,

Targeted Case Management, Intensive Care Coordination, or Medication Support Services.

The Children, Youth and Families Behavioral Health service array includes:

a. The critical care/emergency screening unit, which provides emergency psychiatric evaluation, crisis stabilization, and screening for inpatient care for families during mental health crisis.

b. Outpatient services include crisis intervention, mental health assessments, medication management, family therapy, group therapy, substance use disorder (SUD) issues and case management. Services are clinic based, school based, institutionally based, and community based and offered through contracted and Fee for Service providers. These include several specialized programs that focus on specific populations.

c. Case Management/wraparound services are for children, youth and families with complex needs and require intensive supports in addition to treatment service.

d. Therapeutic Behavioral Services are one on one behavioral service provided by BHS contractors in conjunction with other treatment services.

e. Day treatment services are several hours per day and all-inclusive in terms of the mental health services provided.

f. School based day rehabilitation services are provided through the San Diego Unified, Cajon Valley, and Grossmont Union School Districts. Services are accessed through referral by the district.

g. Day Treatment is offered for Dependents of the Court residing in residential treatment and long-term placement at San Pasqual Academy.

h. Inpatient services which are for mental health emergencies requiring a hospital setting.

i. Case Management Juvenile Justice Programs support members referred by the Probation Department and Juvenile Drug Court to assist in the intervention, treatment and recovery from substance abuse issues. Juvenile justice programs offer services at designated County Probation service centers and the Juvenile Drug Court.

Special Populations Selection

DHCS no longer requires the identification of *class* or *subclass* when determining eligibility for ICC/IHBS services, however, counties are recommended to continue tracking of those youth who would have been subclass to facilitate data collection and

reporting of all services provided. BHPs must continue to ensure appropriate claiming of ICC, IHBS, and TFC services. BHPs are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of twenty-one (21) who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services. All youth under age twenty-one (21) and eligible for full scope Medi-Cal must be assessed for criteria to receive ICC/IHBS services. Neither membership in the *Katie A.* class nor subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to be considered for receipt of these services. All children and youth should be screened for ICC and IHBS services as part of the Assessment process, and these services should be provided to youth when medically necessary.

When ICC/IHBS services are assessed to be medically necessary, these youth should be entered into the appropriate *Special Populations* category in SmartCare – this will link the appropriate modifier (HK) for billing and tracking purposes when providing these services. Special populations "ICC/IHBS" is used for any youth receiving ICC/IHBS services. Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria**.**

For more information, please reference:: How To Identify a Client as Katie-A or Other Special Population

Program Procedure(s) for Medi-Cal Eligible Children in AAP/KinGAP under SB 785

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The program providing the services will submit the Service Authorization Request (SAR*)* to the county of origin for authorization and signature.

3. For outpatient services, if county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.

4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

5. Services shall be entered into the EHR by MIS.

6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.

7. SPA shall submit the notification SAR and the DSR to Optum.

8. STRTPs shall contact the COR for written prior authorization for admission to mental health treatment services and confirm that out-of-county youth has a San Diego connection/caregiver to whom they will be discharging to.

9. STRTPs shall submit the completed SAR to the county of jurisdiction and forward a copy of the SAR and DSR to Optum with a written COR approval to serve youth under County contract due to discharge to San Diego residence.

10. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR and BHS CCR team by the 15th day of the following month and clearly indicate that the AB1299 STRTP Admission Report is being utilized to provide information about an out of county KinGAP or AAP youth under a COR written authorization.

There are, in essence, two types of OOC Medi-Cal members:

1. OOC members who fall under the aid codes AAP or KinGAP. For those members the program shall submit a SAR to the Behavioral Health Plan (BHP) from the County of Jurisdiction. The members are subject to our local UM process and the services are entered into our EHR.

2. OOC members who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for programs to serve them. Programs need to get written authorization from COR to serve those children prior to Medi-Cal shifting to San Diego. When authorization is granted prior to the Medi-Cal shift it is with the expectation that the program is actively and promptly collaborating with the guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process.

All BHS CYF contracted programs are to ensure that the “County of Responsibility” code is accurate and up to date for each youth admitted to the program to also track all youth’s Medi-Cal County of origin.

CFT Meetings

There is a distinction between a CFT *Team* and a CFT *meeting*. Under Pathways to Well-Being, all children entering the CFWB system receive a mental health screening conducted by CFWB and based upon need, are part of a collaborative, youth and family-centered teaming process, referred to as the *Child and Family Team (CFT).* The CFT consists of people identified to ensure the youth has access to appropriate mental health and supportive services to promote safety, permanency, and well-being. The

CFT, including the Intensive Care Coordinator, makes individualized determinations of each child/youth's need for Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), based on strengths/needs and reassesses the strengths and needs of child/youths, and their families, at least every ninety (90) days and as needed. The CFT meeting is just one way in which the team members communicate. The team composition is guided by the youth and family's needs and preferences.

For children or youth who are receiving ICC, IHBS, or TFC, a CFT meeting must occur as needed, but at least every ninety (90) days.

More information regarding the CFT meeting can be found in the The Medi-Cal Manual for ICC, IHBS, and TFC Services.

The CFT is comprised of the following members:

- Child/youth/TAY (Mandatory)
- Family/caregiver (Mandatory)
- CWS social worker (Mandatory)
- BHS provider (Mandatory)
- Probation (Mandatory when youth is a ward of the court)
- Tribal Members (When applicable)
- Court Appointed Special Advocate (CASA) (Mandatory when assigned by a judge)
- Natural supports
- Education and Other Formal Supports

All youth who receive Enhanced Services will have a Care Coordinator**.** BHS and CFWB will work together to identify the Care Coordinator who will take the lead in identifying CFT members with input from the youth/family. The Care Coordinator is also responsible for adherence to CFT meeting requirements, timelines, and referrals to the CFT Meeting Facilitation Program. A Care Coordinator serves as the single point of accountability to ensure that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the youth.

CFT Meeting Facilitation Program

All mental health treatment programs (other than those with a written COR-approved exception) that serve youth and families who are participating in CFT meetings, are required to utilize the CFT Meeting Facilitation Program. The CFT Meeting Facilitation Program is responsible for scheduling, organizing, and facilitating CFT meetings for children/youth up to twenty- one (21) years of age, within the BHS Children, Youth and Families system of care who are receiving Intensive Care Coordination (ICC) and are either required to have CFT meetings due to Pathways to

Well-Being criteria, or would benefit from a CFT meeting due to multi-system involvement.

The program also serves Child and Family Well-Being and Probation involved youth while closely collaborating and coordinating with all pertinent people in the youth and family's life including CFWB workers, Probation Officers, BHS providers, educational supports, other identified formal supports, and natural supports. Providers will initiate the CFT meeting process by completing the *Child and Family Team Meeting Referral Form* and faxing to the CFT Meeting Facilitation Program.

Please note that if a member is **not** involved with CFWB, the program does **not** have to utilize a facilitation Fred Finch for CFT meetings. In these cases, the CFT meetings can be self-facilitated by the provider within regular timelines.

Documenting and Billing for CFT Meetings in SmartCare

Providers should utilize **Procedure Code: CFT/MDT** when documenting a CFT meeting. Each treatment team member that plans to bill for their time spent discussing the member with other treatment team members must create their own service note. Additional guidance: Document Treatment Team Meetings - 2023 CalMHSA

For more information, please reference:

School Interface

Aligned with AB114, students with behavioral health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access Children, Youth & Families services through the County system when they meet access criteria for specialty mental health services.

Children, Youth & Families standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical. Through contracts with Community Based Organizations, School ink services are offered on identified school campuses. Information about SchoolLink can be accessed through the School Based Services webpage.

Day School Services

Intensive outpatient programs that include a full range of short-term specialty mental health services including assessment, evaluation, plan development, coordination of care, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services. These services may be provided to children and youth identified through an IEP or school district process as needing a Special Education Classroom setting to be

successful in school. Services are intensive and flexible to meet the needs of the member and assist in transitioning to a less restrictive classroom setting.

For more information, please reference: School-Based Services

Pathways to Well-Being and Continuum of Care Reform

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates. The lawsuit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. PWB was implemented in March 2013 in the County of San Diego as a joint partnership between Behavioral Health Services (BHS) and Child and Family Well-Being (CFWB), in collaboration with Probation and Youth/Family Support Partners. The County of San Diego is dedicated to collaborative efforts geared toward providing safety, permanency, and well-being for youth identified as having complex or severe behavioral health needs and to establish long term permanency within a home-like setting.

PWB includes services that are needs driven, strengths-based, youth and family focused, individualized, culturally competent, trauma informed, and are delivered in a well-coordinated, comprehensive, community-based approach with a central element of engagement and participation of the youth and family. PWB services are available to youth across the System of Care, including Transitional Age Youth (TAY) who are involved in County of San Diego Behavioral Health Services.

Bulletins: PWB Bulletins are used to inform and provide procedures. Bulletins are located on the BHS Pathways to Well-Being Website

Trainings: All Program Managers and direct service staff shall complete the one-time Pathways to Well-Being and Continuum of Care Reform (San Diego) eLearning training. All mental health Program Managers shall complete the AB 2083 online training within ninety (90) days of hire. Both of these trainings are located on the Pathways to Well-Being website.

Forms: Member related forms specific to Pathways to Well-Being which must be completed include the following below. Forms referenced below are located on the BHS Pathways to Well-Being website under the Tools and Forms tabs. The page includes general information, required forms, training, schedules, and contact information for BHS Pathways to Well-Being staff.

Form	Details
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an

	exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Pathways to Well-Being BHS/CFWB Information Exchange Form	Provider completes and submits form to CFWB (see secure region fax numbers on form) initially within thirty (30) days of determining eligibility and for any update (upon significant change or revision to either a care plan or problem list).

Resources:

- DHCS Medi-Cal Manual Third Edition (2018):
- DHCS Integrated Core Practice Model Guide (2018):

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR), initiated across California on January 1, 2017, builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care.

CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive support through teaming and youth not having to change placement to get services and support. CFWB and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as**:**

- Court hearing schedules
- Placement changes
- Child removed from his or her home and a plan is needed for the youth and family
- Child is in out of home care and a change in placement is required or requested
- Child returning home

- Permanent plan for a child needs to be made
- Child/youth's mental health needs or placement in a group home should be assessed
- Any family member involved in a child's case requests to meet to talk about the child's placement or the family's service plan.

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as well as technical assistance for STRTPs and group home providers who are transitioning to a STRTP. The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CFWB, Probation, and Youth/Family Support Partners. Program staff can be reached through the BHS Pathways to Well-Being Website.

Serving Youth with an Open Child and Family Well-Being Services Case

Per BHIN 21-058, BHP's must make individualized determinations for each child/youth's need for ICC, IHBS or TFC upon intake and at each assessment interval. Having an open child welfare services case is not required for a child or youth to receive ICC, IHBS or TFC. BHP's are obligated to provide ICC, IHBS, and TFC to all children and youth under the age of twenty- one (21) eligible for full scope Medi-Cal and who meet access criteria for these services.

The BHP cannot develop or utilize a screening or assessment tool or policy that narrows the eligibility for ICC, IHBS or TFC *beyond being medically necessary.* Providers should be considering ICC and IHBS services for all youth as part of the assessment process and indicate as such in their documentation at intake and re-assessment. Members identified as meeting criteria for these services will be indicated as a "Special Population" in the EHR.

Intensive Services

Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their country of origin, have had difficulty receiving timely access to specialty mental health services. Assembly Bill (AB) 1299 and Senate Bill (SB) 785 intend to improve the timely access to services.

SB 785 for AAP and KinGAP : Transfers the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP and KinGAP children. DMH Information Notice No. 08-24 and 09-06 . Although the statutory sections included in the originally enacted version of SB785 have been amended over time, none of these amendments changed any of the original provisions of SB785. Furthermore, the original provisions of SB 785 did not change as a result of AB1299. However, the provisions of SB785, including Service Authorization Request (SAR) provisions, are no longer

necessary or required for foster children or youth under the conditions of presumptive transfer, or under a waiver of presumptive transfer. However, for children and youth who receive assistance under Kin-GAP and AAP, the county of original jurisdiction continues to retain responsibility for authorizing and reauthorizing SMHS.

Out of County Services for Children and Youth

Presumptive transfer means a prompt transfer of the responsibility for the provision of, or arranging and payment for Specialty Mental Health Services (SMHS) from the county of original jurisdiction to the county in which the foster child resides. Presumptive transfer is intended to provide children and youth in foster care who are placed outside their counties of original jurisdiction timely access to SMHS, based upon their individual strengths and needs, and consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Discussions regarding presumptive transfer should occur with the child and his or her parent, Child and Family Team (CFT) members, and in consultation with other professionals who serve the child or youth, as appropriate.

When a child or youth is placed outside of their county of original jurisdiction into a community treatment facility (CTF), group home (GH), or short-term residential therapeutic program (STRTP) or admitted to a children's crisis residential program (CCRP), the responsibility to provide or arrange and pay for SMHS shall remain with the Behavioral Health Plan BHP) in the county of original jurisdiction unless certain circumstances apply. Notification of Presumptive Transfer is submitted to the Behavioral Health Plan (BHP) in the new county of residence by the placing agency within three (3) business days of the decision to place the youth outside their county of jurisdiction.

To notify the San Diego County BHP single point of contact for presumptive transfers, please contact Optum at 1-800-798-2254 option 3, then option 3 again, or fax 1-866-220-4495.

For more information, please reference: BHIN 24-025 & Presumptive Transfer – FAQ & AB 1299 Step by Step Process

Presumptive Transfer Procedure for Medi-Cal Eligible Children in Foster Care under AB1299

AB 1299 for Foster Youth establishes the presumptive transfer of responsibility and payment for providing or arranging mental health services to foster children from the county of original jurisdiction (placing county) to the foster child's county of residence. MHSUDS Information Notice No. 17-032. (For foster children whose care is presumptively transferred to San Diego)

1. The placing agency informs Optum of the presumptive transfer.

2. If requested by the placing agency of the county of original jurisdiction, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

3. Services shall be entered into the EHR by the provider rendering services.

4. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services.

5. STRTPs who provide day services shall submit DSR to Optum.

6. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR, BHS CCR team, and Optum San Diego with a copy of the Notice of Presumptive Transfer form by the fifteenth (15th) day of the month following admission to the STRTP.

Please see BHIN 24-025 for more information

C. Practice Guidelines

Practice guidelines refer to methods and standards for providing clinical services to members. The BHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs Welfare and Institutions Code 14184.402. They are based on clinical consensus and research findings as to best practices and evidence-based practices available. Because they reflect current best practices, the guidelines may change as new information and/or technology becomes available.

As these changes occur, the BHP is responsible for disseminating the guidelines to Providers, as well as ensuring that changes being made are done so with consideration to the needs of the consumers. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. The BHP collaborates with Providers as needed, with continuous feedback channels established through various venues including Provider Association Executive meetings and Quality Improvement subcommittee meetings, Quality Improvement Partners (QIP) meetings and various Level of Care Program Manager meetings. .

Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the member's service needs. Members shall be routinely asked, at the time of accessing services, about their needs for language assistance. Providers must document the offer and whether linkage was made to interpreter service for members requesting or needing translation services in threshold or other languages.

BHS policy prohibits the expectation that family members, including minor children will provide interpreter services., If members choose to use family or friends, this choice also should be documented. To comply with State and federal regulations, providers must be able to provide information on Behavioral Health Plan (BHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

If program staff are not available to meet the language needs of a member, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. The County contracts with several vendors to provide written translation and interpreter services, including ASL.

County operated programs can contact Interpreters Unlimited at (800) 726-9891 to arrange for language assistance, including ASL,for reoccurring and/or one-time meetings occurring both virtually and in person. Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website, San Diego's Insite- Purchasing & Contracting > Language website.

Member Deaths

All member deaths must be reported promptly and in accordance with County requirements. Notify both the HIMS department and the County MEDS Coordinator when a member passes.

1. Submit a BHS 025 Form with date of member death in the comments

2. Send an email to 37Crdnt.HHSA@sdcounty.ca.gov including:

    i. Member Name
    ii. Social Security Number
    iii. Date of Birth
    iv. Date of Death

Retain a copy of the sent email(s) as documentation of compliance. Death reporting is monitored by QA as part of the Medi-Cal recertification process. The program should ensure all documentation is entered within the EHR prior to emailing these departments

Please reference the Optum Website > *Incident Reporting tab* to determine if the member death also requires a Critical Incident Report (CIR).

Admission Policies, Procedures and Protocols

Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that members are admitted to treatment regardless of anticipated treatment outcome that are in line with harm reduction principles. Policies shall also comply with the entry criteria and priority as defined by the contracts.

In the occasion that providers should exclude members from their program (example: member become violent), providers are to engage in warm hand-offs to appropriate services. Medi-Cal members are entitled to receive Medi-Cal services. Providers should consult with their legal entity and/or CORs when excluding Medi-Cal members from receiving services.

Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for: W&I Code 14148.402 Access Criteria. The Target Population for Adult/ Older Adult BHS programs include:

- Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.

- People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational, and educational goals.

This criterion applies to all members, including Medi-Cal and indigent members.

Coordination of Care & Transitioning Planning

Coordination of care among service providers is essential to ensuring continuity of care for members and supporting an efficient behavioral health system. Providers are expected to complete a **warm handoff** when transitioning members between services to promote continuity of care and facilitate successful linkage to the receiving provider. Providers shall develop discharge plans that support members transitioning between the same or different levels of care, including transitions to services outside the Behavioral Health Services (BHS) system of care.

This may include the referring provider contacting and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage.

As appropriate, the warm handoff may include the referring provider establishing collaborative communication with a designated staff member responsible for intake at the receiving provider, arranging transportation to the receiving provider, and supporting appointment attendance. Providers should confirm and document that the member has successfully linked to the receiving provider, including completion of a face-to-face appointment when applicable.

Long Term Members

The BHP defines a long-term member as an individual who receives behavioral health services for more than sixty (60) days following admission to a behavioral health program. Long-term members are expected to have a completed behavioral health assessment, problem list, and care plan, as applicable.

Medication-Assisted Treatment (MAT) and Overdose Prevention

Members diagnosed with a primary or co-occurring opioid use disorder and/or alcohol use disorder should be offered a referral for an assessment for Medication-

Assisted Treatment (MAT), as clinically indicated. Although recommending specific medications is outside the scope of practice for non-prescribing staff, staff may recommend a referral for a MAT assessment during intake and at other points throughout the treatment process, as appropriate.

Staff are encouraged to use motivational interviewing to support members in exploring medication treatment options when clinically appropriate. Members with an opioid use disorder and/or stimulant use disorder should also be referred or linked to naloxone access and overdose prevention services, as appropriate, to reduce the risk of overdose.

Program policies and procedures shall address clinical training and supervision to ensure staff can provide appropriate MAT referrals when clinically indicated, including during treatment and following an overdose. Training and supervision should also address access to naloxone, particularly for members with an opioid use disorder who decline a MAT referral, to support overdose prevention and member safety.

Transition of Care Tool

Completion of the Transition of Care Tool for Medi-Cal Mental Health Services is required when facilitating applicable transitions of care between the Behavioral Health Plan (BHP) and Managed Care Plan (MCP) delivery systems, including transitions from Specialty Mental Health Services (SMHS) to Non-Specialty Mental Health Services (NSMHS), and when coordinating additional services across delivery systems, consistent with applicable requirements.

The TOC Tool supports continuity of care by leveraging existing clinical information to document a member's mental health needs and facilitate referrals for transitions of care or additional services through the MCP or BHP, as appropriate. Members may transition all or a subset of their mental health services to another delivery system based on their individual needs. The tool applies to both adults and youth. The TOC Tool supports members in achieving and maintaining the highest possible level of stability and independence. The BHP System of Care requires providers to assign each member a care coordinator who serves as the single point of accountability for rehabilitation and recovery planning through service coordination and linkage to appropriate resources. The BHP monitors coordination of care to support continuity and effective service delivery.

Purpose and Required Information

The TOC Tool communicates relevant member information from the referring entity to the receiving delivery system to support a coordinated transition or referral. It includes fields for the following information:

- Referring plan contact information and care team.
- Member demographics and contact information.

- Behavioral health diagnoses, cultural and linguistic needs, presenting behaviors and symptoms, environmental factors, behavioral health history, medical history, and current medications.

- Services requested and receiving plan contact information.

Additional supporting documentation, such as medical history reviews, care plans, and medication lists, may be attached to the tool as appropriate.

The TOC Tool is intended to facilitate coordinated care when:

- **Existing services need to transition** to another delivery system, such as from BHP SMHS to MCP NSMHS or to substance use disorder services, as applicable.

- **Additional services are needed** from another delivery system while the member continues receiving existing services. This includes coordination consistent with *No Wrong Door* policies regarding concurrent treatment under Welfare and Institutions Code section 14184.402(f), BHIN 22-011, and APL 22-005, as well as applicable continuity-of-care requirements under MHSUDS Information Notice 18-059 and APL 18-008, or subsequent updates.

Limitations

Completion of the TOC Tool does not constitute a clinical assessment and does not replace:

- BHP policies and procedures addressing urgent or emergency care needs, including crisis response and urgent or emergent referrals.
- BHP protocols for ensuring clinically appropriate, timely, and equitable access to care.
- Required clinical assessments, level-of-care determinations, or service recommendations.
- BHP requirements to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Administration of the TOC Tool

BHPs are required to use the TOC Tool to facilitate applicable transitions of care to MCPs for members of all ages, including adults age 21 and older and youth under age 21, when their service needs change. The decision to transition services to another delivery system or add services from the MCP must be made by a clinician through a **patient-centered, shared decision-making process**, consistent with BHP protocols.

Once the clinician determines that a transition or referral for additional services is appropriate, the TOC Tool may be completed by a clinician or non-clinician. Clinicians include provider types identified as providers of Rehabilitative Mental Health Services in Supplemental 3 to Attachment 3.1.A, pages 2m–2p, of the California Medicaid State Plan.

Non-clinicians may include administrative staff, peer support staff, or other professionals who do not meet the definition of a clinician.

Members must be engaged in the process, and appropriate consents must be obtained in accordance with accepted standards of clinical practice. The tool may be completed in person, by telephone, or by video conference. The TOC Tool must be completed in the electronic health record (EHR). A downtime PDF version is available on the Optum website. If the downtime version is used, the completed document must be scanned into the EHR. Additional supporting documentation, such as medical history reviews, care plans, and medication lists, may be attached as appropriate.

Follow-Up

After the Transition of Care Tool is completed, the member shall be referred to their MCP. Consistent with BHIN 22-011, APL 22-005, and subsequent updates, BHPs must coordinate with MCPs to facilitate transitions of care and referrals for additional services. Coordination must include ensuring that:

- The referral process has been completed.
- The member has been connected with a provider in the receiving delivery system.
- The receiving provider has accepted responsibility for the member's care.
- Medically necessary services have been made available to the member.
- All appropriate consents have been obtained in accordance with accepted standards of clinical practice.

For MCP contact information related to the TOC Tool, refer to the Screening and Transition of Care Contact Card, available on the Optum website under the *Healthy San Diego* page. The TOC *Tool* and its *Explanation Sheet* are also available on the Optum website under the *UCRM* tab.

Members Who Must Transfer to a New Provider

Many members are unable to complete an entire treatment episode with the same therapist or mental health worker. This happens because of staff resignations, program closings, member change of residence or placement, transition of youths to programs that serve Adults as clinically indicated and/or age appropriate, and completion of internships and field placements. Good clinical practice indicates that the following should be implemented whenever possible to ease transition.

The member and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least fourteen (14) days prior to the final visit with the first provider. The member and caregiver should be informed of the member's right to request a new provider. The member and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.

Report transfers on the *Suggestion and Provider Transfer Log*, which is found on the required Quarterly Status Report. The member should be assisted in making a first appointment with the new program. The old and new program/provider must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials. A thorough discharge summary (or a transfer note if the member will continue in the same program) should be written and incorporated into the chart. Final outcome tools should be administered if the member will go to another provider program. A written plan for emergency services should be developed with the member and caregiver, to include the ACL, the new program, and informal supports.

Transitional Age Youth (TAY) Transition Process

Youth receiving behavioral health services in the Children, Youth and Families Behavioral Health System of Care may require system coordination to successfully transition to the Adult/Older Adult Behavioral Health System of Care when they reach the ages of eighteen to twenty- one (18-21).

Planning and consultation with the youth prior to a referral is needed so that the planned services match the needs and desires of the transition aged youth. Clinical staff shall meet with the youth and their supports, including other system of care partners such as CFWB & Probation as applicable, to strategize about planned services as some youth may be best served by continued services in BHP programs that serve Children, Youth and Families, and for others a referral to BHP programs that serve Adults may be indicated. Involvement of the family in transition planning is integral when family is available. It is critical that the youth and family understand the differences within the BHP System of Care in terms of consent to treat and expectations of support systems.

The following considerations should be taken if the youth is also involved with the following sectors:

- Child and Family Wellbeing Services: In an effort to coordinate care with CFWB, a call to 858-694-5191can be made to access the name and phone number of a San Diego County foster youth's social worker. To access the name of a youth's Independent Living Skills (ILS) worker, the ILS INFO Line can be called at 866-ILS INFO (866-457-4636). The ILS INFO Line can also be used as the starting point for an eligible former foster youth to re-enter foster care after age 18. Additional information about ILS and transitional housing opportunities can be found at https://www.fosteringchangeforchildren.org/.

- Probation: If a youth has probation involvement, communication with the Probation Officer would be an important aspect of services.

- Education: If a youth has been in Special Education and did not receive a diploma, they are eligible for educational services through their school district until age 22. Their last school of attendance would be able to assist with school records and

educational placement. If there is any difficulty at the school site getting information, it is advised to contact either the Special Education Department Chair at that school site or the Vice Principal of Special Education. If a youth was not receiving Special Education services, they can be referred to "Adult Education" which is provided through the San Diego Community College District.

If a referral to a BHS program that serves Adults, it is recommended that a call to the selected program be made to discuss the referral process and to allow for some transition time when the youth can be introduced to the new program on a timeline that is comfortable to all parties. It is also recommended that visits with the youth, their supports, the existing provider, and the prospective provider occur, as this can be a helpful step in supporting a transition.

Procedures to follow if a routine referral is unsuccessful:

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the current program, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:

    - Referral Form/Cover Letter
    - Children's Behavioral Health Assessment and most recent update
    - The Mental Health Diagnosis
    - Youth Transition Evaluation
    - Mental Status conducted by psychiatrist within the last forty- five (45) days
    - Physical Health Information
    - Medication Sheet
    - Care Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
    - Psychological Testing done within past year (if available)
    - Individual Education Plan and Individual Transition Plan
    - Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
    - Any self-evaluations recently given to youth.

2. This packet shall be submitted with releases to the Behavioral Health Program Coordinator (BHPC) of Behavioral Health Services in the region where the youth resides. The BHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108. The BHPC will review the packet to determine if access criteria are met for SMHS and the Service Eligibility Policy.

3. If the member does not meet criteria to access SMHS, then the member shall be referred back to the referral source for services in the community. If the youth is eighteen (18) or over, an assessment will be requested from a BHS provider agreeable to the member and family. If the assessment indicated a Medi-Cal member does not meet criteria to access SMHS, a Notice of Adverse Benefit Determination (NOABD) will be issued, advising him/her of his/her rights to appeal the decision.

4. If a transition plan is agreed upon, the member's BHS program Case Manager or Care Coordinator will attempt to link the member with the appropriate service. If the linkage is not successful, the BHPC shall coordinate an initial meeting with a multidisciplinary support team within two (2) weeks of the initial referral that will include relevant persons that may include, but are not limited to, the following:

    - Youth
    - Support System as defined by the youth/family (i.e. parent, social worker, family members
    - Existing BHS Program Case Manager and /or Therapist
    - Current Psychiatrist
    - Children, Youth and Families BHS Contracting Officer's Representative (CORS), or designee
    - New Program BHS COR if applicable, or designee
    - Probation Officer (if applicable)
    - CFWB Social Worker (if applicable)
    - Education/Vocational Specialist

5. Team will review youth defined needs and options and create a transition plan, The Care Coordinator will include a copy of the transition planin the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified, and same procedure followed.

Post Discharge Coordination of Care

New members discharged from a twenty- four (24)-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within seventy-two (72) hours, unless deemed Urgent, as indicated below. Current members discharged from an acute care twenty-four (24) hour facility (hospital or crisis house) must receive a high-risk assessment within a clinically appropriate timeframe and thereafter anytime a member presents with risk factors. The County of San Diego is defining a "clinically appropriate

timeframe" as between seventy- two (72) hours and five (5) days post discharge. If the risk assessment cannot be completed for any reason within timeframes the documentation must at minimum document attempted efforts to complete the risk assessment and/or reasons why it was not completed on time.

If the referral is deemed urgent, member shall be seen within forty-eight (48) hours of contact with program. A need for urgent services is defined in 8 HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21) health care provided to a member when the member's condition is such that the member 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 member's life or health or could jeopardize their ability to regain maximum function.

The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. Compliance to this standard is monitored through the Quality Assurance Program Review process.

Requests for Continuity of Care

Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State (and BHP) to have in effect a transition of care policy to ensure continued access to services during a member's transition from Medi-Cal fee-for-service (FFS) to a managed care program or transition from one managed care entity to another, when the member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

All eligible Medi-Cal members who meet access criteria for SMHS have the right to request continuity of care. Members with pre-existing provider relationships who make a continuity of care request to the county BHP must be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the BHP or a contracted organizational provider, provider group, or individual practitioner).

This policy applies to all Medi-Cal members who are transitioning as follows:

- The provider has voluntarily terminated employment or the contract with the BHP.
- The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.
- Transitioning from one county BHP to another county BHP due to a change in the member's county of residence.

- Transitioning from an MCP to an BHP; or,

- Transitioning from Medi-Cal FFS to the BHP.

A member, the member's authorized representatives, or the member's provider may make a direct request to an BHP for continuity of care. Members may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request. BHPs must provide reasonable assistance to members in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

Member and Provider Outreach and Education

BHPs must inform members of their continuity of care protections and must include information about these protections in member informing materials and handbooks. This information must include how the member and provider initiate a continuity of care request with the BHP. The BHP must translate these documents into threshold languages and make them available in alternative formats, upon request. BHPs must provide training to staff that come into regular contact with members about continuity of care protections.

Continued Care Criteria

After the admission criteria for a given level of care have been met, it is appropriate to retain the member at the present level of care if:

- The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan or making progress on identified problems on problem list.

- The member continues to work toward treatment goals or problems

- The member is not yet making progress but has the capacity to address his or her problems.

- The member is actively working on the goals articulated in the individualized treatment plan or working on identified problems on problem list.
- New problems have been identified that are appropriately treated at the present level of care. The current level of care is the least intensive at which the member's new problems can be addressed effectively.

Timeline Requirements

Each continuity of care request must be completed within the following timelines:

- Thirty (30) calendar days from the date the BHP received the request.

- Fifteen (15) calendar days if the member's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

- Three (3) calendar days if there is a risk of harm to the member.

BHPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided to a member under the following circumstances:

- The provider meets the continuity of care requirements.

- Services were provided after a referral was made to the BHP (this includes self-referrals made by the member); and,

- The member is determined to meet criteria for access to SMHS.

A continuity of care request is considered complete when:

- The BHP informs the member and/or the member's authorized representative, that the request has been approved; or,

- The BHP and the out-of-network provider are unable to agree to a rate and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,
- The BHP has documented quality of care issues with the provider and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,

The BHP makes a good faith effort to contact the provider, and the provider is non-responsive for thirty (30) calendar days and the BHP notifies the member and/or the member's authorized representative that the request is denied.

Continuity of Care Reporting Requirements

BHPs are required to report to DHCS all requests, and approvals, for continuity of care. The BHP must submit a continuity of care report, with the BHPs quarterly network adequacy submissions, that includes the following information:

- The date of the request;

- The member's name;

- The name of the member's pre-existing provider;

- The address/location of the provider's office; and,

- Whether the provider has agreed to the BHPs terms and conditions; and,

- The status of the request, including the deadline for deciding regarding the member's request.

Continuity of Care Requests Processed by the Administrative Services Organization (ASO)

All continuity of care requests shall be directed to the Administrative Services Organization (ASO), Optum. Optum will manage all continuity of care requests for the Behavioral Health Plan (BHP). Providers shall notify all members with existing non-BHP providers that continuity of care requests are available as the member transfers care over to the BHP. Providers are expected to assist members and work directly with Optum to ensure a smooth transfer of care. To begin the process, instruct the member to call the Access and Crisis Line and initiate the Continuity of Care request.

Requirements Following Completion of Continuity of Care Request

If the provider meets all the required conditions and the member's request is granted, the BHP must allow the member to have access to that provider for a period of up to twelve (12) months, depending on the needs of the member and the agreement made between the ASO on behalf of the BHP and the out-of-network provider. When the continuity of care agreement has been established, the BHP must work with the provider to establish a Care Plan and transition plan for the member.

Upon approval of a continuity of care request, the BHP must notify the member and/or the member's authorized representative, in writing, of the following:

- The BHPs approval of the continuity of care request.

- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period; and

- The member's right to choose a different provider from BHPs provider network.

The written notification to the member must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

- The BHPs denial of the member's continuity of care request.

- A clear explanation of the reasons for the denial.

- The availability of in-network SMHS.

- How and where to access SMHS from the BHP.

- The member's right to file an appeal based on the adverse benefit determination; and,

- The BHPs member handbook and provider directory.

At any time, members may change their provider to an in-network provider whether or not a continuity of care relationship has been established. BHPs must provide SMHS and/or refer members to appropriate network providers without delay and within established appointment time standards.

The BHP must notify the member, and/or the member's authorized representative, thirty (30) calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

Repeated Requests for Continuity of Care

After the member's continuity of care period ends, the member must choose a mental health provider in the BHPs network for SMHS. If the member later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the BHP for SMHS, the twelve (12) month continuity of care period may start over one time.

If a member changes county of residence more than once in a twelve (12) month period, the twelve (12) month continuity of care period may start over with the second BHP and third BHP, after which, the member may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the BHP should communicate with the BHP in the member's new County of residence to share information about the member's existing continuity of care request.

Validating Pre-existing Provider Relationships

An existing relationship with a provider may be established if the member has seen the out-of-network provider at least once during the twelve (12) months prior to the following:

- The member establishing residence in the county.
- Upon referral by another BHP or MCP; and/or,
- The BHP determining the member meets criteria for access to SMHS.
- A member or provider may make available information to the BHP that provides verification of their pre-existing relationship with a provider.

Following identification of a pre-existing relationship with an out-of-network provider, the BHP must contact the provider and make a good faith effort to enter a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the member.

Discharge Criteria

It may be appropriate to transfer or discharge the member from the present level of care if the following criteria are met:

- The member has achieved the goals articulated in their individualized treatment plan or resolved problems identified on the problem list, thus resolving the need(s) that justified admission to the current level of care.

- The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan or problem list. Treatment at another level of care or type of service therefore is indicated

- The member has demonstrated a lack of capacity to resolve their problem(s). Treatment at another level of care or type of service therefore is indicated;

- The member has experienced an intensification of their problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Providers should clearly document and communicate the member's readiness for discharge or need for transfer to another level of care. If the criteria apply to the existing or new problem(s), the member should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

Provider Termination of Services

Providers shall make a good effort to give written notice of a termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Providers shall report to the QA Unit and COR upon receiving any changes affecting the Provider Directory. The BHP shall update the paper Provider Directory monthly. The BHP shall update the electronic provider directory no later than thirty (30) days after receiving updated provider information. The BHP does not currently offer any physician incentive plans.

Telehealth Services

Each telehealth provider is required to be licensed in California and enrolled as a Medi-Cal provider. If the provider is not located in California, they must be affiliated with

an enrolled Medi-Cal provider group (or border community) as indicated in the Medi-Cal Provider Manual. Each telehealth provider must meet the requirements of Behavioral Health Information Notice (BHIN 23-018), BPC Section 2290.5(a)(6), or equivalent requirements under California law in which the provider is licensed.

Existing Medi-Cal covered services may be provided via telehealth modality if all the following criteria are met:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment, and that the member has a right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit

2. The member has provided verbal or written consent, at least once prior to initiating applicable health care services via telehealth, and it has been documented in the medical record

3. An explanation that the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time by the Medi-Cal member without it affecting their ability to access covered Medi-Cal services in the future,

4. The member has been provided with an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted

5. The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site

6. An explanation of the potential limitations and risks related to receiving services through telehealth as compared to an in-person visit to the extent that any limitations or risks are identified by the provider

7. The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and

8. The services provided via telehealth meet all laws regarding confidentiality of health care information and a member's right to the member's own medical information.

Medi-Cal providers have the flexibility to determine if a service is clinically appropriate for telehealth via audio-visual two-way real time communication. No limitations are placed on origination or distant sites. Providers must use the applicable billing indicators for services delivered via telehealth.

Videoconferencing Guidelines for Telehealth

Telehealth services are designed to assure timely access of routine and urgent mental health and psychiatric services to reduce emergency and acute hospital inpatient services Specialty Mental Health Provider; hereafter referred to as "telehealth provider" will perform various specialty mental health services via tele-video linkage when an on-site mental health provider is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged.

When telehealth is being utilized between two program sites, the site where the telehealth provider is located who will provide the mental health service will be termed "distant" site and the site where the mental health services are being received by the member will be termed the "originating" site. This practice also extends mental health services to members in remote areas of the county.

The standards of telehealth practice will be the same as for on-site mental health services as described in the California "*Telehealth Law of 2012*". County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telehealth services.

1. Use a secure, trusted platform for videoconferencing.

2. Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.

3. Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any member data locally, but if it must, it should be encrypted.

4. Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

5. Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in

which you practice. Just because software says its HIPAA-compliant is not enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, "all technologies" perspective.

6. It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

7. When reviewing software options, you will notice that many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.

8. County operated programs shall connect to the County's secure network when providing telehealth services as the network meets the above requirements and is a trusted platform for videoconferencing. Hardware shall be installed by the County's IT department.

NOABD Log

The BHP programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of eighteen (18), plus seven (7) years.

- All BHP programs shall maintain on site a monthly NOABD Log.
- Programs shall include the following in their NOABD Logs:
    - Date NOABD was issued.
    - Member identification number/medical record number
    - Mode of NOABD Delivery
    - Member response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known.
        - Logs to contain copies of each NOABD and "Your Rights" forms attached.

- Logs to contain documentation of inability to contact the member, if applicable.
- Log to reflect "NO NOABD ISSUED" if none are issued within a month.
- NOABD Logs must be available for review at COR or QA request.

- Monthly logs are to be submitted to QA on a quarterly basis. Dates for submission are as follows:
  - Quarter One: October 15th
  - Quarter Two: January 15th
  - Quarter Three: April 15th
  - Quarter Four: July 15th

QA has developed an Excel NOABD Log that programs can use to track monthly NOABD's. If programs choose to create their own log, it must contain all the same elements listed above. All NOABD's will be stored in the Logbook, therefore not being stored in the member's individual chart.

Missed Appointment and Follow Up Standard

County of San Diego BHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. "Missed Appointment" policies and procedures shall cover both new referrals and existing members, and at minimum, include the following standards:

For new referrals: When a new member (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

For current members: When a member (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For members who are at an elevated risk and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the member's emergency contact, or initiating a welfare check.

Additionally, the policy shall outline how the program will continue to follow up with the member (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the members' whereabouts and admittance to different levels of care throughout the County (e.g., hospital, PERT or jail admissions). All providers shall have policies and procedures in place regarding the monitoring of missed appointments for members (and/or caregivers, if applicable).

All attempts to contact a new referral and/or a current member (or caregiver, if applicable) in response to a missed appointment must be documented by the program. "Elevated risk" is to be defined by the program and/or referral source.

Prior Authorization

On August 19, 2026 the Department of Health Care Services (DHCS) released BHIN 26-030 titled 'Authorization of Outpatient Specialty Mental Health Services (SMHS). The guidance stipulates that:

Behavioral Health Plans (BHPs) shall not require prior authorization for the following services/service activities:

- Intensive Home-Based Services (IHBS)
- Crisis Intervention (CIS);
- Crisis Stabilization (CSS);
- Mental Health Services, including initial assessment;
- Targeted Case Management (TCM);
- Intensive Care Coordination (ICC);
- Peer Support Services (PSS);
- Medication Support Services (MSS);
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Individual Placement and Support (IPS) Supported Employment
- Clubhouse Services
- Parent-Child Interaction Therapy (PCIT)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- High Fidelity Wraparound (HFW)
- Enhanced Community Health Workers (E-CHW)

Prior authorization or BHP referral is required for the following outpatient services:

- Day Treatment Intensive (DTI);
- Day Rehabilitation
- Therapeutic Behavioral Services (TBS);
- Therapeutic Foster Care (TFC);
- Assertive Community Treatment (ACT)

- Forensic ACT (FACT)

Details regarding prior authorization criteria and processes can be found on the Optum website> SMH & DMC-ODS Health Plans page> *Prior Authorization* tab.

Utilization Management

Utilization Management (UM) is required for service providers across all levels of care, including outpatient, crisis residential, and case management programs. The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, medication services, and case management services. Authorization decisions are based on the access criteria delineated in Welfare and Institutions Code section 14184.402 and relevant DHCS guidance. The BHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for mental health treatment programs.

Although specific utilization review processes may vary based on the program and level of care, all providers participating in UM must establish an internal Utilization Review Committee (URC) and adhere to the minimum requirements outlined below. These requirements include standards for committee membership, clinical review, authorization decisions, documentation, and maintenance of utilization review records.

Utilization Review Criteria

Members who have been receiving services for more than two (2) years must be reviewed by the Utilization Review Committee (URC) to evaluate the clinical appropriateness and continued need for services based on the access criteria outlined in DHCS BHIN 26-002 or any superseding DHCS guidance. Other members may also be referred for utilization review based on treatment team recommendations when clinical justification is needed to support continued services. Reviews should consider whether the member continues to meet the program's target population and applicable access criteria, demonstrates benefit from services, and has an ongoing medically necessary need for treatment.

Utilization Review Committee (URC)

Each program must maintain an internal Utilization Review Committee (URC) responsible for reviewing member records and conducting the utilization review process. The committee must meet the following minimum requirements:

- **Committee Composition:** The URC must consist of at least three (3) staff members. The chairperson must be a licensed, registered, or waivered mental health clinician. At least two (2) additional members must be staff who provide direct services or clinical oversight.

- **Independence of Review:** The requesting clinician may provide clinical information and recommendations but cannot participate in authorization decisions regarding their own client.

- **Review Frequency:** The URC must review a minimum number of members quarterly, as established by the Legal Entity's policy.

- **Documentation and Review:** The committee must review the member's services, treatment plan, Utilization Management (UM) Request Form, and updated Care Plan/Client Clinical Problem List to support its determination and document the results of the review.

- **SmartCare Documentation:** Member service reviews must be conducted through SmartCare. Members who have not received services for six (6) months or longer should be considered for discharge, as appropriate.

- **UM Form Review:** The completed UM Form must be reviewed by the program manager or designee within five (5) business days. The program manager or designee must be licensed.

- **Authorization Determination:** The program manager or designee reviews the clinical recommendation and may agree with the primary provider's recommendation or recommend a different level of service. The final determination must be made following consultation and agreement between the program manager or designee and the primary provider.

- **Medical Record Maintenance:** The completed UM Form must be maintained in the member's medical record.

- **Continued Monitoring:** Members approved for ongoing services must remain on an established UM review cycle to evaluate continued eligibility and clinical appropriateness for services.

The URC operates at the program level and bases its decisions on whether the member continues to meet applicable access criteria and requires the requested level of care. The committee works collaboratively with the treating clinician to determine whether proposed services are medically necessary, appropriate to the member's current needs, and likely to support progress toward treatment goals or address identified needs documented on the *Client Clinical Problem List.*
Secondary and subsequent UM reviews must also be conducted by the program-level URC to evaluate the continued appropriateness and authorization of services.

Utilization Review Documentation and Oversight

Utilization review is a **never-billable activity**. Each program must maintain URC logs documenting utilization review activities and outcomes. These logs must be available for review by the Behavioral Health Plan (BHP) upon request. As part of the Quality Assurance Program Review (QAPR), QA Specialists will review completed UM Forms and evaluate the program's compliance with its quarterly URC review requirements. Questions regarding the utilization review process should be directed to the Quality Assurance (QA) Unit.

Utilization Review for Outpatient Level of Care Programs Serving Adults

Each program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of continuation of medically necessary treatment and level of services indicated. These decisions will be based on Welfare and Institutions Code Section 14184.402 and most recent DHCS BHIN criteria for diagnosis, impairment and interventions. All UR decisions shall be supported by chart documentation of the member's individual functioning level, symptoms, and needs.

URC review will be required as clinically determined by program protocols and at minimum, after two years of outpatient services enrollment. . The URC may only authorize up to one year of service at the same level. (Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability). .

Providers shall utilize the BHS Adult Outpatient Utilization Management Form posted on the Optum website under the SMH & DMC-ODS Health Plans page under the *UCRM* tab. This form provides an overview of overall functioning along with the primary domains reviewed to inform clinical decision-making and level-of-care recommendations.

Case Management (CM) programs shall utilize the Case Management Six-Month Review Progress Note to document medical necessity and service level of care criteria for continuing services and CM URC specific forms found on the Optum website under the SMH & DMC-ODS Health Plans page under the Forms tab.All URC Records shall be maintained and be available for review as needed by the QA unit.

Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (ACT) services require prior and ongoing authorization; this review is conducted by Optum and details including criteria, timelines and the request form can be found on the Optum website under the SMH & DMC-ODS Health Plans page under the *Prior Authorization* tab.

Utilization Review for Crisis Residential Programs

Each crisis residential program meets the utilization management requirement through the service authorization process conducted by the County's Administrative Services Organization (ASO), Optum. Referrals to crisis residential level of care can be made directly to the intake staff but do require initial authorization from Optum. Crisis residential intake staff shall submit the initial authorization request, documenting access criteria for crisis residential level of care, to Optum for review. Optum will review the initial authorization request form to identify if crisis residential services are medically necessary and respond to the provider with a final determination.

For continued stay services, the crisis residential program shall submit requests for concurrent authorization review based on the member's need. Optum will then reauthorize, as appropriate, concurrently with the members' stay based on the continued need for services.

Crisis residential programs invite members to attend their treatment team meeting when continuation of care is being discussed. Should members decline to attend the treatment meeting, staff will have input from the member prior to the meeting and will meet with the member again following the meeting to review the request for concurrent authorization determination. The treatment team meeting will be documented and submitted to Optum along with the request for concurrent authorization. The authorization determination shall be maintained in the member's hybrid chart.

If a request for authorization is incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmits with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review for Day Treatment Intensive and Day Rehabilitation Services

Utilization review of Day Treatment Intensive and Day Rehabilitation services for Medi-Cal members is delegated to Optum and managed on a twelve (12) week cycle for IOP & and a four (4) week cycle for PHP. The Day Service Request (DSR) for IOP and PHP states that the member cannot be served at a lower level of care and that a recommendation for intensive services has been made. If access or service necessity criteria are not met, the Medi-Cal member will be issued an NOABD (which must also be documented in the NOABD log) and the member rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD shall be issued by Optum. Programs are responsible to check monthly all Medi-Cal and UMDAP members for eligibility and update the MIS as appropriate. Authorizations should be filed in the medical record in the Plans section or be accessible upon request. Without authorization approval services may not be billable.

Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4. Without authorization approval services are not billable. Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4. Additional resources for IOP/PHP services, including criteria and timelines for initial and continuing authorizations, can be found on the Optum website, SMH & DMC-ODS Health Plans page> *Prior Authorization* tab.

Utilization Review for Outpatient Programs Serving Children/Youth

Child/Youth members receive treatment services that focus on the primary areas of need identified/confirmed by the member/family and conclude when those are stabilized. The focused model shall be communicated at the onset of treatment so the member/family can maximize use of sessions and be prepared for conclusion of treatment.

Members who meet the access criteria for specialty mental health services shall be eligible for up to six (6) months of treatment sessions , with the exception of services provided in STRTPs which have a three (3) month UM cycle aligned with DHCS 90-day Clinical Review requirement. This will apply to Medi-Cal members and other eligible members outlined in this handbook. Additional treatment time may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

To continue beyond limited brief sessions members shall be reviewed through a Utilization Management process and must meet eligibility criteria by indicating how the Child/Youth meets Medical Necessity (per BHIN No. 26-003 or any superseding DHCS related requirements), and by specifying how services will be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR 438.210).

The Child/Youth UM Request form can be found on the Optum website, SMH & DMC-ODS Health Plans page> *UCRM* tab. Additional resources regarding STRTPs, including the specific STRTP UM form, can be found on the Optum website> SMH & DMC-ODS Health Plans page> *MH Resources* tab.

Integration with Physical Health Care

Coordination of care between physical and behavioral health providers is necessary to optimize the overall health of a member. All providers are expected to coordinate mental health care with a member's Primary Care Physician (PCP) and should have a policy and procedure in place regarding this coordination of services. Almost all Medi-Cal members are enrolled in one of the Medi-Cal Managed Care Plans (MCPs) that are part of Healthy San Diego (HSD). To find a list of included MCPs go to the *Healthy San Diego*

website. The "Healthy San Diego Medi-Cal Managed Care Plan Contact Card" is a helpful tool to use for coordination of care and is located on the Optum Website

Contracted providers are required by the BHP to complete the *Coordination with Primary Care Physicians and Behavioral Health Services* form with the member to facilitate coordination with the member's PCP. For members that do not have a primary care physician, provider shall connect them to a primary care facility. The Coordination with PCP form should be introduced at intake and completed no later than thirty (30) days upon opening the member to program services. Users of the form shall check the appropriate box at the top of the form noting the nature of the referral. Requesting member /guardian authorization to exchange information with primary care physicians is mandatory. Please see the *Coordination with PCP Explanation Sheet* on the Optum Website> *UCRM* tab for more information.

Clinical Consultation with Primary Care

Members with less severe problems or who have been stabilized shall be referred back to their Primary Care Physician or non-specialty mental health provider within the Managed Care Plan for continuing treatment. The Transition of Care (TOC) Tool found on the Optum website on the Healthy San Diego page shall be used for these transitions. To help support treatment by the Primary Care Physician, the BHP as well as organizational providers and County operated programs shall make clinical consultation and training, including consultation and training on medications, available to a member's health care provider for members whose mental illness is not being treated by the BHP or for members who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the BHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

Pharmacy and Lab Services

Each MCP has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each member's MCP to refer the member to the appropriate pharmacy or lab. HSD website lists all the contracted pharmacy or lab services for each Medi-Cal MCP. Additionally, the member's MCP enrollment card has a phone number that providers and members can call to identify the contracted pharmacy or lab. Providers must use the health plans contacted lab vendor.

Psychiatrists may order the following lab studies without obtaining authorization from the member's Primary Care Physician: CBC and Liver function study: Electrolytes, BUN or Creatinine, Thyroid panel, Valproic acid, Carbamazapine, Tricyclic blood levels, Lithium level.

All other lab studies require authorization from the member's Primary Care Physician. It is recommended that each provider contact the member's MCP Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the member's Primary Care Physician.

Medi-Cal members who are not members of a Medi-Cal MCP may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible members with complex needs often engaged with several systems of care. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. While this benefit is provided by the member's Managed Care Plan (MCP) – it may include engagement and collaboration with our BHP system of care providers to refer members and coordinate care. BHP providers should be familiar with the basics of ECM and the Populations of Focus (described below) that are eligible for this benefit and make the appropriate referral to the member's Managed Care Plan for ECM services, when appropriate.

Enhanced Care Management is available to specific groups (aka "Populations of Focus"):

- Adults and families experiencing homelessness
- Adults, youth and children at risk for avoidable hospital or emergency department care
- Adults, youth and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization.
- Adults transitioning back to the community from a residential nursing facility
- Children and youth enrolled in California's Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s).
- Children and youth involved in child welfare (foster care)
- Adults and youth transitioning back to the community after incarceration
- Pregnant and post-partum individuals, birth equity population of focus

For additional information and definitions, please see: ECM Policy Guide Updated January 2026.pdf (ca.gov)

Managed Care Plan (MCP) Enhanced Care Management (ECM) Referral Forms / Contacts

Providers should utilize the below links for ECM referrals and contacts – all referrals should be directed to the MCP using the below forms/email contacts:

Medi-Cal Managed Care Plan	Referral Form	Email Address
Blue Shield Promise	ECM Referral Form (blueshieldca.com)	Email: ECM@blueshieldca.com
Community Health Group	ECM Referral Form (chgsd.com)	Email: ecm-cs@chgsd.com
Kaiser	ECM Referral Form (kaiserpermanente.org)	Email: RegCareCoordCaseMgmt@KP.org
Molina	ECM Referral Form (molinahealthcare.com)	Email: MHC_ECM@Molinahealthcare.com

Non-Medi-Cal Members

Non-Medi-Cal clients who meet financial eligibility requirements may have their prescriptions filled at little or no cost or the Health and Human Services Agency Pharmacy at the Health Services Complex (3851 Rosecrans Street, San Diego, California, 92110). Contracted providers shall provide medications to non-Medi-Cal members who meet financial eligibility requirements. Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services. Providers shall make every effort to enroll members in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

Physical Health Services in a Psychiatric Hospital

Healthy San Diego Recipients: The member's HSD Medi-Cal MCP is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The member's MCP also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The health plans do not require prior authorization for the initial health history and physical assessment. All other physical health services provided while a member is in a psychiatric hospital require authorization from the health plan.

Transfers from Psychiatric Hospital to Medical Hospital : Psychiatric hospitals may transfer a member to a medical hospital to address a member's medical problems. Except in an emergency, the psychiatric hospital must consult appropriate MCP staff to arrange such a transfer for physical health treatment. It is the responsibility of the MCP

to pay for transportation in such cases. The Optum Health Medical Director or Liaison and the MCP Medical Director or Liaison will resolve any disputes regarding transfers.

Medical Transportation

HSD Medi-Cal MCPs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. MCP members who call the ACL for medical transportation are referred to the Member Services Department of their MCP to arrange such services.

Home Health Care

Clients who are members of one of the HSD Medi-Cal MCPs must request in-home physical health services from their Primary Care Physician. The MCP will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHCS. The BHP will pay for services solely related to the included mental health diagnoses. The MCP Case Manager and the Primary Care Physician coordinate on-going in-home treatment. The MCP is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the MCP.

D. Compliance and Confidentiality

The County of San Diego Health and Human Services Agency (HHSA) shall adhere to all laws, rules, and regulations, especially those related to fraud, waste, abuse, and confidentiality.

Reporting Fraud, Waste and/or Abuse

Any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.

Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations
1-800-822-6222 | Fraud@dhcs.ca.gov
P.O. Box 997413 MS 2500 Sacramento, CA 95899-7413

Any indication that any one of these activities is occurring including suspected fraud, waste and/or abuse, should be reported immediately to your program COR, as well as the BHS QA team at QIMatters.BHS@sdcounty.ca.gov. If there is a need to remain anonymous, then providers may contact Business Assurance & Compliance (BAC) at ((619) 237-8571 or email Compliance.HHSA@sdcounty.ca.gov

False Claims Act

The Federal False Claims Act (FCA) helps the government combat fraud in federal programs, purchases, and contracts and applies to fraud involving state, city, county or other local government funds. All workforce members shall report any suspected inappropriate activity related to these Acts, which include acts, omissions or procedures that may violate the law or HHSA procedures. Some examples include billing for services not rendered or not medically necessary, billing separately for services that should be a single service, falsifying records and/or duplicate billing.

The FCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Programs and legal entities may not have any rule that prevents workforce members from reporting, nor may programs or legal entities retaliate against a workforce member because of his or her involvement in a false claims action. County and County Contracted Programs are required to promptly report circumstances that may affect the members' eligibility to the California Department of Health Care Services (DHCS). They are also required to conduct an internal investigation to determine the validity of the issue/complaint as well as develop and implement corrective action, if needed.

If any County or Contracted program needs training on the False Claims Act, reach out to the BAC at 619-237-8571 or email Compliance.HHSA@sdcounty.ca.gov

Compliance for County and Contracted Programs

As part of this commitment, all County Behavioral Health Services workforce members shall be familiar with and adhere to Business Assurance & Compliance (BAC) policies and procedures. County Behavioral Health Programs shall have processes that ensure adherence to the HHSA Code of Conduct. All BAC policies and procedures, including the Code of Conduct, may be found on the BAC website. Contracted providers with the BHP are obligated to have an internal compliance program commensurate with the size and scope of their agency. Further, contractors with more than $250,000 (annually) in agreements with the County must have a Compliance Program that meets the Federal Sentencing Guidelines (Sections 8 B2.1 & 42 CFR 438.608(b) 1 –7) including the seven elements of an effective compliance program, listed below:

1. Development of a Code of Conduct and Compliance Standards.

2. Assignment of a Compliance Officer who oversees and monitors implementation of the compliance program.

3. Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise complaints and concerns about compliance issues without fear of retribution.

4. Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.

5. Development and monitoring of Auditing Systems to detect and prevent compliance issues

6. Creation of Discipline Processes to enforce the program.

7. Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.

Please note: Contracted programs may use their own forms so long as they comply with all applicable rules and regulations. If a Contracted Program chooses to use a County HHSA form, it must replace the HHSA logo and contact information with its own and should also review the contents of the HHSA form to ensure it meets all applicable privacy requirements.

Compliance Standards

All County and Contracted Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards:

- All new employees shall receive a thorough employee orientation about compliance requirements prior to employment.
- Staff shall have proper credentials, experience, and expertise to provide member services.
- Staff shall document member encounters in accordance with funding source requirements and HHSA policies and procedures.
- Staff shall bill member services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.
- Staff shall promptly elevate concerns regarding possible deficiencies or errors in the quality of care, member services, or member billing.
- Staff shall act promptly to correct problems if errors in claims or billings are discovered.

Documentation Standards

Please note that it is the responsibility of the program to have staff provide services within their scope of practice. This includes co-signing of documentation as appropriate.

Reference: CalMHSA Clinical Documentation Guide- Appendix III Scope of Practice Matrix- pg. 40

Assessment Standards

To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. Assessments shall be updated **as clinically appropriate,** such as when the member's condition changes.

Care Plan Standards

DHCS no longer requires prospectively completed, standalone care plans for Medi-Cal Specialty Mental Health Services. The intent of this change is to affirm that care planning is an ongoing interactive component of service delivery rather than a one-time event.

Required care plan elements may be notated within the assessment record, problem list, or service notes, or the provider may use a dedicated care plan template within the Electronic Health Record. The provider shall be able to produce and communicate content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws if requested.

Federal or state laws continue to require the following services to have care plans and/or specific care planning activities in place. All required elements of the Care Plan must be addressed as indicated in Enclosure 1a of BHIN 23-068: TCM, ICC, Peer Support Services, TBS, STRTPs, Crisis Houses FSPs and Medicare recipients.

For more information on specific requirements please refer to the *Care Plan Explanation Sheet* on the Optum Website> *UCRM* tab.

Problem List Standards

All member receiving services after July 1, 2022, are required to have a Problem List documented within the EHR. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. Updates to the Problem List are to be completed on an on-going basis within the EHR on the "*Client Clinical Problem Details*" page as well as service notes to reflect the current presentation of the member, with problems being added or removed when there is a relevant change to the member's condition.

Service Note Standards

Providers shall create service notes for the provision of all services. Each service note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. Notes are to be completed and signed within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within twenty-four (24) hours. Please be advised certain service lines have requirements which remain in effect due to applicable federal regulations or guidance, regulations which supersede these indicated timelines above. In these cases, regulations must be followed as indicated by DHCS.

Record Retention

Per WIC 14124.1, records are required to be kept and maintained under this section shall be retained:

- by the provider for a period of ten (10) years from the final date of the contract period between the plan and the provider,
- from the date of completion of any audit,

- or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations

County TLS Email Encryption

The County has Transport Layer Security (TLS) available for sending encrypted email through a secured connection. This means when a TLS connection is established with a vetted County business partner, all email communication sent between the County and the business partner will be automatically encrypted in transit over the internet through the secured connection. Contact the County BHS COR or COR's designee for more information about TLS and how to initiate the process for your agency.

Confidentiality for County and Contracted Programs

Member and community trust is fundamental to the provision of quality mental health services. Abiding by confidentiality rules is a basic tenet of that trust. County and Contracted workforce members shall follow all applicable state and federal laws regarding the privacy and security of information. Programs are responsible for ensuring compliance with the latest requirements within the State Agreement, which can be found at the Optum website > *Manuals* tab. If any County or Contracted provider has questions about privacy or security requirements, reach out to the BAC at 619-237-8571 or Compliance.HHSA@SDCounty.ca.gov.

To ensure compliance with applicable privacy laws as well as the State Agreement, the BHP has the following requirements for County and Contracted Programs. As of 2018, requirements include that all workforce members shall:

- Be trained in privacy and security of member data and shall sign a certification indicating the workforce member's name and date on which the training was completed. The certifications shall be kept at least six (6) years. Training must be provided within a reasonable period upon hire and at least annually thereafter. If any County or Contracted program needs assistance with privacy and security training, reach out to the BAC at 619-237-8571 or privacyofficer.hhsa@sdcounty.ca.gov.

- Sign a confidentiality statement prior to having access to member information. The signed statement must be maintained for at least six years. The statement must adhere to State Agreement requirements, currently including, at a minimum: General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies sections.

- Only access member records as necessary to perform their jobs.

- Staff shall act in accordance with good judgment, clinical and ethical standards and applicable privacy laws to ensure that all written and verbal communication regarding each member's treatment and clinical history is kept confidential.

Notice of Privacy Practices

County and Contracted Programs must provide a HIPAA-compliant *Notice of Privacy Practices (NPP)* to all members, as well as those with authority to make treatment decisions on behalf of the member. A member acknowledgement of the NPP is maintained in the EHR and/or the hybrid chart. Providers should ensure members (and those with authority) understand the NPP and address any member questions about member privacy rights and the Program's privacy requirements.

For County programs, a definition of Authority may be found at *BAC Policy and Procedure HHSA L-27*. County Programs shall use the HHSA NPP and adhere to all related policies and procedures (HHSA L-06), including *the NPP Acknowledgement form* (Client Rights and Notice of Privacy Practices). All forms are available on the BAC website. Contracted Programs may, but are not required, to use, the HHSA NPP located on the Optum Website> *Beneficiary* tab. If a Contracted Program chooses to use the HHSA NPP, it must replace the HHSA logo and contact information with its own and should review the contents of the HHSA NPP to ensure it meets all applicable privacy requirements. Contracted Programs shall have an NPP policy or procedure to ensure NPP requirements are followed by workforce members.

Privacy Incidents

A *privacy incident* (for definition, County programs may see *BAC Policy L-30*. Contracted Programs may review their Article 14) is an incident that involves the following:

- Unsecured protected information in any form (including paper and electronic)
- Any suspected incident, intrusion, or unauthorized access, use, or disclosures of protected information
- Any potential loss or theft of protected information

Common Privacy Incidents may include, but are not limited to:

- Sending emails with member information to the wrong person
- Sending unencrypted email with member information outside of your legal entity
- Giving Member A's paperwork to Member B

- Lost or stolen charts, paperwork, laptops, or phones
- Unlawful or unauthorized access to member information

Privacy Incident Reporting (PIR) Process

If any Program believes a privacy incident has occurred, they must complete the online HHSA Privacy Incident Report . For Contracted Programs, this is outlined in Article 14 of your County contract. For County programs, follow BAC policies and procedure (L-24). Contracted Programs must additionally ensure compliance with HIPAA breach requirements, such as risk analysis and federal reporting and inform BAC of any applicable requirements. Contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements. Additional compliance and privacy resources are available at the HHSA BAC website.

Mandated Reporting

All County and Contracted workforce members shall comply with the *Child Abuse Reporting Law* (California Penal Code section 11164) and *Adult Abuse Reporting Law* (California Welfare and Institutions Code section 15630). For further information regarding legal and ethical reporting mandates, contact your agency's attorney, State licensing board, or your professional association.

Uses and Disclosures of Records

When a third-party requests member information, the program should ensure compliance with applicable privacy laws and relevant BAC policies and procedures (HHSA L-25 and HHSA L-09). Programs shall reasonably ensure the authorization is valid and verify the identity of the requestor before providing member information. County Programs shall also use the HHSA-approved authorization form (HHSA 23-09) when soliciting member records from a third party. Contracted Programs may, but are not required to, use the HHSA Authorization form located on the Optum Website > *UCRM* tab. Contracted Programs shall have an authorization policy and a Uses and Disclosures policy to ensure these requirements are followed by workforce members.

Member Requests for Records

When a member (or individual with authority of record), or a third-party request access to their record, all programs shall comply with applicable privacy laws. The Privacy Rule requires a covered entity to take reasonable steps to verify the identity of an individual making a request for access. (45 CFR 164.514(h).)

Please note that member requests for records are not the same as a request for records from a third party. County Programs shall follow the relevant BAC policies and

procedures related to record requests (HHSA L-01). Contracted Programs may but are not required to use the *HHSA Client Record Request Form* (HHSA 23-01). This form and information regarding privacy policies and procedures are located on the HHSA BAC Website- Forms. County and Contracted providers may charge a reasonable fee for labor associated with copying, supplies, postage, or preparation of summary as agreed to by the member.

Summary of PHI

The covered entity also may provide the individual with a summary of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided in addition to that PHI, so long as the individual in advance: a. Chooses to receive the summary or explanation (including in the electronic or paper form being offered by the covered entity); and b. Agrees to any fees that may be charged by the covered entity for the summary or explanation (45 CFR 164.524(c)(2)(iii)).

Timelines to Access Per state law, a covered entity must provide access to the PHI requested or in part, no later than five (5) business days from receiving the individual's request and copies within fifteen (15) business days after receiving the request (45 CFR 164.524(b)(2).

Contracted Providers have access to a member's medical record for three hundred and sixty five (365) days post-discharge. Once that timeframe expires, a request will need to be made via MIS to access the client's medical record. MIS will grant access for seventy-two (72) hours, closing the record again after that time.

Denial of Member Access to Records

County or Contracted providers may deny a member's request for records if a licensed healthcare professional has determined that the access requested is reasonably likely to endanger the life or physical safety of the member or another person. The member must be given the right to have such denials reviewed by a licensed health care professional designated by the BHP to act as the reviewing official and who did not participate in the original denial. The covered entity must provide a denial in writing to the individual no later than within thirty (30) calendar days of the request.

Member Requests for Amendment

When a program receives a request to amend SmartCare records and or when a program receives a request for an accounting of disclosures of SmartCare records, the program should contact the SDCBHS MIS team and, if necessary BAC at 619-237-8571 or privacyofficer.hhsa@sdcounty.ca.gov. When a program receives a request to amend records within their internal electronic health records, the program should work with their Compliance Officer and follow internal policies and procedures in alignment with related regulations.

Handling/Transporting Medical Record Documents

To maintain the confidentiality and security of member records, all programs will securely store and transport medical records, including laptops, phones, and tablets, which may contain member identifying information in accordance with applicable laws and the State Agreement:

- Member records must be maintained at a site that complies with Article 14 requirements, including the current State Agreement.
- County workforce members may, as needed, transport member records and/or keep member records overnight at a personal residence if they have completed the BAC approved *data safeguarding form* (HHSA 23-26) and follow the applicable BAC Policy and Procedures (HHSA L-26). Contracted workforce members should develop their own policies and procedures that comply with Article 14 and State Agreement requirements.
- Programs should only remove member information from program offices for approved business purposes, with prior management approval, and information shall be stored in an appropriate manner.
- Programs shall sign in and out records, as needed.
- When saving member contact information on an encrypted device, such as a phone or laptop, or transporting member information out of the office/clinic, only include the minimum member identifying information necessary.
- Member information must not be stored on a non-encrypted device.
- No workforce staff may ever leave member information unattended in a car for any amount of time.

For more information and details for all sections below, please see: HHS.GOV-Your Rights Under HIPAA.

E. Member Rights, Grievance and Appeals

San Diego County Behavioral Health Services is committed to honoring the rights of every member to have access to a fair, impartial, effective process through which the member can seek resolution of a grievance or adverse benefit determination by the BHP. All county operated and contracted providers are required to participate fully in the Member Grievance and Appeal Process. Providers shall comply with all aspects of the process.

According to Title 9 and 42 CFR 438.1000, the BHP is responsible for ensuring compliance with member rights and protections. The BHP, operating from a shared concern with providers about improving the quality of care and experience of members, will monitor feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the BHS System of Care and stakeholders through system-wide meetings and councils

Providers, as contractors of the BHP, must comply with applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR, Part 80), the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR, part 91; the Rehabilitation Act of 1973; Title II and Title III of the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and other laws regarding privacy and confidentiality. These rights and protections can be summarized as follows:

- *Easily understandable information*- Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

- *Dignity, respect, and privacy*- Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- *Receive information on the managed care plan and available treatment options*. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.

- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.

- *Right to health care services*. Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

- *Free exercise of rights*. Each managed care enrollee is guaranteed the right to free exercise of his/her rights in such a way that those rights do not adversely affect the way the BHP and its providers treat the enrollee.

More information about Member Materials and Processes can be found on the Optum Website> *Beneficiary* tab.

Definitions (Title 42 CFR § 438.400 (b)

- The Grievance and Appeal System includes the processes the County and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them

- A Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships (i.e. rudeness of a provider or employee), failure to respect the rights of the member, and the member's right to dispute an extension of time proposed by the Plan to make an authorization decision.

    - There is no distinction between an informal and formal grievance. A complaint is the same as a grievance- a compliant shall be considered a grievance unless it meets the definition of an "Adverse Benefit Determination".

- An Inquiry is a request for information that does not include expression of dissatisfaction. Inquiries may include questions pertaining to eligibility, benefits, or other fee-for-service- processes. If the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

- A Discrimination Grievance-is filed when a member believes they have been unlawfully discriminated against. Discrimination Grievance posters can be found

in the Member Handbook and printed for posting. The member has a right to file a Discrimination Grievance with the county Plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. (45 CFR §§ 92.7 and 92.8; WIC§14029.91).

- A Grievance Exemption is a grievance received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Grievances received via mail by the Plan, or a network provider of the Plan, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a Plan or a network provider of the Plan receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance, and the exemption does not apply.

- An Appeal is a review of an adverse benefit determination or "action" which may include:

    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medically necessary specialty mental health services, appropriateness, setting, or effectiveness of a covered benefit.

    - Reduction, suspension, or termination of a previously authorized service.

    - Denial, in whole or in part, of payment for a service.

    - Failure act within the timeframes regarding the standard resolution of grievances and appeals.

    - Failure to provide services in a timely manner.

    - Denial of a member's request to dispute financial liability.

- A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal member is required to exhaust the BHP problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal member may request a state fair hearing.

Authorized Representatives

With written consent of the member, a provider or authorized representative may file a grievance, request an appeal, or request a State hearing on behalf of the member.

Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR §438.420(b)(5).

Advocacy Services and Records Requests

In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F –Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to State and Federal law. These processes may include but are not limited to: consulting with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, BHP providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within three (3) business days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the member with the request if the member has not signed the Coordinated Care Consent form in the EHR.

Members should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations. If the member is uncomfortable approaching program staff or feels that the expressed grievance has not been successfully resolved at the program level, the member is welcome to contact an advocacy agency. The member shall not be discouraged, hindered, or otherwise interfered with when seeking or attempting to file a grievance/appeal. The member is also not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

Providers shall inform members, their authorized representative, or the provider acting on behalf of the member, about their right to file a grievance with assistance from one of the County's contracted advocacy organizations listed below (42 CFR §438.406):

Jewish Family Services, Patient Advocacy Program (JFS)
(For inpatient or residential services)
1-800-479-2233 or 619-282-1134
Email: jfsonline@jfssd.org

Consumer Center for Health, Education, and Advocacy (CCHEA)
(For outpatient services)
1-877-734-3258
TTY-1-800-735-2929

JFS Patient Advocacy facilitates the grievance process for members in inpatient and other 24-hour residential facilities. **CCHEA** facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within two (2) business days of receiving written permission from the member to represent him/her. Securing this permission can be difficult and time consuming. To ensure compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly. If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the member's condition to review and make a decision about the case.

Providing Member Materials

Please use the **Behavioral Health Plan Informing Materials Order Form** to request hard copies of brochures and posters related to the Member Grievance and Appeal Processes as well as other Member Materials. Electronic versions of all materials are available to print on the Optum Website> *Beneficiary* tab. The order form also includes information on where to access grievance and appeal forms and how to request required postage paid envelopes for members to mail grievances and appeals. To receive the materials in the audio or large print format contact QIMatters.HHSA@sdcounty.ca.gov, or providers may duplicate their own copies. The BHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within ninety (90) days of the law change.

Member Grievance and Appeals Process

Members are encouraged to direct their grievances directly to program staff or management (either orally or via writing) for the most efficient way to resolve problems. In accordance with 42 CFR §438.402, a member may file a grievance at any time. The Plan shall provide to the member written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the member may contact about the grievance. The written acknowledgement to the member must be postmarked within five (5) calendar days of receipt of the grievance.

Providers shall log of all grievances containing the date of receipt of the grievance, the name of the member, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance in the *Client Suggestions and Provider Transfer Request Log*. The log shall be secured to protect member confidentiality. This log shall be submitted with the provider's Monthly/Quarterly Status Report (QSR).

Providers shall have self-addressed stamped envelopes (CCHEA and JFS will provide upon request), posters, brochures, grievance/appeal forms in all threshold languages to

include interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. These materials shall be displayed in a prominent public place. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider shall cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

ASCMI Form

As of 3/31/26 the Coordinated Care Consent form will be deactivated and replaced with the Authorization to Share Confidential Member Information (ASCMI) Form to share information within SmartCare and "drop or raise" the CDAG wall. If members choose to sign, this form allows the member to provide consent to share sensitive physical health, behavioral health, housing, and social services information across providers outside of the electronic health record. The Grievance process can be facilitated via member signing of this form as it will grant permission for advocacy agencies to access needed information in the member's chart which can reduce coordination time in the event that the member files a grievance during his/her time in treatment.

Although this form is required to be offered to all members, signing the form is optional. Member denial to sign the form can be documented on the form itself within the EHR. All paper downtime forms must eventually be entered into the EHR for the form to be effective. Details on how to use the form, FAQs, and additional information can be found at ASCMI – CalAIM.

Transgender, Gender Diverse or Intersex Grievances

Per BHIN 25-019 if a member submits a grievance against a BHP, its subcontractors, or staff for failure to provide trans-inclusive health care, the BHP is required to submit quarterly reports to DHCS. BHPs are also required to submit additional information when the outcomes of the grievance reported are resolved in a member's favor. If the grievance is resolved in the member's favor, then the individual named in that grievance must complete a refresher course by retaking the trans-inclusive health cultural competency training (outlined within BHIN 25-019) within 45 days of the resolution of the grievance and before they have direct contact with members again. BHPs are required to submit to DHCS verification of the completed refresher training quarterly as well as a reporting template to be submitted within quarterly submission timelines outlined in the BHIN.

Grievance Resolution

Timeline: Thirty (30) days from receipt of grievance to resolution. The BHP must resolve grievances within the established timeframes.

The Plan must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the Plan has reached a decision with respect to the member's grievance and notified the member of the disposition.

2. Plans shall comply with the established timeframe of thirty (30) calendar days for resolution of grievances. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall not exceed thirty (30) calendar days.

3. The Plan shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.

    a. In the event that resolution of a standard grievance is not reached within thirty (30) calendar days as required, the Plan shall provide the member with the applicable NOABD and include the status of the grievance and the estimated date of resolution.

Adverse Benefit Determination (ABD)

The definition of an "Adverse Benefit Determination" encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving access to medically necessary services, appropriateness and setting of covered benefits, and financial liability. An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, meeting criteria for 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 member's request to dispute financial liability.

Beneficiaries must receive a written Notice of Adverse Benefit Determination (NOABD) when the BHP takes any of the actions described above. The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing,

consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs.

The NOABD must explain all of the following:

1. The adverse benefit determination the Plan has made or intends to make.

2. A clear and concise explanation of the reason(s) for the decision. For determinations based on criteria for access to medically necessary SMHS, the notice must include the clinical reasons for the decision. The Plan shall explicitly state why the member's condition does not meet specialty mental health services and/or DMC-ODS criteria for access to medically necessary services criteria.

3. A description of the criteria used. This includes criteria for access to medically necessary SMHS, and processes, strategies, or evidentiary standards used in making such determinations; and reference to specific regulations or payment authorization procedures that support the decision.

4. The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination.

5. The member's right to a second opinion from a network provider, or for the Plan to arrange for the member to obtain a second opinion outside the network, at no cost to the member.

Decisions shall be communicated to the provider verbally and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the Plan must also include the name and direct telephone number or extension of the decision-maker. Programs shall review the member's chart for an emergency contact. If the program has a Release of Information on file for the individual, they are to send the NOABD to the emergency contact. If not, document the inability to reach member on the NOABD log and place a copy of the NOABD in the *NOABD Log* as well.

If the Plan can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension is not required. However, the Plan must conduct ongoing oversight to monitor the effectiveness of this process.

Timing of the Notice

The Plan must also communicate the decision to the affected provider within

twenty- four (24) hours of making the decision. The BHP shall mail the notice to the member within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health service, at least ten (10) days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214.

2. For denial of payment, at the time of any action denying the provider's claim; or,

3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two (2) business days of the decision.

NOABD Considerations for Minors

If the member is a minor (unless it is a minor consent case) the original should be sent to the minor and a copy should be sent to the minor's parent(s) or legal guardian. Where involvement of the parent or guardian is determined to be inappropriate, BHPs and providers shall establish and ensure safeguards are in place to suppress confidential information and prevent appointment notifications, NOABD documents, and any other communications that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian. (BHIN 24-046)

NOABD Templates

All templates are located on the Optum Website > SMH & DMC-ODS Health Plans> > *NOABD* tab. In accordance with the federal requirements, the BHP (providers) shall use DHCS' uniform notice templates, or the electronic equivalent of these templates generated from the Plan's EHR when providing members with a written NOABD. The notice templates include both the enclosed NOABD and **"Your Rights"** documents to notify members of their rights in compliance with the federal regulations. Below are descriptions of the different adverse benefit determinations and corresponding templates:

1. **NOABD Denial of Authorization Notice** - When the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for criteria for access to medically necessary services, appropriateness, setting or effectiveness of a covered benefit.

2. **NOABD Denial of Payment for a Service Rendered by a Provider** - When the Plan denies, in whole or in part, a provider's request for payment for a service that has already been delivered to a member.

3. **NOABD Delivery System Notice** - Wehn the Plan has determined that the member does not meet the criteria to be eligible for specialty mental health through

the Plan. The member shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

4. **NOABD Modification of Requested Services Notice** - When the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

5. **NOABD Termination of Previously Authorized Services Notice** - When the Plan terminates, reduces, or suspends a previously authorized service. This notice is also required for all members who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to: AWOL, unwillingness to continue with services, member terminated services AMA, etc.

6. **NOABD Delay in Processing Authorization of Services Notice** - When there is a delay in processing a provider's request for authorization of specialty mental health service. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the member or provider, when the extension is in the member's interest.

7. **NOABD Failure to Provide Timely Access Notice** – When there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service.

8. **NOABD Dispute of Financial Liability Notice** - When the Plan denies a member's request to dispute financial liability, including cost-sharing and other member financial liabilities.

9. **NOABD Failure to timely Resolve Grievances and Appeals** – When the Plan does not meet required timeframes for the standard resolution of grievances and appeals.

10. **The "NOABD Your Rights" Attachment -** A notice that informs members of critical appeal and State Hearing rights. There are two types of "Your Rights" attachments- one accompanies the NOABD, and the other accompanies the Notice of Appeals Resolution. These attachments must be sent to members with each NOABD or NAR.

    a. The "**NOABD Your Rights**" attachment provides members with the following required information pertaining to NOABD:

        i. The member's or provider's right to request an internal appeal with the Plan within sixty (60) calendar days from the date on the NOABD;

ii. The member's right to request a State Hearing only after filing an appeal with the Plan and receiving a notice that the Adverse Benefit Determination has been upheld;
iii. The member's right to request a State Hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe;

iv. Circumstances under which an expedited review is available and how to request it;

v. The member's right to be either self-represented or represented by an authorized third party (including legal counsel, relative, friend, or any other person) in a State Hearing;

vi. The member's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420, and

vii. Notification that, if the final resolution of the appeal or State Hearing decision upholds the Plans' Adverse Benefit Determination, the member shall not be held liable for the cost of continued services provided to the member while the appeal or State Hearing was pending.

The member's right to a second opinion from a network provider, or the Plan to arrange for the member to obtain a second opinion outside the network at no cost to the member.

Non- Discrimination and Language Assistance Notices

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services, Office for Civil Rights issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require the BHP (and providers) to post nondiscrimination and language assistance notices in significant communications to beneficiaries. The BHP has created a "Member Non-Discrimination Notice" and "Language Assistance Notice", which shall be sent along with each of the following significant notices sent to beneficiaries:

- NOABD, Grievance Acknowledgment Letter,
- Appeal Acknowledgment Letter,
- Grievance Resolution Letter, and
- Notice of Appeal Resolution Letter.

Appeal Process

Federal regulations require members to file an appeal within sixty (60) calendar days from the date on the NOABD. Members must also exhaust the Plan's appeal process prior to requesting a State Hearing unless the member has been deemed to have exhausted that process. A member, or a provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the member require written consent from the member.

BHPs shall assist the member in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the member of the location of the form on the BHP's website or providing the form to the member upon request. BHPs shall advise and assist the member in requesting continuation of benefits during an appeal of the Adverse Benefit Determination in accordance with federal regulations. BHPs shall inform members that they shall not be held liable for the cost of these continued benefits

Standard Resolution of Appeals

The BHP shall provide to the member written acknowledgement of receipt of the appeal. The letter of acknowledgment shall include the date of receipt and name, telephone number, and address of the Plan representative who the member may contact about the appeal. The written acknowledgement to the member must be postmarked within five (5) calendar days of receipt of the appeal. The BHP shall resolve an appeal within thirty (30) calendar days of receipt. In addition to providing a written Notice of Appeal Resolution, the BHP shall make reasonable efforts to provide prompt oral notice to the member of the resolution. In the event that the Plan fails to adhere to the noticing and timing requirements for resolving appeals, the member is deemed to have exhausted the BHP's appeal process and may initiate a State Hearing.

Expedited Resolution of Appeals

The BHP maintains an expedited review process for appeals when the Plan determines (from a member's request) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's mental health and/or the member's ability to attain, maintain, or regain maximum function. If the BHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution.

In addition, the Plan shall complete all of the following actions:

1. The Plan shall make reasonable efforts to provide the member with prompt oral notice of the decision to transfer the appeal to the timeframe for standard

resolution;

2. The Plan shall notify the member in writing of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the member of the right to file a grievance if they disagree with the decision; and

3. The Plan shall resolve the appeal as expeditiously as the member's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within thirty (30) days of receipt of the appeal).

4. For expedited resolution of an appeal and notice to affected parties (i.e., the member, legal representative and/or provider), the Plan shall resolve the appeal, and provide notice, as expeditiously as the member's health condition requires, no longer than seventy-two (72) hours after the Plan receives the expedited appeal request.

Notice of Appeal Resolution (NAR) Requirements

A NAR is a formal letter informing a member that an Adverse Benefit Determination has been overturned or upheld. In addition to the written NAR, the BHP is required to make reasonable efforts to provide prompt oral notice to the member of the resolution.

NAR "Your Rights" Notice

The NAR "Your Rights" attachment provides members with the following required information pertaining to NAR:

- The member's right to request a State hearing no later than one hundred and twenty (120) calendar days from the date of the Plan's written appeal resolution and instructions on how to request a State hearing; and,

- The member's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the member) in accordance with Title 42, CFR, Section 438.420.

- Notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the Plan's Adverse Benefit Determination.

NAR Adverse Benefit Determination Upheld Notice

For appeals not resolved wholly in favor of the member, the BHP shall utilize the DHCS template, or the electronic equivalent of that template generated from the Plan's

Electronic Health Record System, for upheld decisions, which is comprised of two components:

1. NAR Adverse Benefit Determination Upheld Notice, and

2. "Your Rights" attachment.

These documents are a "packet" and shall be sent together to comply with all requirements of the NAR. The BHP shall send written NARs to beneficiaries. The written NAR shall include the following:

- The results of the resolution and the date it was completed;

- The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;

- For appeals not resolved wholly in the favor of the member, the right to request a State Hearing and how to request it, the right to request and receive benefits while the State Hearing is pending and how to make the request; and,

- notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the Plan's Adverse Benefit Determination

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the member, the Plan shall use the Adverse Benefit Determination Overturned (NAR) notice template as a written notice to the member that includes the results of the resolution and the date it was completed. The BHP shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned.

Plans must authorize or provide the disputed services promptly and as expeditiously as the member's condition requires if the Plan reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The BHP shall authorize or provide services no later than seventy- two (72) hours from the date and time it reverses the determination.

- **Note:** A decision by a therapist to limit, reduce, or terminate a member's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the member's grievance or appeal, the advocacy organization will issue a finding, to be sent

to the member, provider and Behavioral Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Behavioral Health Director or designee in ten (10) days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Behavioral Health Director within ten (10) days, requesting an administrative review. The Behavioral Health Director or his designee shall have the final decision about needed action.

State Fair Hearing (SFH)

Members must exhaust the BHP's appeal process prior to requesting a State Hearing. A member has the right to request a State Hearing only after receiving notice that the Plan has upheld an Adverse Benefit Determination. If the Plan fails to adhere to the notice and timing requirements in 42 CFR§438.408, including the BHP's failure to provide a NOABD or a NAR the member is deemed to have exhausted the Plan's appeals process. The member may then initiate a State Hearing. Members may request a State Hearing within one hundred and twenty (120) calendar days from the date of the NAR which informs the member the Adverse Benefit Decision has been upheld by the Plan.

The Grievance/Appeals and State Fair Hearing process is designed to:

- Provide a grievance/appeals and State Fair Hearing process adhering to Federal and State regulations
- Provide straightforward member /provider access
- Support and honor the rights of every member
- Be action-oriented
- Provide resolution within State established timeframes
- Encourage effective grievance resolution at program level
- Improve the quality of Behavioral Health services for all County of San Diego residents

- For **Standard Hearings,** the BHP shall notify members that the State must reach its decision on the hearing within ninety (90) calendar days of the date of the request for the hearing.

- For **Expedited Hearings,** the BHP shall notify members that the State must reach its decision on the state fair hearing within three (3) working days of the date of the request for the hearing.

- For **Overturned Decisions,** the BHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy- two (72) hours from the date it receives notice reversing the Plan's adverse benefits determination.

Continuation of Services

Members have the right to keep receiving approved services while waiting for a final decision from an appeal or State Hearing. This request is called *Aid Paid Pending* (APP). If a member requests an appeal, the BHP shall continue to provide APP to the member while the appeal is pending if all of the following conditions are met:

- The member timely files a request for an appeal in accordance with Title 42, CFR, sections 438.402(c)(1)(ii) and (c)(2)(ii)

- The appeal involves the termination, suspension, or reduction of a previously authorized service,

- The member's services were ordered by an authorized provider;

- The period covered by the original authorization has not expired, and,

- The request for continuation of benefits is filed on or before the following: Within ten(10) calendar days of the BHP sending the NOABD, or the intended effective date of the Adverse Benefit Determination.

If a member has been receiving disputed services during the BHP's appeal process and requests a State Hearing, the BHP shall continue to provide APP to the member. If the BHP continues to provide APP to the member while the appeal or State Hearing is pending, the services shall be continued until:

- The member withdraws the appeal or request for State Hearing;

- The member does not request a State Hearing and continuation of benefits within ten (10) calendar days from the date the BHP sends the notice of an adverse appeal resolution; or

- A State Hearing decision adverse to the member is issued.

If the final resolution of the appeal or State Hearing upholds the BHP's Adverse Benefit Determination, the BHP shall not recover the cost of continued services provided to the member while the appeal or State Hearing was pending

Member's Rights

Member Notification of Rights

In accordance with DHCS regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal members shall be provided/made available to new members upon first admission to Behavioral Health Services, along with the Integrated Behavioral Member Handbook. Programs attest to this during the "Program Compliance" portion of the QAPR that they are in compliance with applicable Federal and State laws by providing the Handbook information and materials to members. Additionally, programs submit a signed "*Client Notification of Significant Changes for the Integrated Behavioral Health Member Handbook Attestation*" annually to QI Matters.

Right to Provider Selection

In accordance with 42 CFR 438.10 and Title 9, enrollees (all members) have the right to choose and obtain a list of BHP providers, including name/group affiliation, location, telephone number, specialties, hours of operation, type of services, cultural and linguistic capabilities, ADA accommodation, and whether provider is accepting new enrollees.

When feasible and/or upon request, enrollees shall be provided with their initial choice of provider. Each enrollee shall be offered a paper copy of the BHP Provider Directory and/or instructions in their threshold language of how to access the Provider Directory at the time of enrollment and anytime at enrollee's request within (5) five business days. If requested, staff shall assist the member or responsible adult, in reviewing the list of available options and/or obtaining an appointment. Providers shall log all requests for services prior to the onset of services on the Request for Service Log.
The BHP Provider Directory is available on the County's website or by calling Behavioral Health Services at (619) 563-2788. The Fee-for-Service Provider Directory is available by calling Optum at 1-888-724-7240 and online at the Optum website.

Right to a Second Opinion

If the MHP or its designee determines that a member does not meet criteria for access to inpatient or outpatient specialty mental health services, a member or someone on behalf of the member, may request a second opinion. A second opinion from a mental health clinician provides the member with an opportunity to receive additional input on his

or her mental health care at no extra cost. As the BHP designee, Optum is responsible for informing the treating provider of the second opinion request and for coordinating the second opinion with an BHP contracted individual provider.

The second opinion provider is required to obtain a release of information from the member in order to review the member's medical record and discuss the member's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the BHP Program Monitor/COR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the BHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

Right to Transfer

Members have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the *Client Suggestions and Provider Transfer Reques*t tab of the Monthly/Quarterly Status Report (QSR). Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer if specified by the member. The Log shall be submitted with the provider's Monthly/Quarterly Status Report.

Right to Language, Visual and Hearing Impairment Assistance

Members shall be routinely informed about the availability of free language assistance at the time of accessing services. The BHP prohibits the expectation that the member uses family or friends for interpreter services, however, if the member chooses, this should be documented in the medical record. Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and Behavioral Health Services policy.

Right to a Patient Advocate

A member pursuant to W&I Code 5325 (h) has a right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services. The rights specified in this section may not be waived by the person's parent, guardian, or conservator. The Patient Advocate does not need to have access to the entire chart, but rather, the portions that have to do with the potential denial of rights.

Right to Access Health Information (45 CFR § 164.524)

The Privacy Rule

The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. A "designated record set" is defined at 45 CFR 164.501 as a group of records maintained by or for a covered entity that comprises the:

- Medical records and billing records about individuals maintained by or for a covered health care provider;
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Other records that are used

This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Individuals have a right to access this PHI for as long as the information is maintained by a covered entity, or by a business associate on behalf of a covered entity, regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether the covered entity, another provider, the member, etc.).

For more information, please see: US Dept. HHS- Individuals' Right Under HIPAA to Access their Health Information.

Personal Representatives

An individual's personal representative (generally, a person with authority under State law to make health care decisions for the individual) also has the right to access PHI about the individual in a designated record set (as well as to direct the covered entity to transmit a copy of the PHI to a designated person or entity of the individual's choice), upon request. See 45 CFR 164.502(g) and Your Rights Under HIPAA for more information .

Information Excluded from the Right of Access

An individual does not have a right to access PHI that is not part of a designated record set. For example, a hospital's peer review files or practitioner or provider performance evaluations, or a health plan's quality control records that are used to improve customer service or formulary development records, may be generated from

and include an individual's PHI but might not be in the covered entity's designated record set and subject to access by the individual.

In addition, two categories of information are expressly excluded from the right of access:

- Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the member's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.

- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

Right to Direct PHI to Another Person

An individual also has a right to direct the covered entity to transmit the PHI about the individual directly to another person or entity designated by the individual. This request must be in writing, signed by the individual, and clearly identify the designated person and where to send the PHI. A covered entity may accept an electronic copy of a signed request (i.e. PDF), as well as an electronically executed request (i.e. via a secure web portal) that includes an electronic signature. The same requirements for providing the PHI to the individual, such as the fee limitations and requirements for providing the PHI in the form and format and manner requested by the individual, apply when an individual directs that the PHI be sent to another person. (45 CFR 164.524(c)(3).

Right to Request Materials in Alternative Formats

Members reserve the right to request written information in their preferred formats (large print, braille, audio or other accessible electronic formats). Requests for alternative formats may be made directly with programs or through Optum's Access & Crisis Line. Programs are expected to address and assist members with these requests. Below are the steps to follow if a program or Optum ACL receives a request.

Process for Requests Made to the Program

- If materials requested are not already available on the Optum website, programs shall contact QIMatters.BHS@sdcounty.ca.gov with the following information:

    - Member name and contact information (address, phone number, email address)
    - Preferred method of delivery (mail, email (if applicable), pick up at program)

- QA will coordinate directly with the program once materials are ready

Process for Requests made to Optum's ACL

- If materials requested are not already available on the Optum website, ACL staff shall contact QIMatters.BHS@sdcounty.ca.gov with the following information:
  - Member name and contact information (address, phone number, email address)
  - Preferred method of delivery (mail, email (if applicable), pick up at a program)
- QA will coordinate directly with the member once the materials are ready

For additional information on these rights and for items that are readily available in alternative format, programs may refer members to the Optum Beneficiary & Families page.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the BHP to ensure that all adults and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation).

An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to comply with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated members:

1. Provide written information on the member right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new member, and thereafter, upon request.
2. Document in the member's medical record that this information has been given and whether or not the member has an existing Advance Directive.

3. If the member who has an Advance Directive wishes to bring in a copy, the provider shall add it to the member's current medical record.

4. If a member is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the member at the appropriate time. In the interim, the provider may choose to give a copy of the information to the member's family or surrogate.

5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.

6. Should the situation ever arise, provide information about the State contact point to members who wish to complain about non-compliance with an Advance Directive.

The BHP is required to provide brochure on Advance Directives to new members or members of the community who request it. All brochures are available on the Optum website >*Beneficiary* tab. Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Guidance on Service and Support Animals

Service Animals

"Service animals" are animals that are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified. Under the Americans with Disabilities Act, service animals can only be dogs or miniature horses. Staff members are not permitted to request documentation for a service animal. Service animals are not required to be formally trained, nor must they wear a special tag or vest. Unless there is a reason to believe that an animal poses a threat to others, facility representatives can only ask two questions to determine whether an animal qualifies as a service animal:

1. Is the animal required because of the handler's disability?

2. What work or task the animal has been trained to perform?

If the member affirmatively answers the two questions above, the animal would be considered a service animal under the law and should be allowed in the facility unless one of the legal justifications (described below) for denial applies.

Support Animals

"Support animals" are animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified. The current Fair Housing Act (and regulations) indicate that support animals should be allowed in any dwelling or housing accommodation, subject to limited exceptions. If a facility has a "no pets" policy, any member may request a "reasonable accommodation" to allow their support animal in the facility. Requests for a reasonable accommodation do not have to be in writing. Evaluating reasonable accommodation(s) should be an interactive process between the requester and the facility staff. If the facility staff members do not understand the initial request, they should continue to work with the requester until they can understand how the support animal will assist with the requester's disability-related need.

Staff can request documentation regarding the member's disability and the need for the support animal. This documentation should only be requested if the disability and/or need for the animal are not already apparent. Facility staff can also require that emotional support animals be licensed and/or vaccinated according to state and local laws that apply to all other animals. If the connection between the disability-related need and the support animal is readily apparent, or if the requester submits appropriate documentation establishing this connection, staff members should allow the support animal, unless one of the legal justifications for denial applies (see below). If the connection is not readily apparent, and the requester does not submit appropriate documentation, then the individual's request could possibly be denied (pending submission of documentation).

Denial of a Service or Support Animal

Staff are not permitted to preemptively deny a service animal or deny based solely on the animal's breed. In all cases, facilities need to and document case-by-case determinations via an "individualized assessment" of a service animal's behavior and its handler's ability to care for it. Facility staff are only authorized to deny service animals in limited circumstances. If facility staff decide to deny a reasonable accommodation for a support animal or deny access to a service animal, they must provide a specific legal justification to the member.

Examples of specific legal justifications include the following:

1. Fundamental Alteration - Permitting the animal would alter the essential nature of the program.

2. Undue Burden - Permitting the animal would cause significant difficulty or expense.

3. Direct Threat - Permitting the animal would lead to significant risk of substantial bodily harm to the health or safety of others or would cause

substantial physical damage to the property of others, and that harm cannot be sufficiently mitigated or eliminated by a reasonable accommodation.

The reasons for denial of a service animal should be carefully documented by facility staff and clearly communicated to the handler. For any non-English speaking individuals, the facility should attempt to provide this information in the individual's preferred language. Facilities should also consider consulting their own legal counsel or risk management coordinator as appropriate.

In cases when facility staff are denying an animal because the requester fails to establish the connection between their disability-related need and the support animal, facility staff should explain why they believe the connection was not established but would not be required to cite one of the specific legal justifications above. Also, to the extent practical, if an animal requires removal, efforts should be made to ensure that it is retrievable by the owner.

Individuals who feel they have been wrongfully denied a service or support animal can file complaints with the U.S. Department of Justice, the U.S. Department of Housing and Urban Development, the California Department of Fair Employment and Housing, and the California Civil Rights Department. They may also file suit in state, federal, or small claims court or seek other legal representation. Additionally, individuals can choose to file a grievance or complaint through the appropriate patient advocacy agency

The information provided above is a summary of applicable law, regulations, and is intended as guidance. In developing policies and procedures, it is recommended that facility representatives utilize the legal guidelines that can be found in Cal. Code Regs. Title 2 § 12005, Cal. Code Regs. tit. 2 § 12176-12181, Cal. Code Regs. Title 2, § 12185, Cal. Code Regs. Title 2 § 14020, Cal. Code Regs. Title 2 § 14331, 28 C.F.R. § 36.104, 28 C.F.R. § 36.302, 28 C.F.R. § 36 app A to Part 36, 28 C.F.R. § 36 app C to Part 36.

For more information please see: ADA Requirements: Service Animals and FAQs about Service Animals and the ADA.

Urgent Walk-In Clinical Standards for Programs Serving Adult/Older Adults

Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to a primary care provider with known capacity, outpatient mental health provider, or a fee for service provider, via the Access and Crisis Line. The member's choice prevails as per DHCS regulations. Members who are already receiving mental health services and walk in to request medication will be triaged/screened. If they are not deemed in need of urgent services, they may be referred back to their own provider/ prescribing physician.

Members with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless if the member may be already receiving services.

New members assessed as needing urgent services that are referred from a Hospital or Jane Westin Center must be prioritized for admission at an outpatient clinic within forty-eight (48) hours. All referrals received that indicate urgency or high risk and that do not show up to the walk-in clinic will prompt a response from the walk-in clinic to the referring party for follow up. If the referring party is a Hospital or Crisis Residential program, the walk-in clinic will follow up with the member directly.

Outpatient Clinics with Walk-In Urgent Components

All outpatient clinics in all shall accommodate their opened members for urgent services to prevent them from needing access to walk in services. All members who are triaged/screened and are deemed appropriate for routine admission must be admitted in accordance with acceptable access times already established for routine services, or according to the seventy-two (72) hour policy for members leaving twenty-four (24) hour settings or known case management members. Institutions and Case Managers can call a clinic to arrange for a triage day during walk-in times, within seventy-two (72) hours, and individuals will be given the highest priority to be triaged/screened that day.

New members assessed as needing urgent services that are referred from Hospitals or Jane Westin Center must be prioritized for admission at an outpatient clinic within forty-eight (48) hours. Programs must have processes in place to follow up with members who come in for walk-in services, are triaged/screened and not deemed urgent, but need specialty mental health services at the clinic and are asked to return the following day but who do not show up.

Members receiving urgent or at-risk referrals are responsible for ensuring members are screened within designated timelines and shall be responsible for contacting the member for follow up if they do not show up during walk in times.

All Programs:

- The initial site providing service shall ensure that members do not have to go to multiple facilities for an evaluation.
- MD's/Nurse Practitioners (NP's) must be prepared to provide care to a member who is in urgent need of medications even though the member may be open at another clinic.
- MD's/NP's should be prepared to provide outpatient detox medications to COD members entering County-contracted detox programs, if in the MD's/NP's opinion it is deemed safe. This will be evaluated on a case-by-case basis.
- All programs shall post signage to inform members what to do after hours. i.e. "In case of an emergency after business hours please go to the nearest emergency room, call the Access and Crisis Line at-1-888-724-7240, or call 911."
- *HIPAA Privacy Rule* (Sec. 164.506) states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred member appeared for their intake process.

Priority List: Prioritization is always based on clinical judgment regarding highest acuity and risk; however the following will generally be highest priority: A member appearing agitated in the waiting room, any member referred/discharging from a Psychiatric hospital/crisis residential, a member brought in by Police/PERT, jail, a member referred from an IMD Client/Out of County locked facility, a member with a case manager, a member referred/discharged from an acute facility (i.e. CSU) acute, any member that is homeless or at risk of homelessness with SMI or co-occuring disorder or a member whose mental status jeopardizes SUD residential placement.

SMHS Provided During the Assessment Period

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the member meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the member does not meet criteria for access to SMHS. BHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the member does **not** meet criteria for access to SMHS or meets the criteria for NSMHS.

BHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established:

- ICD-10 codes Z55-Z65: "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- ICD-10 code Z03.89: "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a member's treatment when a diagnosis has yet to be established.

Per CalAIM, a mental health disorder diagnosis is not required to receive medically necessary SMHS. However, ICD diagnostic codes are required on claims in order for DHCS to receive federal financial participation. Z codes meet the federal requirement for claims and do not indicate a diagnosis of a mental health disorder or a substance use disorder (BHIN 22-013). LPHA and LMHP may use any clinically appropriate ICD-10 code. Programs should maintain history of their intakes/documentation even if they do not end up fully enrolling with the program.

Medi-Cal Transformation Initiative for Co-Occurring Treatment Disorders

Members with co-occurring mental health and substance use issues are common in the public mental health system and present complex needs. The presence of substance use should be explored with all members and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment. For all members who do not meet the criteria for access to Specialty Mental Health services, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.

The Medi-Cal Transformation initiative seeks to reduce or eliminate barriers to treatment for members with co-occurring disorders. Therefore, services provided in the presence of co-occurring disorders will be reimbursable when a medically necessary service is documented. BHPs must not deny or disallow reimbursement for SMHS provided to a member who meets SMHS criteria based on the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met.

Please note, Department of Health Care Services is not allowing specialty mental health providers to automatically bill DMC services- specialty mental health program

providers must still deliver covered specialty mental health services at sites that have specialty mental health certifications.

When serving adults, children, adolescents, or their families that meet the criteria for co-occurring disorders these guidelines are to be implemented:

- Documentation on the Admission Checklist that the member and/or family was given a copy of your program's *Welcoming Statement* outlining the programs capacity to address co-occurring needs as well as physical health needs, including tobacco use.

- Include substance use and abuse issues in your initial screening, assessment and assessment updates. In addition, use any screening tools that may be adopted or required. For members under the age of twenty- one (21), the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

- If both types of disorders are indicated for the member at diagnostic levels, list the mental health diagnosis or Z03.89 Deferred Diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.

Treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). Treatment planning should deal with the substance use issue, either by referral or direct treatment. The co-occurring substance use issue may be integrated into the member's problem list and service may be provided in relation to how it impacts the functional impairment related to the mental health diagnosis.

Documentation of treatment services and interventions must meet the federal and W&I Code 14184.402 requirements if mental health services are to be claimed to Medi-Cal. Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use concerns a collateral person, the progress note must focus on the impact of the substance use on the identified member. In most instances, it is preferable to approach the substance use in the context of the mental health disorder and create an integrated note and treatment regime.

It is not appropriate to exclude a member from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the member's accessibility for treatment, as well as member and provider safety concerns.

Concurrent NSMHS and SMHS

Members may concurrently receive NSMHS via FFS or MCP provider and SMHS via a BHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for access to both NSMHS and SMHS, the member should receive services based on individual clinical need and established therapeutic relationships. BHPs must not deny or disallow reimbursement for SMHS provided to a member based on the member also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a member based on the member also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under twenty- one (21) years of age, must be coordinated between MCPs and BHPs to ensure member choice. BHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

Members with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an BHP provider (billed to the BHP), as long as the services are coordinated between these delivery systems and are non-duplicative (i.e. a member may only receive psychiatry/ therapy services in one network, not both networks).

Members with established therapeutic relationships with a BHP provider may continue receiving SMHS from the BHP provider (billed to the BHP), even if they simultaneously receive NSMHS from an FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

Network Adequacy

The State requires County Behavioral Health Plans to comply with BHIN 26-023 to ensure covered services are available, accessible, and in accordance with timely access requirements as well as time or distance standards per the Medicaid Managed Care Final Rule (Mega Regs). Behavioral Health Plans are required, per BHIN 22-032, to report data on its network providers using the “274” standard which is an Electronic Data Interchange selected by DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. This information is

used by DHCS to monitor whether the BHP's provider network is adequate to support the estimated need and demand for behavioral health services. For these purposes, required provider information, inclusive of identifying information, is sent to DHCS on a monthly basis

Out of Network (OON) Access

The State Department of Health Services (DHCS) requires that Behavioral Health Plans (BHPs) ensure that Members receive medically necessary services within applicable time, distance, and timely access standards. If the BHP's provider network is unable to meet those standards, the BHP shall allow Members to access out-of-network services and ensure they are adequately and timely covered. Accordingly, when required access standards cannot be met through in-network providers, the BHP must arrange and authorize services through an Out-of-Network (OON) provider at no greater cost to the Member.

San Diego BHP contracts with Optum as its Administrative Services Organization (ASO) to administer and execute Out-of-Network (OON) authorizations through Accommodation Agreements. MHP and DMC-ODS providers shall refer Members to in-network providers when arranging services related to the Member's care. If medically necessary services are not available within required time, distance, or timely access standards, Members may access services from an OON provider through the process described below.

Procedure for Out-of-Network Service Access

1. **Criteria for Executing an Accommodation Agreement:** Accommodation Agreements with OON providers are carried out when one or more of the following criteria are met:

    a. There are no San Diego County network providers within a reasonable geographic range who meet the cultural, ethnic, and/or clinical needs of the member

    b. Treatment by an OON provider is in the best clinical interest of the member as determined by County of San Diego Behavioral Health Services (BHS)

    c. Special requests made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds

2. **Referring Provider Responsibilities:** When a provider determines that medically necessary SMHS or SUD services cannot be delivered within required time, distance, or timely access standards:

a. The provider shall provide case management services.

b. The provider shall assist the Member in contacting the ASO's Access and Crisis Line at 888-724-7240 (TTY 711) for referral to an appropriate provider.

c. The provider shall facilitate a warm handoff to ensure continuity of care.

d. Providers shall initiate and support the established OON process when required access standards cannot be met.

3. **ASO (Optum) Responsibilities:** Upon receipt of an OON service request:

   a. ASO Review and Processing

      i. Send written acknowledgment to the Member within three (3) working days.

      ii. Determine whether network adequacy or timely access standards cannot be met.

      iii. Complete review and authorization within thirty (30) calendar days of receipt of required documentation.

      iv. If standards cannot be met:
         1. Identify an appropriate OON provider; or
         2. Offer telehealth when clinically appropriate.

      v. If telehealth is declined and no in-network provider can meet standards, coordinate transportation for an in-person visit.

      vi. Notify the Member in writing within seven (7) calendar days of approval.

   b. Execution of Accommodation Agreement. If OON criteria are met, the ASO shall:

      i. Contact the identified OON provider.

      ii. Execute an Accommodation Agreement requiring the OON provider to:
         1. Follow County standard care procedures;
         2. Accept standard Medi-Cal rates unless otherwise negotiated;
         3. Submit required documentation (license, liability insurance, DEA if applicable).

4. Verify licensure (Primary Source Verification through the Credentialing Committee does not occur).
5. Establish the provider in the Designated Database (DDS) to enable authorization and payment.

Accommodation Agreements are time-limited and apply only to authorized service dates.

4. Member Protections

a. The Member may access the OON provider for as long as medically necessary, unless the OON provider agrees to provide services for a shorter timeframe.

b. If the BHP does not have an in-network provider able to meet applicable access standards, OON authorization shall be maintained as necessary to ensure uninterrupted access to medically necessary services.

c. The BHP shall ensure that the cost to the Member for authorized OON services is no greater than it would be if services were provided in-network.

Non- Behavioral Health Plan Services: Screening, Referral and Coordination

All providers shall give appropriate referrals and/or coordination for treatment of services provided outside of the Behavioral Health Plan's (BHP's) jurisdiction. When an individual contacts a provider and requests referral and coordination of services that are outside of the BHP's jurisdiction, (education, health, Regional Center, housing, transportation, vocational, etc.), the provider will make or coordinate such referrals based on the individual's residence and specific need.

Appropriate referrals will include providing necessary information such as phone numbers, addresses, etc. If the provider lacks the necessary information, they will offer the individual two options:

1. Give the individual the number to Optum's Access and Crisis line # at 1-888-724-7240 **or**

2. Get the individual's phone number and call them back with requested information. Requests for assistance shall be entered in the Access to Services Journal in the EHR.

Access Criteria

Criteria for Members Twenty- One (21) Years of Age or Older

As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through BHIN 20-073 and supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210 and other guidance published prior to January 1, 2022 regarding access criteria for BHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services) until DHCS implements new regulations.

For more information, please reference DHCS Behavioral Health Information Notice BH IN 25-020 which provides guidance on screening and Transition of Care tools; BHIN 26-002 which addresses criteria for member access to SMHS, medical necessity and other coverage requirements and BHIN 22-011 '*No Wrong Door for Mental Health* 'Policy.

When the provider conducts an assessment of a member who has called or walked into the program, providers will follow the "*SmartCare Walk-in Workflow*" located at the Optum Website> *SmartCare* tab. If the Access and Crisis Line refers a member to an organizational provider or to a County-operated facility, the ACL completes an inquiry for each member. The provider's program staff is then responsible for recording all ongoing activity for that member into the EHR.

For members twenty-one (21) years of age or older, a county behavioral health plan shall provide covered specialty mental health services for members who meet **both of the following criteria**, (1) and (2) below:

The member has **one or both** of the following:

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

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

AND

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

1. 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.

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

Criteria for Members Under Twenty- One (21) Years of Age

For members under age 21, a service is medically necessary if it meets criteria of Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct and ameliorate mental illness or condition discovered by a screening service, despite if such services are covered under the State Plan. 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 and are covered as EPSDT.

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria below. Please note: If a member under age 21 meets the criteria as described in (1) above, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (2) above.

1. The members have 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

    a. (Note: Children/Youth meeting medical necessity due to significant trauma shall be based on the assessment of a licensed mental health professional.).

OR

The member meets **both of the following** requirements in a) and b) below:

a. The member has at least one of the following:

    1. Significant impairment

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

    3. A reasonable probability of not progressing developmentally as appropriate.

4. 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 member's condition as described in subparagraph (2) above is due to one of the following:

1. 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.

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

3. Significant trauma* placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

    a. *If it has been determined that a youth trauma screening tool is necessary to identify whether a member under 21 years old meets access criteria to the SMHS delivery system, as of April 1, 2026, only the DHCS-approved tools listed in Enclosure 1 may be used. DHCS Approved Youth Trauma Screening Tools. Please note that the County already requires the CA IP-CANS as an integrated part of the intake workflow.

This criterion 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:

a. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

b. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

c. The member has a co-occurring substance use disorder.

Adult and Youth Screening Tools for Medi-Cal Behavioral Health Services

The Adult and Youth Screening Tools are designed to capture information necessary for identification of initial indicators of a member's mental health needs for the purpose of determining whether the BHP must refer the member to their MCP or to an BHP provider (county-operated or contracted) to receive an assessment. DHCS is requiring MCPs and BHPs to use the Screening and Transition of Care Tools – for all members age twenty- one (21) and under (children/youth) and ages twenty- one (21) and over (adults). (BHIN 22-065) The Adult and Youth Screening Tools include both screening questions and an associated scoring methodology.

The Adult and Youth Screening Tools determine the appropriate delivery system referral for members who are not currently receiving behavioral health services when they contact the MCP or BHP. The Screening Tools are not required or intended for use with members who are currently receiving behavioral health services. The Screening Tools are also not required for use with members who contact behavioral health providers directly to obtain services.

Behavioral health providers who are contacted directly by members seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, via the *No Wrong Door for Mental Health Services Policy* (BHIN 22-011) or subsequent updates.

The Screening Tool will be completed by either the MCP or Optum ACL and if deemed appropriate, a referral will be made to the appropriate individual FFS or organizational provider. Upon receiving the referral, the provider/program will ensure that Timeliness Standard requirements are followed.

The Adult and Youth Screening Tools do **not** replace:

- BHPs' protocols for emergencies or urgent and emergent crisis referrals and/or P&Ps. For instance, if a member is in crisis or experiencing a psychiatric emergency, the BHP's emergency and crisis protocols shall be followed.
- BHP protocols that address clinically appropriate, timely, and equitable access to care.
- BHP clinical assessments, level of care determinations, and service recommendations.
- BHP requirements to provide EPSDT services.

Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a member is referred to the MCP or BHP, they shall receive an assessment from a provider in that system to determine medically necessary mental health services.

Adult Screening Tool

The Adult Screening Tool includes screening questions that are intended to elicit information about the following:

- Safety: whether the member needs immediate attention and the reason(s) a member is seeking services.
- Clinical Experiences: whether the member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
- Life Circumstances: challenges the member may be experiencing related to school, work, relationships, housing, or other circumstances.
- Risk: suicidality, self-harm, emergency treatment, and hospitalizations. Please note that If the member responds affirmatively to the question related to suicidality, the BHP must immediately coordinate referral to an BHP provider (County-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.
- Substance Use: The Adult Screening Tool also includes questions related to substance use disorder (SUD). If a member responds affirmatively to these SUD questions, they shall be offered a referral to the county behavioral health plan for SUD assessment. The member may decline this referral without impact to their mental health delivery system referral.

Youth Screening Tool

The Youth Screening Tool includes screening questions designed to address a broad range of indicators for members under the age of twenty-one (21). A distinct set of questions are provided for when a member under the age of twenty-one (21) is contacting the BHP on their own. A second set of questions with slightly modified language is provided for use when a person is contacting the BHP on behalf of a member under the age of twenty-one (21).

The Youth Screening Tool screening questions are intended to elicit information about the following:

- Safety: whether the member needs immediate attention and the reason(s) a member is seeking services.

- System Involvement: whether the member is currently receiving treatment and if they have been involved in foster care, child welfare services, or the juvenile justice system.

- Life Circumstances: challenges the member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.

- Risk: suicidality, self-harm, harm to others, and hospitalizations. Please note-If the member responds affirmatively to the question related to suicidality, the BHP must immediately coordinate referral to an BHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.

- SMHS Access Criteria- including those related to involvement in foster care or child welfare services, involvement in the juvenile justice system, and experience with homelessness. If a member under the age of twenty-one (21), or the person on their behalf, responds affirmatively to the questions related to SMHS access criteria, they shall be referred to the BHP for an assessment and medically necessary services. Please reference BHIN 23-041 for additional detail on SMHS criteria and definitions of key terminology.

- Substance Use: If a member under the age of twenty-one (21), or the person on their behalf, responds affirmatively to the question related to substance use, they shall be offered a referral to the county behavioral health plan for SUD assessment. The member may decline this referral without impact to their mental health delivery system referral.

Administering the Adult and Youth Screening Tools

The Adult and Youth Screening Tools can be administered by clinicians or non-clinicians in alignment with BHP protocols and in a variety of ways, including in person orby telephone/video conference. Adult and Youth Screening Tool questions shall be asked in full using the specific wording provided in and in the specific order they appear in the tools. Additional questions shall not be added to the tools. The scoring methodologies within the Adult and Youth Screening Tools shall be used to determine an overall score for each screened member. The score determines whether a member is referred to their MCP or the BHP for assessment and medically necessary services.

The Adult and Youth Screening Tools are available on the Optum Website > *UCRM* tab. For instructions on how to complete the Adult and Youth Screening Tools, please refer to the *Explanation Sheets* and other resources that can be found on the Optum Website > *UCRM* and *SmartCare* tabs.

BHPs are not required to use the PDF format and instead may build the Adult and Youth Screening Tools into existing software systems, such as electronic health records (EHRs). Contents of the Adult and Youth Screening Tools, including the specific wording, the order of questions, and the scoring methodology shall remain intact.

Following Administration of the Adult and Youth Screening Tools

After administration of the Adult or Youth Screening Tool, a score is generated. Based on their screening score, the member shall be referred to the appropriate Medi-Cal behavioral health delivery system (i.e., either the MCP or the BHP) for a clinical assessment. If a member is referred to the BHP by the MCP, based on the score generated by the Screening Tool, the BHP must offer and provide a timely clinical assessment to the member without requiring an additional screening and in alignment with existing standards and medically necessary mental health services.

If a member is referred to the MCP by the BHP based on the score generated by the Screening Tool, BHPs shall coordinate member referrals with MCPs or directly to MCP providers delivering NSMHS. Referral coordination should include sharing the completed Adult or Youth Screening Tool with the receiving program(s) and following up to ensure a timely clinical assessment has been made available to the member. Members shall be engaged in the process and provide appropriate consents in accordance with accepted standards of clinical practice.

Access and Crisis Line: 1-888-724-7240

Optum, the Administrative Services Organization (ASO) for the BHP, operates the statewide San Diego County Access and Crisis Line (ACL) which provides telephone crisis intervention, suicide prevention services, behavioral health information and referral twenty- four (24) hours a day, seven (7) days a week. The ACL may be the initial access point into the BHP for routine, urgent or emergency situations.

All ACL staff evaluates the degree of immediate danger and determines the most appropriate intervention. In an emergency, ACL staff makes direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the member at risk. The ACL staff makes a follow-up call to that provider to ensure that the member was evaluated and that appropriate crisis services were provided. The ACL also provides access to interpreter services through the Language Line, which provides telephonic interpreter services for approximately one hundred and forty (140) languages at the point of an initial ACL screening. Members who have hearing impairment may contact the ACL via the TTY line at 711.

Provider Interface with the ACL

Providers may utilize the ACL as an adjunct to services in emergencies and after hours. To provide the most effective emergency response and back-up to their services, office voice mail should state: "*If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-888-724-7240."* If a member is high risk and may be calling the ACL for additional support, the member's therapist or care coordinator may call (with member's approval) the ACL in advance on behalf of the member.

Referrals to the ACL

Providers shall inform members about the option of directly using the Access and Crisis Line by calling 1-888-724-7240. It is appropriate to refer individuals to the ACL for:

- Access to publicly funded Specialty Mental Health Services
- Crisis intervention for urgent situations
- Suicide Prevention
- Referrals for routine behavioral health services
- Information about mental health and mental illness
- Referrals to community resources for vocational, financial, medical, and other concerns.

Mobile Crisis Services

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to members experiencing a behavioral health crisis. Goals include providing services through de-escalation and stabilization techniques; reducing immediate risk of danger and subsequent harm; and avoiding unnecessary emergency department care and psychiatric inpatient hospitalizations.

Psychiatric Emergency Response Team (PERT)

PERT has been designed to improve collaboration between the behavioral health and law enforcement systems with the goal of a more humane and effective handling of incidents involving law enforcement officers and members with mental illness, developmental disabilities and/or substance use disorders.

- The PERT team shall provide direct member interventions in conjunction with law enforcement officers to individuals experiencing a mental health crisis.

- The PERT team works to reduce inappropriate hospitalization and/or incarceration and refer members to the most appropriate, least restrictive mental health program.

- Contractor shall refer to and link members to the services needed and provides follow-up services as appropriate.

Mobile Crisis Response Teams (MCRT)

The County of San Diego has contracted with current system of care providers to provide these services and align with the requirements outlined in BHIN 23-025. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Mobile crisis services shall be available to members experiencing behavioral health crises twenty- four (24) hours a day, seven (7) days a week, and three hundred and sixty-five (365) days a year. Mobile crisis response teams shall arrive at the community-based location where a crisis occurs in a timely manner within sixty (60) minutes of the member being determined to require mobile crisis services in urban and within one hundred and twenty (120) minutes in rural areas. Follow-ups to the member shall occur within seventy-two (72) hours of the initial crisis response. (2 42 U.S.C. § 1396w–6(b)(2)(C); CMS, SHO #21-008, (Dec. 28, 2021) p. 7),

Mobile crisis services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile crisis services are directed toward the member in crisis but may include contact with a family member(s) or other significant support person(s) if the purpose of the support person's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level.

For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Assisted Outpatient Treatment- Laura's Law

Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for

individuals who have a history of untreated mental illness and meet all seven of the following criteria stipulated in the Code:

1. The person is at least eighteen (18) years of age.

2. The person is mentally ill as defined in WIC 5600.3

3. There has been a clinical determination based on the person's treatment history and current behavior that at least one of the following is true:

    a. The person is clinically determined to be unlikely to survive safely in the community without supervision.

    b. The person needs assisted outpatient treatment in order to prevent relapse or deterioration that would result in grave disability or serious harm to the person or others.

4. The person has a history of treatment non-compliance as evidenced by one of the following:

    a. Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last thirty- six (36) months

    OR

    b. One occurrence of serious and violent behavior (including threats) within the last forty-eight (48) months.

5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.

6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.

7. The person is expected to benefit from AOT.

A request for an assisted outpatient treatment examination is made through one of the two In Home Outreach Team (IHOT) programs: Telecare or Mental Health Systems, Inc. The IHOT program is an outreach and engagement program for individuals who are resistant to treatment.

In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter the assisted outpatient treatment program.

If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.

1. The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within ten (10) days prior to the submission of the petition; the person meets all nine (9) criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,

   OR

   The licensed mental health clinician has made within ten (10) days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.

2. If the individual refuses to be examined by a licensed mental health clinician from IHOT, the court may request the individual's consent to the examination by a licensed MH treatment clinician appointed by the court. In the County of San Diego, the Public Conservator's Office is the designated program to conduct the AOT court order examination for individuals who refused the initial examination by IHOT.

3. If the individual does not consent and the court finds reasonable cause, the court may conduct the hearing in the person's absence OR order an individual to be transported to San Diego County Psychiatric Hospital for examination by a licensed mental health professional under WIC 5150. The hold may not exceed seventy-two (72) hours.

4. In the event that the AOT examination is upheld, the County's designee, San Diego County Counsel, will file the petition with the AOT Judge and upon receipt of the petition, the court must schedule a hearing within five (5) business days. Individuals will be personally served with the petition and notice of hearing date.

5. If after hearing all evidence the court finds the individual does not meet criteria for AOT, the court may dismiss the petition.

6. If the court finds that all nine (9) criteria are met, the court may order the person to AOT for an initial period not to exceed six (6) months. The individual may voluntarily enter into a settlement agreement for services after a petition for an order of AOT is filed, but before the conclusion of the hearing. Settlement

agreements may not exceed one hundred and eighty (180) days and has the same force as an order for AOT.

7. If the person is court ordered for AOT services and is not participating in the AOT program, and if unsuccessful attempts are made to engage the person in AOT, the person may be transported to San Diego Psychiatric Hospital for up to seventy-two (72) hours to be examined to determine if the person is in need of treatment pursuant to Section 5150.

Accessing Services for Specific Populations

Community Assistance Recovery and Empowerment (CARE) Act

The Community Assistance, Recovery and Empowerment (CARE) Act program was implemented on October 1, 2023. In collaboration with County and community partners, the CARE Act program creates a new pathway to deliver mental health and substance use services to individuals who are diagnosed with schizophrenia or other psychotic disorders and are not engaged in treatment. Families, clinicians, first responders, and others may begin the process by filing a petition with the civil court to connect adult members to court-ordered, voluntary treatment if they meet criteria and may benefit from the program.

CARE Eligibility Criteria:

An individual shall qualify for the CARE process only if **ALL** of the following are true:

1. The person is eighteen (18) years of age or older.

2. The person is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

    a. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.

    b. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for CARE process.

c. A person with a diagnosis identified in the class of mood disorders, including mood disorders with psychotic features, does not meet the required eligibility criteria for CARE process.

3. The person is not clinically stabilized in on-going voluntary treatment.

4. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

5. It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

6. At least one of the following is true:

   a. The person's condition is substantially deteriorating.

   b. The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

CARE Process

1. Referral**:** A referral can be initiated by family members, behavioral health providers, first responders, or other approved petitioners, by filing a petition with the Superior Court. Petitions must include required State documentation to establish clinical history. Detailed instructions on filing a CARE petition and forms can be found here: CARE Act | Superior Court of California - County of San Diego

2. Initial Determination: The Superior Court makes an initial determination as to whether the petition appears to meet criteria for the CARE Act program. If the petition appears to meet initial criteria, the Superior Court will order County Behavioral Health Services (BHS) to conduct an investigation.

3. Investigation and Engagement: County BHS will investigate and report back to the Superior Court within 14 days with a recommendation regarding the establishment of a CARE Act case. During the investigative process, BHS will conduct outreach and attempt to engage petitioned individuals with treatment and may avoid the need for a CARE Act case.

4. Establishing a CARE Agreement/ Plan: If the Superior Court determines that a case should be established, a CARE Agreement/Plan will be developed with County BHS, in partnership with the petitioned individual and their counsel. The CARE Agreement/Plan will be submitted to the Superior Court for review.

5. Connection to Services: Once a CARE Agreement/Plan is accepted by the Superior Court, BHS and its network of community-based providers such as the Telecare CARE ACT team, will actively engage the individual for whom a CARE Agreement/Plan has been established to connect to services, including behavioral health treatment, stabilization medication, a housing plan, and other supports as needed.

Program participation is twelve (12) months but may be extended for an additional twelve (12) months depending upon individual circumstances.

Secure Facility/ Long-Term Care (SF/LTC) – Adult Mental Health Services

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded by the County of San Diego include Institution for Mental Disease Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities/Special Treatment Program (SNF-STP), additional funds for a County SNF Patch, and State Hospitals.

Target Population: The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The member must have a Title 9, ICD 10 psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent Lanterman-Petris-Short (LPS) Conservator. For an MHRC and SNF/STP, the age range is eighteen to sixty-four years old (18-64).

Admission: Optum provides Utilization Management for County-funded locked/secure facilities. Referring agencies shall submit an information packet to the Optum Long-Term Care (LTC) Coordinator. Please refer to the **resources** below for further details on eligibility criteria, referral process, and forms.

Placement: Individuals who meet SF/LTC Admission Criteria are placed in SF/LTC facilities that are contracted with the County of San Diego. Placement decisions are made by County Contracted SF/LTC facilities and Optum. At times, placement in a County-funded, out-of-County located program may be appropriate.

Resources:

- For additional information, processes and forms, please utilize the Long-Term Care page on the Optum Website > *Long Term Care*.

- Please also reference the Long Term Care Handbook.

BHP and MCP Responsibility to Provide Services for Eating Disorders

BHIN 22-009 states that the BHPs and MCPs share a joint responsibility to provide medically necessary services to Medi-Cal members with eating disorders. Some treatments for eating disorders (both inpatient and outpatient SMHS) are covered by BHPs. Some treatment for eating disorders is also covered by MCPs. Since eating disorders are complex conditions involving both physical and psychological symptoms and complications, the treatment typically involves blended physical health and mental health interventions, which MCPs and BHPs are jointly responsible for providing.

1. MCPs are responsible for the physical health components of eating disorder treatment and NSMHS, and BHPs are responsible for the SMHS components of eating disorder treatment.

2. BHPs must provide or arrange and pay for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

3. MCPs must provide inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

4. MCPs must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.

5. For partial hospitalization and residential eating disorder programs, BHPs are responsible for the medically necessary SMHS components, and MCPs are responsible for the medically necessary physical health components.

6. DHCS does not require a specific funding split for BHPs and MCPs to share the cost of services provided in partial hospitalization and residential eating disorder programs. DHCS recommends that both parties mutually agree upon an arrangement to cover the cost of these medically necessary services.

Mental Health Services for American Indian (AI)/Native American (NA) Enrollees

The contract between the State DHCS and the BHP, to the extent that the BHP has a provider network, which enroll AI/NA must:

- Require the BHP to demonstrate that there is sufficient Indian Health Care Providers (IHCP) participating in the provider network of the BHP to ensure timely access to services available under the contract from such providers for AI/NA enrollees who are eligible to receive services.

- Require that IHCPs, whether participating or not, be paid for covered services provided to AI/NA enrollees who are eligible to receive services from such providers.

- Permit AI/NA enrollees to obtain services covered under the contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

The BHP shall provide behavioral health care services to AI/NA enrollees who choose to have their services delivered by an Indian Health Care Provider. Programs shall contact Optum to arrange for services and payment for members referred to Indian Health Care Providers.

Mental Health Services for Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:

- Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health Care Services and the County of San Diego.

- Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

- Parolees with Medi-Cal coverage can receive inpatient services at any County contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.

- Parolees who are Medi-Cal members and who meet specialty mental health access criteria, as specified in Welfare and Institutions Code section 14184.402 and BHIN 20-073 will be provided medically necessary Medi-Cal covered mental health services.

- Parolees, whether or not they are Medi-Cal members, who do not meet specialty mental health access criteria will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.

- Parolees who are not Medi-Cal members and who do meet specialty mental health access criteria will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.

Mental Health Services for Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC).

Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment"). California veterans in need of mental health services who are <u>not</u> eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

<u>Referral Process for Providing Mental Health Services to Veterans</u>

1. **Adult/Older Adult Mental Health Services: Staff** will ask the member if he or she is receiving veterans' services benefits. If the member states he or she is

receiving benefits or claims to have served in the military, the staff will be responsible for completing the following procedure:

a. The staff will complete "*Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form*" that will contain all appropriate demographic information and required member signature.

b. The form shall be faxed to the Veterans Service Office for verification at (858) 505-6961, or other current fax number.

c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

d. If the member meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the member can be offered mental health services.

e. If the member meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the member can be offered mental health services until the veterans' services benefit determination is completed.

2. **Veterans Service Office:** The Veterans Service Office will receive the "Request for Verification Eligibility to Counseling and Guidance Services Fax Form" confirming member's eligibility or ineligibility for veterans' services and mail or fax findings to the County mental health program or contracted program.

   a. The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two (2) to three (3) business days upon receipt of the Fax Request.

   b. The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans' services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.

G. Quality Assurance

The BHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the BHP Quality Assurance Program is to ensure that all members *regardless of funding source* receive mental health care in accordance with these principles. To achieve this goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the BHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Assurance department, which offers training and technical assistance to program staff.

Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Assurance Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of members, family members, clinicians, paraprofessionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services. Indicators of care and service evaluated include, but are not limited to, member satisfaction, effectiveness of service delivery, performance and treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of member rights.

Internal monitoring and auditing should include the provision of prompt responses to detected problems. All providers shall attend regular provider meetings, special forums, in-services/trainings as required by the Contracting Officer Representative (COR), BHS System of Care Executive Leadership and/or Quality Assurance Unit. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts. The quality of the BHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, (Code of Federal Regulations)
- Title 9, Chapter 11, of the California Code of Regulations
- Welfare and Institutions Code 14184.042
- State Department of Health Care Services (DHCS) Letters and Notices
- BHP Managed Care contract with the State DHCS
- Annual DHCS State Protocol for BHPs
- Behavioral Health Services Act (BHSA) requirements, and
- State DHCS mandated Performance Improvement Projects (PIP) - The State has mandated that each BHP undertake one administrative and one clinical PIP yearly.

The evaluation process has also expanded to meet several Federal regulations and legislative mandates under the new Medi-Cal Transformation as specified in Welfare and Institutions Code 14184.042 effective January 1, 2022, and the Medicaid and CHIP Managed Care Final Rules, effective July 5, 2016. The Federal Managed Care Regulations, specifically Part 438 of title 42 Code of Federal Regulations, applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), and Pre-paid Ambulatory Health Plans (PAHPs). Behavioral Health Plans are PIHPs.

Key goals of the final rule are:

- Support state efforts to advance system reform and improve quality of care
- Strengthen the member experience of care and key member protections
- Align key Medicaid and CHIP managed care requirements with other health coverage programs
- Strengthen program integrity by improving accountability and transparency

All providers shall adhere to the rules and regulations stipulated in the W&I Code 14184.042, Medi-Cal Transformation and Medicaid and CHIP Managed Care Final Rules. Information about the final rule is available at the following link: Medicaid and CHIP Managed Care Final Rules.

Quality Improvement Work Plan (QIWP)

The purpose of the County of San Diego's BHS Quality Improvement (QI) Program is to ensure that all members and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available. The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. The QI Program encompasses the efforts of members, family members, clinicians, behavioral health advocates, substance use treatment programs, quality improvement personnel, and other stakeholders.

The QI Program and QI Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with members and stakeholders.
- Member feedback is incorporated into the QI Program and QIWP objectives.

- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate member feedback to improve systems and services.

The QI Unit monitors the services provided for safety, effectiveness, responsiveness to members, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to members and family members are measured and analyzed on a weekly, quarterly, or annual basis. QI staff perform member record reviews and work with contracted providers on continuous improvement activities. Access times, serious incidents, and grievances are tracked and trended. Surveys are conducted to monitor member and provider satisfaction.

COSD QA Program Monitoring

The BHS Quality Assurance Unit shall monitor each organizational provider and county operated program for compliance with requirements, to assure that activities are conducted in accordance with both State and BHP standards. If the delegated entity's activities are found to be out of compliance, the BHP shall require that a corrective action plan be formulated. Progress toward change will be affected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Assurance Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Program Monitoring

A program's designated COR monitors compliance with outcome measures, productivity requirements and other performance indicators, analyzes reports from providers, and provides programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meetings to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

The Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within two (2) business days. Contractors shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Cultural Competence Requirement Monitoring

Providers are expected to provide services that are suitable for and sensitive to members' cultural, developmental, and linguistic needs. Providers are required to adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and shall implement policies and procedures to ensure that all methods utilized, and services provided are in line with this expectation. To provide appropriate and adequate services, it is vital that Providers ensure that these values are ingrained in the structural and daily practices of their organization. The County of San Diego's QA Unit and CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the *County's Cultural Competence Plan* and with State and Federal requirements.

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QA in writing if any of the following changes occur:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS & MIS); or
- Proposed change in Program Manager, Head of Service, or Medical Director.

Quality Review Committee (QRC)

The Quality Review Committee (QRC), mandated by State regulation, is a collaborative group that is chaired by the BHP Clinical Director and consists of BHP stakeholders including members and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss, and make recommendations regarding quality improvement issues that affect the delivery of services through the BHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.BHS@sdcounty.ca.gov.

Program Integrity- Service Verification

San Diego County Behavioral Health Services (SDCBHS) established Program Integrity (PI) procedures to prevent fraud, waste, and abuse in the delivery, claiming and reimbursement of behavioral health services. County and Contracted Programs shall develop a process of verifying that paid claims were provided to beneficiaries and that services meet criteria for access to SMHS and the services were medically necessary. Programs shall complete service verification as outlined in their P&P. County and Contracted Programs are expected to conduct regular PI activities and maintain records for audit purposes. If discrepancies are found during the service verification process, the program will complete the require reporting and corrections as outlined in their P&P.

Paid Claims Verification - Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County requires that each program develop a P & P on Paid Claims Verification – which is how programs will verify whether services reimbursed by Drug Medi-Cal were actually provided to members. Programs must submit their Policy and Procedure for Paid Service Verification to BHS QA. These are filed to help assist with monitoring activities.

Program Integrity includes:

- Accurate eligibility determination
- Services provided are medically necessary and appropriate
- New/current providers are not on the excluded provider list(s)
- Verify with the member that services reimbursed by Medi-Cal were received by member
- Immediate and corrective actions upon discovery that services claimed by Medi-Cal were not received by members

Service verification activity documents may include:

- Service reports from the EHR
- Verification letters with member signature
- Sign in sheets
- Signature logs
- Call logs with attestation

PI activities will be monitored by QA at a minimum annually during site and Quality Assurance Program Reviews (QAPRs). QA tracks and monitors results of Quality Assurance Program Reviews and may require a program to develop a Quality Improvement Plan (QIP) to address specific documentation concerns. Questions regarding PI can be directed to QI Matters at QIMatters.BHS@sdcounty.ca.gov.

Program Integrity Process

It is recommended that programs have an Internal Compliance Program that is commensurate with the size and scope of their agency. Contractors with more than $250,000 annually in agreements with the County must have a Compliance Program that meets the 42 CFR guidelines:

- Development of a Code of Conduct and Compliance Standards
- Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program
- Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise grievances and concerns about compliance issues without fear of retribution
- Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.
- Development and monitoring of Auditing Systems to detect and prevent compliance issues
- Creation of Discipline Processes to enforce the program
- Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.
- All Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards:
    - Staff shall have proper credentials, experience, and expertise to provide member services.
    - Staff shall document member encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures.

  - Staff shall bill services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

- All programs shall have processes for:

  - Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality of care, services, or billing

  - Staff to act promptly to correct problems if errors in claims or billing is discovered.

Program Integrity Monitoring

Programs are expected to conduct their own regular program integrity activities and to maintain records for QA audit purposes. The BHS QA team will run reports on random samples of members, comparing billing entered to supporting documentation in the system. This will help to identify any potential issues (such as data entry errors, any obvious discrepancies between LOC documentation and services provided, etc.) so that the QA team will be able to provide ongoing technical assistance to programs. The BHS QA team will provide tip sheets for programs to run regular SmartCare reports to help with their own internal monitoring processes.

Program Reporting of Fraud, Waste and Abuse

- Concerns about ethical, legal, and billing issues, (or of suspected incidents of fraud, waste and/or abuse) should be reported directly to your program COR immediately, as well as the QA team at QIMatters.BHS@sdcounty.ca.gov.

  - If there are related complaints that wish to remain anonymous, providers may contact Business Assurance & Compliance (BAC) at (619) 237-8571 or email Compliance.HHSA@sdcounty.ca.gov

- In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit.

- Reporting can be done by phone (1-800-822-6222), online form (Stop Medi-Cal Fraud), email (fraud@dhcs.ca.gov) or by mail (Medi-Cal Fraud Complaint – |Intake Unit Audits and Investigations | PO Box 997413, MS 2500 | Sacramento, CA 95899-7413

Staff Signature Logs

All organizational providers are required to maintain an accurate and current staff signature log that includes all staff that document within the program's clinical records. The BHP requires that this staff signature log includes the following elements for each staff person:

- Typed name
- Signature
- Degree and/or license
- Language capability, if applicable

It is very important that the signature on the log be readily identifiable to the staff person's signature, as it appears on hard copy documents in the hybrid medical record. A staff log signature that is not readily identifiable to the staff's signature within the medical record could place the service provided at risk of disallowance.

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e., licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational provider's program location, and be made available at the request of the BHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Provider Feedback

All providers are encouraged to provide feedback regarding their interaction with the BHP by direct communication with the Program Monitor/COR, Quality Assurance Team, and MH Contract Administration Unit. Communication can occur at the contractor's request, at scheduled meetings, and through the status report narrative. QA will provide an opportunity for provider feedback via an online Provider Feedback Survey offered quarterly via a QR Link during the QA Quality Improvement Partners (QIP) Meeting. COR Site Reviews are scheduled on an ad hoc basis to ensure that programs remain in compliance with State Standards. A Pharmaceutical Review is completed annually and conducted by QA staff during the Quality Assurance Program Review (QAPR) process.

The Medical Record

The Hybrid Medical Record for each member must be maintained in a secure location, filed in the prescribed order, and retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Documentation and in-service training are offered by QA to keep providers

informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual may be obtained on the Optum Public Sector website.

Uniform Medical Record – Forms

All programs are required to utilize the forms specified in the San Diego County Behavioral Health Services *Uniform Clinical Record Manual* (UCRM), and any updated forms, issued on an interim basis. Programs may adapt forms for specific program needs upon review and approval by the Health Plan Organization Quality Assurance Unit. Each legal entity shall develop forms for legal consents and other compliance related issues. Out-of-County behavioral health programs may utilize non-San Diego County medical record forms, but they must comply with all State and Federal and requested County guidelines.

Record Maintenance

DHCS, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related services (i.e., Drug Medi-Cal) are conducted. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. County providers are required to retain all Billing Records for a minimum of ten (10) years when the program is funded with State or Federal dollars. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date for adults. For minors, records are to be kept until they have reached the age of eighteen, plus seven (7) years. [ref: MHSUDS IN 18-012; 42 CFR §425.314; 22 CCR §77143; CCR 438.3(u)]

Quality Assurance Program Reviews (QAPRs)

Quality improvement of documentation is an ongoing process shared between programs and County QA. Providers are required to conduct internal reviews of medical records on a regular basis to ensure that service documentation meets all County, State and Federal standards, and that all Short-Doyle Medi-Cal billing is substantiated. If clinical documentation does not meet documentation standards as set forth in the current California State Department of Mental Health "*Reasons for Recoupment*," the provider shall be responsible for addressing the issue by following the current error correction processes as indicated on the Optum Website "*SmartCare*" tab. Providers are responsible for re-entering the non-billable service code for services that are identified as a Medi-Cal billing disallowance and errored out.

The Health Plan Organization Quality Assurance Unit conducts program site and Quality Assurance Program Reviews (QAPRs). Site visits and Quality Assurance

Program Reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and QAPR review tool is distributed to the Program Manager prior to the scheduled review. A QA Specialist will notify the program manager of the designated audit period for the billing claims review. All billings for the designated period will be reviewed on those providers/services that are selected for review. Once the program manager has been informed of the designated billing claims period, no provider self-reports of disallowances will be processed for the program that fall within the billing period until completion of the Quality Assurance Program Review and resulting final written report by the QA Specialist. At the conclusion of each Quality Assurance Program Review, the QA Specialist will present preliminary findings of the review at an exit conference.

For additional record reviews that are conducted by entities other than the BHP [i.e., Department of Mental Health Care Services (DHCS) as part of the Behavioral Health Plan's compliance review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews the same standard will apply.

During the Quality Assurance Program Review, a Quality Assurance Specialist will review clinical records for:

- Assessment/Appropriateness of Treatment
- Access Criteria/Medical Necessity
- Diagnosis(es)
- Clinical Quality
- Problem List, evidence of Care Planning, and Member Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

Quality Improvement Plan (QIP)

Programs will be monitored for trends and patterns in any areas found out of compliance or needing improvement. If patterns or trends related to meeting documentation, billing standards, or other identified Quality of Care concerns are identified, a request for a Quality Improvement Plan (QIP) will be issued by the BHP to the provider. Determination of an additional review will be made under the direction of the QA Supervisor and may take place within thirty (30) days, sixty (60) days or some other identified period depending upon the severity of the noncompliance. After receiving the BHP's written report of findings, the provider will have a specified timeframe in which to complete and submit the QIP to the QA Unit. The QIP must describe the interventions or

processes that the provider will implement to address items that have been identified as out of compliance or that were identified as needing improvement.

When appropriate, the QIP must include all supporting documentation (i.e., copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the QIP, the program is still required to keep this documentation on file at their program. The QIP must also include identified timelines and/or dates as to when the out-of-compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a QIP may result in withholding of payment on claims for non-compliance.

Upon receipt of a QIP, the QA Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the QIP does not adequately address these items, the QA Unit may request that the QIP be re-submitted within a specified period.

QIP Three- Month Follow Up

To track progress of QIP implementation and offer technical assistance and support toward increased quality improvement efforts, the QA Unit will request a written summary from the program on the impact of the QIP on identified deficiencies. This summary will be requested approximately three (3) months after the QIP has been accepted. Details of this process will be discussed with the program during the on-site exit conference after the review.

Corrective Action Plan (CAN)

When a program's compliance issues are not improving as detailed in the program's written QIP, QA may request that the Program COR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program's QIP actions, and a statement about insufficient improvement having been made. QA may recommend identified interventions or process changes to be implemented. If a CAN is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non-compliance and could result in putting the contract at risk.

For billing disallowances or service corrections identified in the Review, programs will be required to submit evidence of correction as delineated in the medical record review protocol for that fiscal year as part of their QIP. Programs are responsible to follow-up on

any pending corrections at QA Specialist direction. If there are additional billing concerns, the QA Specialist may conduct another medical record review prior to the next fiscal year.

Providers shall ensure that the services listed on the *Payment Recovery Form* as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed. The Payment Recovery Form is located on the Optum website > "*Billing*" tab.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term quality improvement project includes a commitment to improving quality through problem identification, evaluating interventions, and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices". The External Quality Review Organization (EQRO), contracted by the State, evaluates progress on each PIP annually.

- The BHP may ask for your involvement in the PIP by:
    - Implementing current PIP interventions/activities/procedures at your programs
    - Supporting survey administration and/or focus group coordination at your programs
    - Developing your own program's PIP projects

Medication Monitoring Reporting

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. Out of County Providers shall adhere to their own County's Medication Monitoring process. Current State Department of Health Care Services (DHCS) requirements for Medication Monitoring are set forth in CCR, Title 9, Chapter 11, Section 1810.440; BHP Contract with DHCS, Exhibit A, Attachment 5, 1.H. The primary purpose of medication monitoring is to ensure the most effective treatment.

Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects

- Evidence of informed consent for use of psychotropic medication within prescriber documentation in the medical record
- Member adherence with prescribed medication and usage
- Member medication education and degree of member knowledge regarding management of medications.
- Adherence to state laws and guidelines

Within the BHS system of care, programs are required to review one percent (1%) of their active medication caseload each quarter, with a minimum of one chart reviewed. Closed cases, cases in which the member has not returned for recent services and members that are not receiving medication are not to be reviewed. The sample shall include representation from all psychiatrists and/or nurse practitioners who prescribe.

The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The Medication Monitoring Committee may be comprised of two or more representatives from different disciplines but at least one of the members must be a psychiatrist or pharmacist. Psychiatrists may not review their own prescribing practices. It is the programs responsibility to assure that there is another psychiatrist to review the charts.

As of FY 24-25, the Clinical Director of Behavioral Health Services has advised that Nurse Practitioners (NPs) who fully qualify for the 103 path may be permitted to review other qualified NPs in the quarterly Medication Monitoring process. 103 NP Eligibility is outlined in Assembly Bill 890 (ca.gov) . This provision does not currently extend to Physician's Assistants (PAs).

Contracted providers and County clinics are required to perform the first-level screening of medication monitoring for their facility. Programs will use the Medication Monitoring Report, Medication Monitoring Screening tool (either Adult or Children's), and the Medication Monitoring Feedback Loop (McFloop) for their screening If a variance is found in medication practices, a McFloop form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval.

QA Medication Monitoring tools for the Systems of Care are located on the Optum Website > *Monitoring* tab.

Send the following forms via secure email QIMatters.BHS@sdcounty.ca.gov or fax (619) 236-1953 to QA:

- Medication Monitoring Submission Form (Via SmartSheet)
- Medication Monitoring Screening Tool (either for Child/Youth or Adult programs)
- Medication Monitoring Feedback Loop (McFloop)

Results of medication monitoring activities are reported quarterly to the QA unit by the fifteenth (15th) of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15.

Report Instructions: Variances are totaled by type of variance. For example, if you reviewed ten (10) charts, and one chart had a variance for variance #2b, then a "1" would be entered in the *variance 2b* box. If three charts had a variance for variance #6, then a "3" would be entered in *variance 6* box.

All programs shall have a procedure in place to ensure the following:

- Evidence that the prescriber has reviewed and obtained informed consent from the member is documented within the medical record.

- Labs are ordered and those results are returned in a timely manner. Programs shall ensure that lab results have been reviewed and filed in the hybrid record in a timely manner.

- Ensure there is sufficient follow up with members/family members in keeping their appointments for labs.

QA monitors the compliance of each program's medication monitoring practices. By completing the submission Quarterly, QA can monitor compliance during quarterly desk reviews and therefore not require the documents to be reviewed during the annual Quality Assurance Program Review process. The assigned QA Specialist reviews the quarterly medication monitoring report, screening tools and McFloops for any identified variances and corrective actions taken. Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement and a QIP may be required.

A second level review by the QA Medication Monitoring Oversight Committee (MMOC), working in collaboration with the Medical Director(s) may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional corrective action will be determined by the MMOC and Medical Director(s).

Monitoring Psychotropic Medications

The following recommendations are not intended to interfere with or replace clinical judgment of the clinician when assessing members on psychotropic medications. Rather, they are intended to provide guidelines and to assist clinicians with decisions in providing high quality care, ensuring that members receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

Informed Consent

Per BHS Notice on 09/12/2023, California Senate Bill (SB) 184 updated and superseded state regulations (Cal. Code Regs. Tit. 9, § 852) that required mental health facilities to obtain patient signatures to demonstrate informed consent for antipsychotic medications delivered in specified community mental health settings. (Reference: WIC § 5325.3).

Instead, facilities must maintain written consent records that contain **both** of the following:

1. A notation that information about informed consent to antipsychotic medications has been discussed with the member; **and**

2. A notation that the member understands the nature and effects of antipsychotic medications, and consents to the administration of those medications.

The minimum requirement going forward is to include the above notations within the medical record progress note(s) when prescribing, adding or adjusting antipsychotic or psychotropic medications. Providers may choose to continue using the *Informed Consent for Psychotropic Medications* form to document that they have reviewed consent and the nature and effects of antipsychotic or psychotropic medications however, use of this form is not monitored as part of the medical record review and member signature is not a requirement. SB184 does not supersede JV-220 requirements for dependent youth or youth in an out-of-home placement.

Antipsychotic Medications

Typical Antipsychotics: also know known as First Generation Antipsychotics: such as chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), perphenazine (Trilafon), prochlorperazine (Compazine), thiothixene (Navane), thioridazine (Mellaril), and trifluoperazine (Stelazine).

Atypical Antipsychotics: also known as Second Generation Antipsychotics: aripiprazole (Abilify), asenapine (Saphris), clozapine (Clozaril), iloperidone (Fanapt), lurasidone (Latuda), olanzapine (Zyprexa), paliperidone (Invega), quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon) and any derivatives of these medications (i.e. long acting injectable formulations, extended release formulation, etc.)

Drug Formulary for Mental Health Services

All contracted provider programs and physicians shall adopt the Medi-Cal Formulary as the San Diego County Behavioral Health Services (BHS) formulary. All members, regardless of funding, must receive appropriate and adequate levels of care at

all MHS programs. This includes the medications prescribed. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

- The likelihood of efficacy, based on clinical experience and evidence-based practice
- Member preference
- The likelihood of adequate compliance with the medication regime
- Minimal risks from medication side-effects and drug interactions

If two (2) or more medications are equal in their satisfaction of the four (4) criteria, choose the medication available to the member and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication, or the side-effect profile favors the brand name medication. Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary. County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible members. There shall be an appeal process for TARs that are not accepted.

Clinical Advisory for Monitoring Antipsychotic Medications

- Ordering labs and monitoring should be tailored to each member. Members may require more or less monitoring than these recommendations.
- All antipsychotic medications carry a Black box warning for increased risk of mortality for older adult members with dementia-related psychosis.
- Geriatric members may require more frequent monitoring due to changes in metabolism and renal function.
- Obtain baseline assessment for Tardive Dyskinesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every six (6) months.

- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.

- Avoid using ziprasidone (Geodon), haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine) in members with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic members on diuretics or having diarrhea which may alter electrolytes.

- All members should be assessed for cardiovascular disease before initiating antipsychotic therapy.

- Refer to Clozapine REMS Program for monitoring Clozaril.

- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.

- Fasting blood glucose is preferred, but HbA_{1c} is acceptable if fasting glucose test is not feasible.

- Neutropenia uncommonly occurs in members taking antipsychotic medications. It is recommended to obtain baseline Complete Blood Count and annually.

- Members with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Naloxone for Risk of Overdose

Effective January 1, 2019, prescribers are required to offer a prescription for naloxone hydrochloride or similar drug to members and/or family when the member is at risk for overdose (because member is taking ninety (90) mm/day or more; member risk is increased due to prior high dose with no tolerance now or prior overdose; or member is concurrently prescribed an opioid and a benzodiazepine).

As of September 5, 2019, the risk factor related to opioids and benzodiazepine only applies when prescribing an opioid within a year from the date a prescription for

benzodiazepine has been dispensed to the member. AB 714 also added member history of opioid use disorder (OUD) to the list of risk factors for overdose.

Monitoring Controlled Substance Prescriptions

For the past number of years, abuse of prescription drugs has become increasingly prevalent. In September 2016, Senate Bill 482 pertaining to controlled substances and the CURES database was enacted. As of July 1, 2021, this law requires a health care practitioner to consult the CURES database to review a member's-controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every six (6) months thereafter, if the prescribed controlled substance remains part of the member's treatment, with specified exemptions. Additionally, this law requires reporting the dispensing of Schedule V drugs. This requirement applies to pharmacists and prescribers who dispense controlled substances.

Starting January 1, 2021, the dispensing of a controlled substance must be reported to the Controlled Substance Utilization Review and Evaluation System (CURES) within one working day after the medication is released to the patient or the member's representative. (Previously, the deadline to report was seven days after dispensing.) The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

Psychotropic Medication in Youth

There are continued active legislative changes around the use/monitoring of psychotropic medication in youth. The County of San Diego has and will continue to disseminate information about legislative changes to the Children's System of Care.

In 2018, Department of Health Care Services published "*California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care*. These guidelines target youth involved in county child welfare and probation agencies and is specific to those children and youth who are placed in foster care. Prescribers should be familiar with the linked document as this shall serve as the guideline for provision of care locally.

The *California Guidelines* document also includes reference to the Los Angeles "*Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents*" (Rev. 03.15.2023) DHCS has recognized this living document as the guideline for provision of psychotropic medication. County of San Diego prescribers should be familiar with this linked document as this shall serve as the guideline for provision of care locally.

Foster Care is defined as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has

placement care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. County of San Diego prescribers should be familiar with the CA Guidelines as they shall serve as the guideline for provision of care locally to all youth.

The Department of Social Services (CDSS), in collaboration with stakeholders, developed measures to track youth in foster care who received a paid claim for psychotropic medication from the California Department of Health Care Services. These measures will be publicly posted with a goal of improving the health and well-being of youth in care. Those measures include select Healthcare Effectiveness Data and Information Set (HEDIS) measures and Child Welfare Psychotropic Medication Measures. County of San Diego providers shall be familiar with these measures as they shall serve as the guideline for provision of care locally to all youth.

Storage, Assisting with Self Administration, and Disposal of Medications

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer medications. These licensed personnel include physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, and licensed psychiatric technicians. In instances where members must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

1. Storage of Medications

    - The member's parent/guardian shall bring in the prescribed medication, which is packaged and labeled in compliance with State and Federal laws.

    - All medications shall be stored in a locked, controlled, and secure storage area. Access to the storage area shall be limited to authorized personnel only.

    - The storage area shall be orderly, well-lit, and sanitary. It shall have the proper temperature, light, moisture, ventilation, and segregation that are required by Federal, State and County laws, rules, and regulations.

    - All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2. Assisting in the Self Administration

    - Careful staff supervision of the self-administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for member to self-administer.

- Staff shall record the self-administration of all medications on the "*Medication Dispensing Log",* located: Optum Website > *Forms* tab

3. Disposal of Medications

- Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal or dispose of medications by placing them in biohazard sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include Stericycle 1 (866) 783-9816 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing them in the trash are both prohibited under environmental and safety regulations.

- Disposal shall be documented and co-signed on the "*Medication Disposal Log*"**.**

"Medication Only" Services for Adult/ Older Adult and Children/ Youth Programs

Adult and Child/Youth members who have never had an open assignment in the program receiving the referral should not be opened as "medication-only" without previous approval from the Contracting Officer's Representative (COR).

When the member has a therapist in a different program, the program shall be contacted for justification to why the needed medications are no longer needed.

In the event that: Service goals had been met, Utilization Management (UM) Committee has denied further treatment or In the opinion of the therapist, member, and caregiver, a break in psychotherapy treatment is appropriate, the member shall be assessed for the need for ongoing medication support by the receiving program's staff psychiatrist. clear documentation should be provided in the member's medical record.

When the decision is to continue the case as medication-only, within the same program, the case shall remain open, but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the HER, the name of the server should be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization management requirements.

Documentation: Documentation for a medication only case shall include: a complete and up to date Mental Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow-up medication management session), and an active *Client Clinical Problem List*. Medication only cases are exempt from completion of outcome measures.

Billing: Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. If case management or formal assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

Utilization Management: Medication-only cases are not subject to UM, but cases open in this status for twelve (12) months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:

1. Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.

2. Whether a return to active psychotherapy is indicated.

Reinstating medication services: If a member who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the member's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UM authorization is in place. When authorization is in place, therapy may resume, however a new *Client Clinical Problem List* is indicated. When authorization has expired, the UM Committee must first authorize services for billing of therapy to resume. In theEHR the name of the server shall be updated to reflect the name of the current clinician.

Considerations for Children/Youth Members

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youths may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server.

The BHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children

and youth who are receiving only medication support and have no therapist or case manager involved. Such cases are not subject to utilization management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only member must have rapid access to a resumption of therapy if a need should arise.

Incident Reporting (IRs)

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), member or community shall be reported to the BHS Health Plan Organization Quality Assurance Unit. There are two types of reportable incidents: 1.) Critical Incidents are reported to the BHS QA Unit and 2) Non-Critical Incidents which are reported via an online submission form that report directly to the program's Contracting Officer Representative (COR) and reviewed by the Quality Assurance Unit.

All providers are required to report critical incidents involving members in active treatment or whose discharge from services has been thirty (30) days or less. Required reports shall be sent to the QA Unit who will review, investigate as necessary, and monitor trends. The QA team will communicate with program's COR and BHS Management. The provider shall also be responsible for reporting critical incidents to the appropriate authorities, when warranted.

QI Matters email: QIMatters.BHS@sdcounty.ca.gov
QA Critical Incident fax number: 619-236-1953

Incident Report Trainings

Webinars are now available on the Optum website > *Incident Reporting* tab for all aspects of the Incident Reporting process. There are two separate, self-paced webinars available: the "CIR and NCIR Webinar" and "ROF and RCA Webinar". All new staff are highly encouraged to view these trainings prior to submitting any incident reports. Tip sheets are also available in the same location for CIRs, NCIRs and ROFs.

Critical Incidents

A "Critical Incident" is the most severe type. Counties are required to implement procedures for reporting incidents related to health and safety issues and develop mechanisms to monitor appropriate and timely interventions of incidents that raise quality of care concerns. Critical Incident categories are related to significant clinical health, safety, and risk concerns.

Critical Incidents are categorized as the following:

- Death/Pending (Pending CME investigation): Member death in which the actual reason for death is not yet confirmed. The subsequent 'Confirmed' reasons for member death should only be chosen when the actual reason for death is known by the Program.

- Death (Non- BHS Client)- Please note that a "non-BHS client" is defined as the following: Non-BHS Contracted members are members that do not meet the County target population / are not funded by Contracted programs (i.e. private pay, cash pay, members who do not qualify for Medi-Cal and members with Other Health Coverage (OHC) who do not qualify for Medi-Cal).

- Death/Natural Causes (Confirmed): CIRs are not required for deaths that are a natural occurrence. Instead, the program shall maintain a Natural Death Log that QA will review during the Medi-Cal recertification site visit. **However**, if a death that is a natural occurrence happens on a program's premises an CIR is required. Deaths **must** be reported to both the COSD HIM Department at: HIMDept.HHSA@sdcounty.ca.gov via the BHS 025 Form and the County MEDS Coordinator at: 37Crdnt.HHSA@sdcounty.ca.gov including: Member Name, Social Security Number, Date of Birth and Date of Death.

- Death/Overdose (Confirmed)

- Death/Suicide (Confirmed)

- Death/Homicide (Confirmed)

- Suicide Attempt

- Non-Fatal Overdose: For Critical Incidents related to an overdose by an opioid or alcohol, the member must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the member is not already receiving MAT services. Information on MAT programs can be accessed through the Provider Directory on the Optum website or by calling the Access and Crisis Line

- Medication Error: Error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Alleged abuse/inappropriate behavior by staff: Serious allegations of or confirmed inappropriate staff (including volunteers, interns) behavior such as sexual relations with a member, client/staff boundary issues, financial exploitation of a member, and/or physical or verbal abuse of a member. Effective 1/1/20, a healthcare facility,

health plan, or other entity that grants privileges or employs a healthcare professional must, **within fifteen (15) days** of receiving a written allegation of sexual abuse or sexual misconduct (inappropriate contact or communication of a sexual nature) against one of its healthcare providers, file a report with that professional's licensing board.

- Injurious assault by a client resulting in hospitalization

- Critical Injury on site (MH/SUD related): Defined as an injury to a member where the injury is directly related to the member's mental health or substance use functioning and/or symptoms. Critical injury means any injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ, or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention, including but not limited to hospitalization, surgery, transportation via ambulance, or physical rehabilitation. Any injury not falling in these categories and/or not related to the member's mental health or substance use symptoms would be reported under the *Non-Critical Incident* process.

- Adverse Media/Social Media Incident (only; no leading incident)

Any incident that does not fall within these categories will be reported as a "*Non-Critical Incident".* The QA Unit shall monitor critical incidents and issue reports to the Quality Review Committee and other identified stakeholders as indicated. After reviewing the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan.

Critical Incident Reporting

The Critical Incident Report must be submitted to the QA Unit within twenty-four (24) hours of knowledge of the incident completed in full. This can be sent to the QIMatters.BHS@sdcounty.ca.gov inbox via secure email or faxed to the secure QA fax at **619-236-1953**. The *Critical Incident report form* can be found on the Optum website> *Incident Reporting* tab. Additionally, consultation can be requested by contacting QI Matters.

IR Timelines: All providers are required to report critical incidents involving members in active treatment or whose discharge from services has been thirty (30) days or less. A Critical Incident Report must be sent to QA **no later than twenty-four (24) hours** from program notification of the incident.

Confidentiality: In the event of a critical incident, the program manager or designee will immediately safeguard the member's medical record. The program manager shall review the chart as soon as possible. The member's medical record shall not be

accessed by unauthorized staff not involved in the incident. All program staff will maintain confidentiality about member and the critical incident. The critical incident should not be the subject of casual conversation among staff. A CIR is never to be filed in the member's medical record. A Critical Incident Report shall be kept in a separate secured confidential file.

Multiple Program Assignments: In instances where an ROF is required for a Critical Incident and there are multiple program assignments, an ROF will be required for the primary client assignment and/or the Program where the critical incident took place. The primary assignment may be viewed in the EHR if the permissions have been granted. Any other program assignments submitting a CIR for the same incident may require an ROF per QA or COR request.

Critical Incident Reporting on Weekends and Holidays

Critical Incidents are required reporting for Legal Entity (LE) behavioral health programs on weekends and holidays to the QA Unit and Designated County Staff. This requirement does not apply to Non-Critical incidents. Follow the procedure below for reporting a **Critical Incident** on Weekends and Holidays:

1. Submit the notification to QI Matters as soon as possible from awareness of the incident occurrence.

2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report Critical incidents on weekends and holidays. This LE designated staff will report the Critical Incident to the County Designated Staff by calling and/or leaving a message with all required information including their call back number. Each LE will be provided with a list of contact phone numbers of County Designated Staff.

3. Program staff should only be reporting the Critical Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.

4. Report Critical Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Critical Incident that occurs outside of reporting hours, then report the Critical Incident on the next or same day during reporting hours. This requirement is only for Critical Incidents.

5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.

LPS & IR Reporting

LPS regulations indicate that certain LPS facilities are required to notify DHCS serious incidents (referred to as "Unusual Occurrences" within regulations) occurring within a CSU or Jail psychiatric units. CIR, NCIR, and ROF submission forms now include a checkbox for LPS-designated facilities. For specific reportable situations, please reference the Inpatient Operations Manual on the Optum website> *Manuals* tab.

Report of Findings

All critical incidents shall be investigated and reviewed by the program. Programs have been informed that they should NOT submit the ROF prior to receiving the CME report. The program shall submit a complete Report of Findings to QA within thirty (30) days of knowledge of the incident. In the case of a member death, there is an exception to the Report of Findings report being due to QA within thirty (30) days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

CME Reports

The CME report is the County Medical Examiner's Report. It provides the final cause of death determination and is required for serious incidents involving death of a client. In addition to notifying the HIMS department and the County MEDS Coordinator programs should request the CME report from the medical examiner's office. Programs will need a copy to complete the ROF / RCA (if applicable). If the CME report indicates that the manner of death was suicide, programs must complete an RCA. To request the CME report, email the County Medical Examiner's Office at: Records.MX@sdcounty.ca.gov requesting the CME report and provide the following information: Name of Program, Name of client, DOB, Date of Incident. Programs will receive a confirmation email from the CME office that the request has been received.

Root Cause Analysis (RCA)

A critical incident that results in: 1) a completed suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QA Unit and require the completion of a Root Cause Analysis (RCA) within thirty (30) days of knowledge of the incident.

San Diego County Contracted programs may use the *Critical Incident RCA Worksheet* or some other process that is approved by their Legal Entity. It is recommended that programs not choosing to use the Critical Incident RCA Worksheet ensure that the process they do use incorporates best practices for their analysis of findings. Technical

assistance is available by request through QIMatters.BHS@sdcounty.ca.gov. RCA training is offered quarterly.

In instances where the RCA is required for a Critical Incident where a member has multiple program assignments, the RCA will only be required for the primary assignment and/or the program where the critical incident requiring the RCA took place. An RCA for any other assignments may be requested by QA or your COR as clinically indicated. The primary assignment may be viewed in the EHR if the permissions have been granted. The Action Items of the RCA shall be summarized and submitted to the QA unit within thirty (30) days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a completed suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect member care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for medical records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QA Chief, Program Managers, County or Contractor QA staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QA Unit by contacting QIMatters.BHS@sdcounty.ca.gov. The *Critical Incident RCA Worksheet* is required for San Diego County operated programs per current HHSA/MHS requirements.

Non- Critical Incidents (N-CIRs)

A Non-Critical Incident is reported directly to your COR/Program Manager and to QA via an online submission form within twenty-four (24) hours of knowledge of the incident. A Non-Critical Incident is defined as an adverse incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), member or community that does not meet the criteria of a critical incident. Any incident that represents “adverse deviation from usual program processes for providing behavioral health care” and not falling into the Critical Incident categories will be considered a Non-Critical Incident.

A program may be asked at any time to complete a Report of Findings for a Non-Critical Incident by the program COR or Quality Assurance Unit.

Non-Critical Incidents may include but are not limited to:

- AWOL
- Contract/Policy violations by staff (unethical behavior)
- Loss or theft of medication from the Facility
- Physical Restraints (prone/supine): Reported only during program operating hours (applies only to Children, Youth & Families mental health clients during program operating hours and excludes SUD programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, CYCSU and PERT). If use of physical restraints leads to member injury, this would be reported as a Critical Incident
- Tarasoffs: Tarasoff incidents will no longer fall under Critical Incidents and will be reported via the online submission form as a Non-Critical Incident. Tarasoff do not require a ROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or member-related treatment issue.
- Non-Critical Injury onsite- injuries that require medical treatment greater than first aid and which occur on program premises.
- Adverse Police/PERT Involvement onsite: Any incident involving Police/PERT, including but not limited to arrests on program site, use of restraints of members, and any notable "adverse deviations" from program processes related to PERT/police engagement will require an N-CIR report.
- Property destruction onsite
- Other: Epidemic, other infectious disease outbreak, and poisoning will be reported under the Non-Critical Incident Reporting process utilizing the "Other" incident category.

Non-Critical Incident Reporting

- N-CIR Timelines: All providers are required to report non-critical incidents involving members in active treatment or whose discharge from services has been thirty (30) days or less.
- Non-Critical Incidents are reported via and online submission form that can be found and on the Optum Website> "*Incident Reporting*" tab.

1. Complete the submission via the online form within twenty- four (24) hours of program knowledge of the incident and complete the form in its entirety.

2. Do **NOT** include PHI within the online submission form—This includes member first and last names, EHR numbers, or any other Protected Health Information.

3. Ensure correct spelling for CORs email information as this will be submitted to them directly through the application, non-submission based on incorrect contact or spelling information will not be tolerated.

- Please review the Non-Critical FAQ/Tip Sheet posted on Optum for additional information for submission of Non-Critical Incidents and completion of the form.

Consultation may be requested by emailing QIMatters.BHS@sdcounty.ca.gov. If an incident is submitted as a Non-Critical Incident that meets criteria for a Critical Incident, your program will be contacted by your COR or QA staff, and the appropriate submission must occur.

Safety and Security Notifications to Appropriate Agencies

When a Non-Critical Incident occurs or is identified, the appropriate agencies shall be notified within their specified timeline and format:

1. Child and Elder Abuse Reporting hotlines.

2. Tarasoff reporting to intended victim and law enforcement

3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.

4. Every fire or explosion that occurs in or on the premises shall be reported within twenty- four (24) hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Children, Youth and Family: Additional Reporting

Children, Youth & Families providers shall notify other outside agencies who serve the member upon consideration of clinical, health and safety issues. Notification should be timely and within twenty- four (24) hours of knowledge of the incident. The required agencies include but are not limited to:

- Children Family Well-Being Services (CFWB)
- Probation Officer
- Regional Center
- School District

- Therapeutic Behavioral Services (TBS) –County and Contractor
- Other programs that also serve the member

Reportable issues may include:

- Health and safety issues
- A school suspension
- A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
- A referral for acute psychiatric hospital care
- An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
- A significant problem arising while TBS worker is with the child

H. Cultural Competency

Cultural Competence involves recognizing that culture impacts our relationships and interactions in ways that may be subconscious or outside our awareness. It is a continual growth process that involves self-awareness, knowledge, skills, advocacy, and the examination of all those factors within a larger context. Recognizing the complex nature of personal identity, how we manage multiple identities, and how the intersection of our experience can be a powerful tool for healing and change helps those providing services within San Diego County Behavioral Health Services (SDCBHS) provide more culturally relevant and responsive care to the people being served.

Another focus that SDCBHS has incorporated is cultural humility to further support the progress toward reducing disparities in mental health services and the Cultural Competence Plan. The term is based on the idea that we must be open to the identities and experiences of others as a primary way of being in the world through a lifelong commitment to self-evaluation, a desire to fix power imbalances, and a willingness to develop partnerships with people and groups who advocate for others.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the Behavioral Health Plan (BHP) and its contracted mental health care providers. The latest estimates for San Diego County from 2023 show that the overall population estimate of the County increased by 0.45% compared to the 2023 estimate. According to the San Diego Association of Governments *SANDAG Demographic and Socio-Economic Estimates, 2024 Estimates, San Diego Region,* 41,7% of the population identified as White, 35.8% as Hispanic, 4.2% as Black, 0.4% as Native American, 12.5% as Asian, 0.40% as Pacific Islander, and 5.0% as "Two or more".

SDCBHS continuously monitors its progress toward reducing disparities and identifies gaps between the demand for and the availability of services. To understand the needs of the County mental health population, SDCBHS and the University of California, San Diego (UCSD) Research Centers analyze service disparities on a triennial basis in a report titled *Progress Towards Reducing Disparities in Mental Health Services*.

The most recent report covers three time points spanning across 8 years (Fiscal Years 2009-10, 2012-13, and 2015-16). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which is used to supplement the State required information. These existing reports and planning structure will assist BHS in establishing a broader county and regional planning process to support all contractual funding requirements. The report has since been reimagined as the *Community Experience Partnership*, with a set of

dashboards that allow flexible queries regarding health equity information that will provide timely, accessible, and actionable data for system policy development and decision making. With the County's renewed commitment to client-centered care, these tools will provide support for initiatives that focus on the member's specific long-term needs and community level services.

Community Experience Partnership

The Community Experience Partnership (CEP) is a joint initiative between San Diego County Behavioral Health Services (BHS) and UC San Diego. The vision of the CEP is the integration of data and community engagement to promote behavioral health equity in San Diego County. The mission of the CEP is to promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans. The goal of the CEP is the integration of data and community engagement to promote behavioral health equity in San Diego County. The CEP allows the public to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Data sources include surveys, vital records, hospitalization and emergency department data, and service and outcome data for individuals served by the Behavioral Health Services system. Users can explore indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the members' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Cultural Competence Training Opportunities through the BHP: Cultural competence trainings are available through some of SDCBHS's larger contractors. SDCBHS contracted trainings and trainings via the Learning Management System (LMS) are available through the BHS Workforce Education and Training Website, and Cultural Competency trainings are offered through Academy of Professional Excellence (APEX). Specific training for the Cultural Competency Academy is available through the Academy for Professional Excellence for BHS and BHS Contractors at no cost.

Cultural Competence Monitoring and Evaluation: The BHP CORs are responsible for monitoring and evaluating compliance with cultural competence standards to align with the State and Federal requirements. The QA Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement.

Cultural Competence Training Requirements

A m*inimum of four (4) hours of cultural competence training annually:* Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with members or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of the annual minimum four (4) hours of training shall be maintained in the Monthly/Quarterly Status Report.

The following conditions also apply:

a. All new staff have one year to complete the four (4) hours of cultural competence training.

b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement “a”.

c. Volunteers, Temporary Expert Professionals (TEP), Retire-Rehires, Certified Temporary Appointments, and Student Workers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

d. All staff billing to Medi-Cal need to review, update, and attest monthly to Cultural Competency (CC) training completion in the SOC Application.

National Culturally and Linguistically Appropriate Services (CLAS) Standards: The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The Standards are as follows:

- Principal Standard**:** 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.

- Governance, Leadership, and Workforce: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to

the population in the service area. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

- Communication and Language Assistance: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

- Engagement, Continuous Improvement, and Accountability**:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Plan

SDCBHS has a long-term commitment to creating and maintaining a culturally relevant and culturally responsive system of care and incorporating the recognition and value of racial, ethnic, and cultural diversity within its system since 1997 in its first Cultural Competence Plan. As of FY 2026-27, the Cultural Competence Plan is no longer required and this requirement has been replaced with the BHSA Implementation Plan as of this fiscal year. Previously, the Cultural Competence Plan summarized SDCBHS's present activities and initiatives. It included information on the eight criteria set by the State as indicators of cultural competence.

CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages

12-13) on the Technical Resource Library (TRL) website. New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan. Plans should be sent via email to their COR and BHS-HPA.HHSA@sdcounty.ca.gov.

The CC Plan Component Guidelines are as follows:

- Current Status of Program
    - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
    - Identify how program administration prioritizes cultural competence in the delivery of services.
    - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
    - Goals accomplished regarding reducing health care disparities.
    - Identify barriers to quality improvement.
- Service Assessment Update and Data Analysis
    - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
    - Comparison of staff to diversity in community.
    - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to member/target population needs.
    - Use of interpreter services.
    - Service utilization by ethnicity, race, language usage, and cultural groups.
    - Member outcomes are meaningful to members' social ecological needs.
- Objectives
    - Goals for improvements.

- Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
- Trauma-informed principles and concepts integrated
- Faith-based services

Program Level Requirements

Culturally and Linguistically Appropriate Services (CLAS) Standards: The CLAS Standards offer a strong framework to provide culturally and linguistically appropriate services. Programs are required to adhere to the CLAS Standards and ensure annual evaluation of programs are conducted in the context of CLAS Standards. San Diego County Behavioral Health Services recommends utilizing the Implementation Checklist for the National CLAS Standards to ensure CLAS Standards are met. The Checklist has listed successful CLAS-related organizational activities that were observed across organizations. A CLAS action worksheet is provided to be used to plan CLAS activities in your setting. The checklist can be found at the following link: An Implementation Checklist for the National CLAS Standards (hhs.gov). Additionally, programs may elect to utilize any of the assessment tools available in the Cultural Competence Handbook as deemed appropriate to evaluate cultural and linguistic competence and ensure CLAS Standards are met.

Cultural Competence Training: Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with members, or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. A record of training shall be maintained in the Monthly/Quarterly Status Report. Please reference *Section O* for more information.

Transgender, Gender Diverse, or Intersex (TGI) Training: On May 12, 2025, the Department of Healthcare Services (DHCS) released the final Behavioral Health Information Notice (BHIN) 25-019 which requires staff who are in direct contact with services recipients to complete an evidenced-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse or intersex (TGI). TGI training is offered in two training formats:

- Live virtual training titled “Culturally Responsive Behavioral Health Care with Trans and Nonbinary People”
- On-demand webinar titled “Culturally Responsive Behavioral Health Care with Trans and Non-binary People” Course Code: CRABHS-Trans_webinar4

Access to these trainings can be found on the BHS workforce training website under

Professional Trainings.

System of Care (SOC) Application Attestations: All staff billing to Medi-Cal need to review, update, and attest monthly to Cultural Competency (CC) training completion in the SOC Application. This includes staff serving in either direct or indirect roles, meaning that if a staff's NPI is used for Medi-Cal billing, they are expected to attest to the accuracy of their information in the SOC Application, including cultural competency training completion. To help ensure information remains accurate, Staff and Program Managers should regularly review their SOC Application information, including CC training completion, and complete the required monthly attestation. More information on the SOC Attestation can be found at the following link: SOC Tips and Resources.

***Member Preference – Cultural/Ethnic Requirements**:* Members must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the members, members have the right to request a change of providers. Requests for transfers are to be tracked via the *Suggestion and Transfer* section attached to the Quarterly Status Report.

***Member Preference – Language Requirements**:* Services should be provided in the member's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. A member may choose to use a family member or friend as an interpreter, but there shall not be the expectation that family members provide interpreter services, including the use of minor children. The offer of interpreter services and the member's response must be documented. Service notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the member, members must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers. All County and Contracted providers must at a minimum be able to link members with appropriate services that meet the member's language needs regardless of whether or not the language is a threshold language.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on the CC Handbook on TRL.

- Conduct a survey or member focus group every couple of years and include members who are bi-lingual and monolingual to assess program and staff cultural

competence, community needs and the success of efforts the program is making to meet those needs. Surveys and discussion questions are available in the CC Handbook on TRL.

I. Staff Qualifications & Supervision

Providers are responsible for ensuring that all staff meets the requirements of Federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct member care and billing for treatment services. The provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

The requirement for credentialing is outlined in the California Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 18-019 (Final Rule: Credentialing), established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214. The credentialing process is one component of the comprehensive quality improvement system included in all Behavioral Health Plan (BHP) contracts and is a required condition for participation in the County's provider network and for reimbursement. Services must be provided by professionals who are credentialed according to state requirements and the County, as a BHP, must certify that a provider meets all credentialing criteria prior to delivery of services.

Additionally, DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements. The County issues monthly attestations to DHCS that all billed services meet medical necessity and that all providers were eligible at the time of service.

Ethical and Legal Standards

Programs shall develop and implement policies, procedures and training protocol that ensure that its employees, subcontractors, subcontractor employees and volunteers adhere to the highest ethical and legal conduct standards when performing work under the terms and conditions of the contract.

Discrimination

Providers shall not unlawfully discriminate against any person as defined under the laws of the United States and the State of California. Programs may not discriminate between employees with spouses and employees with domestic partners or discriminates between employees with spouses or domestic partners of a different sex and employees with spouses or domestic partners of the same sex or discriminates between same-sex and different-sex domestic partners of employees or between same-sex and different-sex spouses of employees. (Public Contract Code section 10295.3)

Programs may not discriminate between employees on the basis of an employee's or dependent's actual or perceived gender identity, including, but not limited to, the

employee's or dependent's identification as transgender. (Public Contract Code section 10295.35)

Federal and State Database Checks

Prior to employment, programs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)

Providers shall ensure that criminal background checks are required and completed prior to employment or placement of program staff and volunteers in compliance with any licensing, certification, or funding requirements, which may be higher than the minimum standard described herein. At a minimum, background checks shall be in compliance with Board of Supervisors policy C-28 and are required for any program staff or volunteer assigned to sensitive positions funded by this contract.

Sensitive positions are those that:

1. Physically supervise minors or vulnerable adults;
2. Have unsupervised physical contact with minors or vulnerable adults; and/or
3. Have a fiduciary responsibility to any County member, or direct access to, or control over, bank accounts or accounts with financial institutions of any member.

Providers shall have a documented process to review criminal history of candidates for employment or volunteers that will be in sensitive positions.

At a minimum, providers shall check the California criminal history records, or state of residence for out-of-state candidates. Programs shall review the information and determine if criminal history demonstrates behavior that could create an increased risk of harm to members. Programs shall document review of criminal background findings and consideration of criminal history in the selection of a candidate. For example, document consideration of such factors as: if there is a conviction in the criminal history, how long ago did it occur, what were the changes, what was the level of conviction, and if selected, where would the individual work and is the conviction relevant to the position. Programs shall either utilize a subsequent arrest notification service during the staff or volunteer's employment or check California criminal history annually. Programs shall keep the documentation of their review and consideration of the individual's criminal history on file.

As of 7/1/22, the COSD BHS Standard for staff free of probation/parole history for a minimum of one (1) year prior to employment has been updated. Staff can now

begin the credentialing process and Optum will alert COR teams for awareness if any staff are identified with active parole, probation or previous criminal history within less than one year prior to starting employment. Providers will ensure that all staff members working with members are fingerprinted (LiveScan) and pass Department of Justice and Federal Bureau of Investigations background checks.

Documentation of Qualification & Signature Log

Providers shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences. Providers shall have a copy of all staff's licenses, qualification and/ or relevant certificates of registration with the Board of Behavioral Sciences available on site, to verify scope of practice. Expired documents are to be maintained as they demonstrate qualifications for a given timeframe. SB 1024 mandates that all licensees and registrants must display their license or registration in a conspicuous location at their primary place of practice when rendering professional clinical services in person.

Each program shall maintain a signature log of all individuals who document in the medical record. Signature logs contain the individual's typed/printed name, credentials/job title and signature. Signature entries and copies of qualifications of staff that are no longer employed by the program are to be maintained as they are documented in the medical record.

License Verifications

All providers are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Service Template requirements. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

Certification on Disbarment or Exclusion

All claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment of exclusion from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the federal System for Award Management (SAM), the Office of the Inspector General (OIG), Government Services Agency (GSA) and the Suspended and Ineligible Provider (S&I) List.

Provider shall be responsible for checking, on a quarterly basis, the office of the Inspector General (OIG) website that none of the Providers officers, board members, employees, and agents providing services are on the OIG or Medi-Cal list of excluded individuals to provide direct services to County members. Providers shall notify, in writing within thirty (30) days if any personnel are found listed on this site and the actions taken to remedy the situation.

Verification

- Federal System for Award Management (SAM) list
- Office of Inspector General - Exclusions Program
- Medi-Cal Provider Suspension
    - Reasons include:
        - Convicted of felony
        - Convicted of misdemeanor involving fraud, abuse of the Medi-Cal program or any member, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.
        - Suspended from the federal Medicare or Medicaid programs for any reasons
        - Lost or surrendered a license, certificate, or approval to provide health care
        - Breached a contractual agreement with the Department of Health Care Services that explicitly specifies inclusion on this list as a consequence of the breach.

Best Practice

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on the *OIG, GSA or Suspended and Ineligible Medi-Cal lists* are prohibited from working in any County funded program.
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

Clearances for Work with Minors

Contractor's employees, consultants, and volunteers, who work under given contract and work directly with minors, shall have clearances completed by the contractor prior to employment and annually thereafter. Employees, consultants, and volunteers shall successfully register with and receive an appropriate clearance by "Trustline Background Checks" or equivalent organization or service that conducts criminal background checks for persons who work with minors. Equivalent organizations or services must be approved by the COR prior to use by contractor. Contractor shall immediately remove an employee, consultant, or volunteer with an unresolved negative clearance.

Credentialing, Recredentialing & Provider Enrollment

The San Diego County Behavioral Health Plan's (BHP) credentialing, recredentialing, and provider enrollment requirements are designed to comply with applicable national accrediting organization standards and local, state, and federal requirements. The requirement for credentialing is established in the California Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 18-019 (Final Rule: Credentialing), pursuant to 42 CFR §438.214. Credentialing is a component of the BHP's quality improvement system and is a required condition for participation in the County's provider network and reimbursement for covered services.

Credentialing verifies that providers meet the qualifications required to participate in the County's provider network. Recredentialing is the periodic review conducted at least every three (3) years to confirm providers continue to meet those requirements. Provider Enrollment (PAVE) is a separate DHCS process used to screen and enroll applicable providers in Medi-Cal. Although these processes are related, each serves a different purpose, and completion of one does not satisfy the others.

Depending on the Legal Entity, credentialing, recredentialing, and applicable provider enrollment activities are completed either through Optum's centralized process or by an approved Credentialing Delegate. Providers delivering direct billable Medi-Cal services who are licensed, registered, certified, or waivered, as applicable, must be credentialed before providing covered services and recredentialed at least every three (3) years in accordance with BHIN 18-019.

As the BHP, the County is responsible for verifying that network providers meet all applicable credentialing requirements and for maintaining documentation demonstrating ongoing compliance. The County also submits monthly attestations to DHCS that billed services met medical necessity requirements and that providers were eligible at the time services were rendered.

Legal Entities remain responsible for ensuring the timely completion of credentialing activities for all applicable staff. Credentialing activities should be initiated as part of the onboarding process. Credentialing is not a new requirement. The following sections describe provider responsibilities related to credentialing, recredentialing, provider enrollment, and delegation.

Credentialing via Optum

The following process applies to Legal Entities that utilize Optum's centralized credentialing program. Legal Entities designated as Credentialing Delegates should refer to the Credentialing Delegates and Delegation Oversight section below.

Optum will also be conducting primary source verification of the following information:

Provider Responsibilities

Legal Entities utilizing Optum's centralized credentialing program remain responsible for ensuring the successful completion of credentialing activities for applicable staff.

To support timely onboarding and SmartCare access, Legal Entities should:

- Notify their assigned Optum Credentialing Representative within two (2) business days of a candidate's acceptance of an employment offer.
- Submit all required credentialing applications, attestations, and supporting documentation in a timely manner.
- Ensure credentialing is completed before applicable providers begin delivering covered services.
- Notify their assigned Optum Credentialing Representative of changes that may affect a provider's credentialing record, including new hires, terminations, changes in licensure, registration, certification, practice location, or other information affecting credentialing eligibility.

Because credentialing materials may change over time, Legal Entities should refer to the Optum *Organizational Providers Credentialing* webpage and the Credentialing Frequently Asked Questions (FAQ) for the most current instructions, forms, required documentation, and contact information.

Credentialing Review

As part of the credentialing process, Optum reviews provider qualifications and verifies information through primary sources, as applicable, to determine eligibility for participation in the BHP provider network. This review includes provider attestations,

primary source verification, and other information required under applicable federal, state, and BHP requirements. Additional information or documentation may be requested as needed.

Residential Program Credentialing Requirements

Residential Programs and Residential Sites are evaluated during both credentialing and recredentialing. Programs accredited by an Optum-recognized accrediting organization shall have their accreditation status verified. Programs without accreditation shall provide documentation from the most recent applicable review conducted by DHCS, DHS, CMS, or another applicable regulatory agency. Questions regarding Optum credentialing may be directed to the assigned Optum Credentialing Representative or BHSCredentialing@optum.com.

Re-credentialing via Optum

The following process applies to Legal Entities utilizing Optum's centralized credentialing program.

Individual practitioners and Residential Program Sites shall be recredentialed at least every three (3) years. Optum will initiate the recredentialing process approximately six (6) months before expiration of the current credentialing period.

Provider Responsibilities

Legal Entities shall:

- Ensure providers submit all required recredentialing applications and supporting documentation within requested timeframes.
- Respond promptly to requests for updated credentialing information.
- Maintain accurate credentialing information throughout the credentialing cycle.

Failure to Complete Recredentialing

Failure to submit a complete and signed recredentialing application and all required supporting documentation within the requested timeframe may result in expiration or termination of credentialing status. Providers whose credentialing expires may be required to complete the initial credentialing process before participation in the BHP provider network can resume. Questions regarding Optum recredentialing may be directed to the assigned Optum Credentialing Representative or BHSCredentialing@optum.com.

Provider Enrollment (PAVE) via Optum

The following process applies to Legal Entities utilizing Optum's centralized provider enrollment process for applicable providers. Provider Enrollment and Credentialing are separate requirements. Completion of one requirement does not satisfy the other. Applicable providers may be required to complete both processes.

Provider Responsibilities

Legal Entities and providers shall:

- Complete all required Provider Enrollment (PAVE) activities for applicable providers.
- Respond promptly to requests from DHCS or Optum related to provider enrollment.
- Complete required PAVE activities within requested timeframes to avoid delays.

For applicable providers, Optum coordinates provider enrollment activities through the DHCS Provider Application and Validation for Enrollment (PAVE) portal in accordance with DHCS BHIN 20-071. Questions regarding Provider Enrollment (PAVE) may be directed to the assigned Optum Enrollment Coordinator.

Delegates and Delegation

Certain Legal Entities have been approved by the BHP to perform credentialing, recredentialing, and applicable Provider Enrollment (PAVE) activities on behalf of the BHP for their own providers, rather than utilizing Optum's centralized credentialing process. These organizations are referred to as Credentialing Delegates.

The following organizations currently serve as Credentialing Delegates:

- Family Health Centers of San Diego (FHSD)
- Fred Finch Youth Center
- HealthRIGHT 360
- Mission Treatment Services / San Diego Health Alliance / San Diego Treatment Services
- San Diego Center for Children (SDCC)
- San Diego Youth Services (SDYS)
- Telecare

Credentialing Delegates are responsible for performing delegated credentialing, recredentialing, and applicable provider enrollment activities in accordance with

applicable federal and state requirements, BHP policies and procedures, NCQA standards, and the terms of the delegation agreement.

On behalf of the BHP, Optum conducts annual Delegation Oversight Audits to evaluate each Credentialing Delegate's compliance with delegated responsibilities. Delegates must achieve a minimum audit score of eighty-five percent (85%) to maintain delegated status. Delegates receiving a score below 85% will be required to complete a Corrective Action Plan (CAP). Optum may also conduct additional oversight, monitoring, or compliance activities related to delegated credentialing, recredentialing, and provider enrollment responsibilities, as appropriate, on behalf of the BHP.

Questions regarding delegated credentialing responsibilities or delegation oversight may be directed to the assigned Optum Credentialing Representative.

Provider Credentials- Definitions

DHCS Behavioral Health Information Notice 24-023 provides the standards and definitions for specific Behavioral Health Provider Types and Services as outlined in SPA 23-0026 and as described in this section below. Please note that it is the responsibility of the program to have staff provide services within their scope of practice. This includes co-signing of documentation as appropriate.

Reference: CalMHSA Clinical Documentation Guide- Appendix III Scope of Practice Matrix- pg. 40

Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), and Professional Clinical Counselor (PCC) Candidates

Candidates who have graduated from a master's program and are completing their required hours for licensure must register with the BBS as an *Associate*. The "90 Day Rule" set by the BBS allows candidates to count supervised experience toward licensure when gained during the window of time between the degree award date and the issue date of the associate registration number if BBS receives the associate application within ninety (90) days of the degree award date.

SPA 23-0026 allows Medi-Cal BH delivery systems to utilize CSW, MFT and PCC candidates who have submitted their applications for Associate registration to BBS within ninety (90) days of their degree award date and are completing supervised experience toward licensure to provide services to members. They must act within their scope of practice under California law. Medi-Cal BH delivery systems must obtain and maintain documentation to verify that the candidate's BBS application has been submitted and is pending and must subsequently verify that the registration is approved. In the event the BBS application is not approved by BBS, the services provided by the candidate are not Medi-Cal reimbursable.

Clinical Trainees (CT)

An unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provide rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements. Clinical Trainees must be under formal agreement between the Masters' program and the Provider to serve as clinical trainees.

The county must ensure that the clinician supervising the Clinical Trainee meets the minimum qualifications described by the applicable licensing board. Medi-Cal behavioral health delivery systems and trading partners may submit claims to Short Doyle for services rendered by the new Clinical Trainee provider types listed below:

- Nurse Practitioner Clinical Trainee
- Psychologist Clinical Trainee
- Clinical Social Worker Clinical Trainee
- Marriage and Family Therapist Clinical Trainee
- Professional Clinical Counselor Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee
- Occupational Therapist Clinical Trainee
- Physician Clinical Trainee (Medical Student)
- Registered Pharmacist Clinical Trainee
- Physician Assistant Clinical Trainee
- (Certified) Clinical Nurse Specialist Clinical Trainee

Clinical Trainees assigned to a program must have on file the written agreement between the school and agency with specific timelines which will act to demonstrate the official intern status of the student which determines scope of practice. Copy of document can be maintained in the Signature Log which often stores copies of staff qualifications. Outpatient providers' ratio of clinicians to Clinical Trainees shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per three (3) FTE Clinical Trainees.

Clinical Trainees may provide psychotherapy services, under the close supervision of the clinician/therapist. Short Doyle will validate the supervisor's NPI against the data in the National Plan & Provider Enumeration System (NPPES). Claims for Clinical Trainees that do not contain a valid supervisor's NPI will be denied. Services rendered by Clinical Trainees will be reimbursed at the same rate as that of licensed or registered

health care professionals within the CTs' profession. For additional guidance see CalAIM Behavioral Health Payment Reform FAQs.

Enhanced Community Health Workers (E-CHW)

Enhanced Community Health Workers provide community-based services to help prevent disease, disability, and other health conditions and promote physical and mental health and well-being. They connect members to health and wellness resources and help address barriers to meeting health and health-related social needs. ECHWs identify members' needs and connect them to resources and services that support their behavioral health goals, including needs related to mental health and substance use. Engagement is short term and subject to applicable service limits per member, per day, and per year. Services exceeding these limits require additional authorization.

DHCS does not currently require standardized statewide certification for this role. ECHWs must obtain a certificate of completion from a qualifying training program. Supervising providers are responsible for verifying that the certificate meets applicable Medi-Cal CHW requirements. Managed care plans and employers may establish additional training requirements.

For additional resources, please see: DHCS- Community Health Workers

Licensed Mental Health Professionals:

Use of these titles varies by behavioral health delivery system. LMHP is a term used in the SMHS delivery system to identify a select group of provider types that provide rehabilitative mental health services. A Licensed Mental Health Professional (LMHP) includes any of the following providers who are licensed in accordance with applicable State of California licensure requirements:

- Licensed physicians;
- Licensed psychologists (includes waivered psychologists);
- Licensed clinical social workers (includes waivered or registered clinical social workers);
- Licensed professional clinical counselors (including waivered or registered professional clinical counselors);
- Licensed marriage and family therapists (including waivered or registered marriage and family therapists);
- Registered nurses (includes certified nurse specialists and nurse practitioners);

- Licensed vocational nurses;
- Licensed psychiatric technicians; and
- Licensed occupational therapists.

Medical Assistant (MA)

An individual who is at least eighteen (18) years of age, meets all applicable education, training and/or certification requirements, and provides administrative, clerical, and technical supportive services according to their scope of practice, under the supervision of a licensed physician and surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant.

Mental Health Rehabilitation Specialists (MHRS)

An individual who has a baccalaureate degree and four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two (2) years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. Up to two (2) years of post-associate arts clinical experience may be substituted for the required educational experience (as defined by Title 9) in addition to the requirement of four years of experience in a mental health setting.

Other Qualified Provider **(**aka. “Para Professional”)

An individual at least eighteen (18) years of age with a bachelor’s degree, high school diploma or equivalent degree plus two (2) years of related paid or non-paid experience (including experience as a service recipient or care giver of a service recipient), or related secondary education. Programs must provide adequate training, supervision, and co-signatures by a licensed/registered/waivered staff.

Peer Support Specialists

California Mental Health Services Authority (CalMHSA) is responsible for certification and for examination and enforcement of professional standards for Certified Peers. For details on training, certification, examination, applying and more, visit the CA Peer Certification website. Contractor shall ensure that Peer Support Services are provided by certified Peer Support Specialists as established in BHIN 21-041. Additional DHCS resources and Behavioral Health Information Notices pertaining to Peer Support Services can be reviewed on the DHCS Peer Support Services webpage.

Programs shall ensure that Peer Support Services are provided under the direction of a Behavioral Health Professional that is licensed, waivered or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of SMHS and DMC-ODS. Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.

Registered Candidate

A pre-licensed mental health professional who is registered with the appropriate licensing board and working in a clinical setting under supervision. A registrant should use the taxonomy code most appropriate for the practitioner and working under supervision. A candidate for licensure who is registered or has submitted a registration application and is in the process of obtaining registration in accordance with the criteria established by the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations.

Student

Individuals who are enrolled in a post-secondary educational degree program in the State of California but who are not yet in practicum. These individuals should use a taxonomy code within the Mental Health Rehabilitation Specialist, Other Qualified Professional, or Certified Peer Specialist categories as appropriate

Waivered Professional

A professional from another state whose license is recognized by California. Waivered professionals can bill under their own license and do not need to use an HL or a GC modifier.

Youth and Family Partners (Y/FSPs)

An overarching term for an individual with experience as a child or youth or a parent/caregiver of a child/youth who is or has received services from a public agency serving children and families. Youth & Family Partner roles may include, but are not limited to Administrative, Advocacy/Community Engagement, Training and Supervision, Support Partners (direct service), Peer to Peer, and Outcome and Evaluation activities. Y/FSPs have firsthand experience as a child or youth or a parent/caregiver of a child/youth that is receiving or has received services from *public agencies serving children* systems in delivering culturally relevant services and increase a family's and/or youth's ability to:

- Access and/or engage in services and resources.
- Foster their ability to gain greater self-sufficiency.

- Enhance navigation to community supports and relationships.

- Reduce stigma associated with behavioral health services and/or diagnosis.

Support Partners do not require a professional license but have firsthand experience in navigating a public agency serving children as well as specific training in the supportive role. YSPs must be at least twelve (12) years of age, meet work permit requirements and be no older than twenty-five (25) years of age. FSPs must be at least eighteen (18) years of age and have high school diploma or equivalent. They must have direct experience a parent or caregiver of a child and/or youth (current or past) in a public agency serving children, youth, and families.

Y/FSPs shall not be employed by the agency where they or their families are currently receiving services.

- Productivity: For each full-time equivalent (FTE) Y/FSPs, a minimum of 32,400 Minutes / 540 hours 30% productivity level) per year will be spent in billable services.

- Member's Choice: If member/family opts to transfer/change to different Y/FSPs, this will be recorded on the agency's Suggestion and Transfer (S&T) Log and reported in the agency's Monthly/Quarterly Status Report.

- Caseload: Y/FSPs shall carry a minimum case load of twenty (20) unduplicated clients per FTE per fiscal year unless otherwise specified in the program's SOW.

Professional Licensing Waiver Requirements

Professional Licensing Waiver Guidelines -Welfare and Institutions Code (W&IC) Section 5751.2. Complete professional licensing waiver information and requirements are available on the DHCS website (Professional Licensing Waivers) and in BHIN 24-033.

Waiver Duration: PLWs granted by DHCS are valid for five (5) years from the first date of employment by, or contract with, a local mental health program, including a BHP or LMHD, or provider subcontracting with the BHP or LMHD, unless the individual seeking waiver obtains appropriate licensure prior to the expiration of the five (5) year-waiver timeframe. PLWs cannot be extended beyond this five (5) year timeframe and must run continuously from the start date. The five (5) year term may not be backdated, postponed, paused, deferred, or extended for any reason.

How To Apply: The director or designee of a BHP or county mental health department may apply on behalf of an individual seeking a PLW. The employer shall not allow an individual seeking a waiver to begin work for which a license or waiver is required until DHCS has approved the PLW application. Applicants must complete the DHCS Form 1739 - PLW Application and submit to QIMatters.BHS@sdcounty.ca.gov.

QA will review the application, submit to BHS for required approval and signatures, and submit to DHCS for final review.

- Prior to submitting the DHCS application, review eligibility requirements outlined in the instructions on the application, on the DHCS website, and in BHIN 24-033 to ensure applicant meets requirements and necessary units are reflected on their transcripts.
- On the application, only complete *Sections A-F* (as apply).
- Submit application as a fillable PDF so required signatures can be obtained by QA & DHCS. No signatures from the applicant or program are required on the application.
- Submit supporting transcripts, and any other necessary documents, when the application is submitted to QI Matters.

Staffing Requirements

The Department of Health Care Services (DHCS) ensures the provision of quality treatment through the enforcement of standards for professional and safe treatment. DHCS does not certify counselors; however, DHCS does ensure counselors provide quality treatment to members by enforcing the Counselor Certification Regulations found in the California Code of Regulations (CCR), Title 9, Division 4, Chapter 8.

Providers shall:

- Administer, staff, and provide management systems and procedures for programs.
- Recruit, hire, train and maintain staff qualified to provide required services.
- Ensure all staff has appropriate experience and necessary training upon hire.
- Ensure members currently in treatment are not to be used in staff positions*.
- Verify identify and determine the exclusion status of all staff prior to hire (see Federal and State Database Checks below).
- Ensure all personnel are competent, trained and qualified to provide any services necessary.
- Ensure non-professional receive appropriate onsite orientation and training prior

to performing assigned duties.

- Ensure professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- Ensure documentation of trainings, certifications and licensure shall be contained in personnel files.
- Ensure professional and/or administrative staff supervise non-professional staff.
- Maintain records of current certification and NPI registration.

All providers shall have staff in numbers and training adequate to meet the needs of the program's target population. Psychotherapy shall be performed by licensed, registered, waivered, or Clinical Trainee (with co-signature by LPHA) staff in accordance with State law. Any exceptions to these requirements must be approved by the COR. Contractor's program staff shall meet the requirements of Title 9, Division 1, Article 8 and Title 9, Chapter 11 of the California Code of Regulations as to training, licensure, and clinician/client ratios. All staff shall operate within the guidelines of ethics, scope of practice, training and experience, job duties, and all applicable State, Federal, and County standards.

The contractor is required to be compliant with all federal and state regulations regarding the provision, documentation, and billing of behavioral health services provided to dual-eligible beneficiaries (Medi-Medi) and follow appropriate staffing requirements. The contractor shall assure sufficient Medicare-approved staff are available for all Medicare-covered services delivered and ensure dual-eligible services are coordinated for Medicare to be billed as the primary payer and Medicaid as the secondary payer, unless otherwise directed by payer-specific rules.

Most programs' contracts require that the Program Manager (Head of Service) be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waivered persons.

Provider to Member Ratio Requirements

DHCS has established specific provider-to-client ratio standards for mental health services to ensure adequate access to care. San Diego BHP organization providers are expected to ensure sufficient staff to meet these ratios:

Category	Provider Classifications	Ratio Standard
Psychiatry – Adults (ages 21+)	Psychiatrists, Physicians, PMHNPs (non-psychiatry NPs excluded)	1:457
Psychiatry – Children/Youth (ages 0-20*)		1:267
Mental Health Services – Adults (ages 21+)	Clinical SW Trainee, ACSW, LCSW, MFT Clinical Trainee, AMFT, LMFT, Professional Counselor Clinical Trainee, APCC, LPCCs, Psychologist Clinical Trainee Psychologists, WAP, LVN, RN, CNS, Psychiatric Technicians, MHRS, PA, Pharmacists	1:85
Mental Health Services – Children/Youth (ages 0-20*)		1:49

*The children/youth age range is from birth through age twenty (20) years, up to but not including the twenty-first (21st) birthday.

Staffing Requirements for Crisis Stabilization Services

- A physician shall be on call at all times for the provision of those crisis stabilization services that may only be provided by a physician.
- There shall be a minimum of one (1) Registered Nurse, Psychiatric Technician or Licensed Vocational Nurse on site at all times beneficiaries are present.
- At a minimum there shall be a ratio of at least one (1) licensed mental health or waivered/registered professional on site for each four (4) beneficiaries or other members receiving crisis stabilization at any given time.
- If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services.
- Persons included in required crisis stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services. CCR, Title 9 1840.348
- Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed.

Staffing Requirements for a CSU that is a 5150 LPS Designated Facility

A Crisis Stabilization Unit that is 5150 LPS designated and approved is required to meet California Code of Regulations (CCR) Title 9, Division 1, Article 10, Section 663

inpatient staffing requirements. Inpatient services shall be under an administrative director who qualifies under Section 620 (d), 623, 624, 625 or 627. In addition to the director of the service, the minimum professional staff shall include psychiatrists if the administrative director of the services is not a psychiatrist, who shall assume medical responsibility as defined in Section 522; a psychologist, social worker, registered nurse, and other nursing personnel under supervision of a registered nurse. Nursing personnel shall be present at all times. Physicians, psychiatrists, registered nurses and other mental health personnel shall be present or available at all times. Psychologists and social workers may be present on a limited-time basis. Rehabilitation therapy, such as occupational therapy, should be available to the members.

The minimum ratio of the full-time professional personnel to members shall be as follows:

Personnel	Ratio per 100 Members
Physician	5
Psychologists	2
Social Workers	2
Registered Nurse	20
Other mental health personnel	25

Staffing Requirements for the System of Care Serving Adults/ Older Adults

Commensurate with scope of practice, mental health and rehabilitation services may be provided by any of the following staff:

- Physician
- Licensed/Registered/Waivered Psychologist
- Registered Psychological Associate
- Licensed/Registered/Waivered Clinical Social Worker
- Licensed/Registered/Waivered Marriage and Family Therapist
- Licensed/Registered/Waivered Professional Clinical Counselor
- Nurse Practitioner
- Registered Nurse
- Licensed Vocational Nurse

- Medical Assistant
- Licensed Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Other Qualified Provider

Contracted Adult/Older Adult programs shall follow the member to direct clinical FTE ratios as outlined in executed contract exhibits A &C.

Staffing Requirements for the System of Care Serving Children, Youth and Families

- Psychiatrists shall have completed appropriate training in a child or adolescent specialty. "*California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care 2018*" recommends psychotropic medications for children be prescribed by Board certified or Board eligible psychiatrists with specialization in child and adolescent or adolescent psychiatry, for programs that serve youngsters under thirteen (13) years of age or have five (5) years of experience offering psychiatric services to children and adolescents. Any exception to this must be approved by the Mental Health Services Clinical Director and the COR.

- Outpatient programs must also have psychiatry time adequate to meet the needs of the program's target population and sufficient to allow the psychiatrist's participation in treatment reviews, as well as meeting specific requirements as they pertain to fidelity or service delivery requirements and contractual requirements. The psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus up to one (1) hour per month for each new member to be assessed and one (1) half hour per month per member on medications, for medication follow up.

- Children, Youth & Families Contractors: shall budget forty-nine (49) unduplicated members per direct clinical FTE (excluding trainees/students); with any exceptions requiring written rationale by program and written COR pre-authorization, noting that billable minutes based on the 1:49 ratio shall be maintained.

- Family / Youth Support Partners who provide direct, billable service must have direct experience as the parent, care giver, or consumer in a public agency serving children, and demonstrate education and/or life experience commensurate with job duties. Youth (12-25 years of age) must meet work permit requirements when applicable. Partners must receive ongoing training and work under the direction of a licensed or waivered staff member.

- Day Treatment staffing: per the requirements of Title 9, the program must maintain a member to staff ratio of 8:1 (for Intensive programs) and 10:1 (for Rehab programs) at all times. Staff counted in the ratio must be Qualified Mental Health Professionals or licensed or waivered. In addition, County guidelines require that at least half the clinical staff in Intensive programs be licensed/waived.

- Short Term Residential Treatment Program (STRTP) staffing: per Interim STRTP Regulations (Version II), STRTP shall have at least one full-time equivalent STRTP mental health program staff from the following list for each six (6) children or fraction thereof admitted to the program:

    - Physicians
    - Psychologist: licensed or waivered,
    - LCSW, LMFT, and LPCC: licensed/registered/waivered
    - RN
    - LVN
    - Psychiatric Technicians
    - MHRS
    - Clinical Trainees
    - Medical Assistants

- Interdisciplinary Teams: Programs must have an interdisciplinary team, mandated by standards of participation within the program SOW. Members must participate in the regularly scheduled interdisciplinary team meetings where cases are reviewed.

Personnel Files

Personnel files shall be maintained on all employees, volunteers, and interns. These records will contain: application for employment and/or resume, signed employment confirmation statement, signed annual confidentiality statements, job description (which shall include position title and classification; duties and responsibilities; lines of supervision; and education, training, work experience and other qualifications for the position), performance evaluations, health records/status as required by program or Title 9 (i.e. health screening report or health questionnaire, including annual TB results), other personnel actions (e.g. commendations, discipline, status change, employment incidents and/or injuries), training documentation relative to substance use disorders and treatment, current registration, certification, intern status or licensure; proof of continuing education required by licensing or certifying agency and program, and program code of conduct.

Code of Conduct

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level. Programs shall have a written code of conduct that pertains to and is known about by staff, paid employees, volunteers, and the governing body and community advisory board members. Each staff, paid employee, and volunteer shall sign a copy of the code of conduct and a copy shall be placed in their personnel file. The program shall post the written code of conduct in a public are that is available to members. The code of conduct shall include the program policies regarding at a minimum the following:

- Use of alcohol and/or other drugs on the premises and when off the premises
- Personal relationships with participants
- Prohibition of sexual contact with participants
- Sexual harassment
- Unlawful discrimination
- Conflict of interest
- Confidentiality

In addition to the minimum requirements listed above, all Programs Serving Children, Youth & Families providers are encouraged to utilize the *2019 Trauma-Informed Care Code of Conduct* in the creation of their agency code of conduct. This document, created by young adults with lived experience, is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings for staff, and to be offered to members to outline the commitment of the program to follow trauma informed principles.

Counselor/Client Relationships

Relationships between members and program staff beyond the realm of treatment are prohibited. Staff must maintain healthy boundaries between themselves and members at all times. Staff members' failure to adhere to this standard shall be disciplined at the discretion of the program director. Sexual contact shall be prohibited between program staff, including volunteers, and members the Board of directors, and the participants. A written statement explaining the sexual contact policy shall be included in every participant's rights statement given at admission to a program. Programs shall include a statement in every personnel file noting that the employees and volunteers have read and understood the sexual contact prohibition. The policy shall remain in effect for six (6) months after a participant is discharged from services, or a staff member of volunteer terminates employment.

New employees will receive a copy of the HHSA Code of Conduct as part of their orientation packet and will provide a signed Code of Conduct Acknowledgement to HHSA Human Resources within thirty (30) days of beginning employment with HHSA. Employees will review the Code of Conduct and complete the acknowledgement through the Learning Management System (LMS) annually.

On-Site Manager/Director: Programs shall provide a full-time on-site Program Manager or Director for each program, unless prior approval received by COR. If the program manager is also serving as the program coordinator, time may be divided between administration and direct services.

Review and Comment on the Qualifications of On-Site Managers, Directors, and Higher-Level Staff: The COR shall review and comment on the final candidates under consideration for hire at the Program Manager, Director, or higher level prior to selection. Should the COR choose to provide written comments, the comments shall be provided within five (5) days of receipt of candidates' resumes and supporting documentation.

Provider Directory

The County of San Diego Behavioral Health Plan (BHP) maintains a public Provider Directory to help clients including Medi-Cal Members locate and access covered behavioral health services. The Provider Directory is maintained in accordance with applicable federal and State requirements, including but not limited to BHIN 25-023.

Link to the searchable BHP Provider Directory: https://sdcountybhs.com/ProviderDirectory.

Provider Responsibilities

Providers are responsible for ensuring that Provider Directory information remains complete, accurate, and current. SmartCare, the BHP's EHR, serves as the source of truth for Provider Directory information. The SOC Application is integrated with SmartCare and provides providers with the ability to review and attest to Provider Directory information that is publicly displayed.

Providers are expected to:

- Review and attest to Provider Directory information through the SOC Application in accordance with County-established timeframes.
- Promptly notify the County of changes affecting Provider Directory information and complete any required updates or attestations.

- Contact the Optum Help Desk at sdhelpdesk@optum.com or call 1-800-834-3792 to request corrections to staff-level information maintained in SmartCare. Requests will be reviewed, and any necessary updates will be made in the Provider Directory within thirty (30) days of receiving requests.

- Contact the assigned Contracting Officer's Representative (COR) to request corrections to program-level information.

- Respond to County requests to verify Provider Directory information within established timeframes.

Staff Supervision and Management Requirements

Programs must provide supervision in amount and type that is adequate to ensure member safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program. Supervisors may supervise up to eight (8) clinical staff (licensed, registered, waivered, and clinical trainees) and up to twelve (12) total staff, including clinical staff. Any exceptions to these requirements must be approved by the COR.

Programs who employ waivered/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered. SB 1024, sponsored by the Board of Behavioral Sciences (Board), effective on January 1, 2025, clarifies the number of supervisees a supervisor can have: and defines who qualifies as a supervisee in group supervision, which is capped at eight (8) individuals; and specifies who is included in the limit of six (6) supervisees receiving individual or triadic supervision per supervisor in nonexempt settings. Please see linked "Clarification on Number of Supervisees" for more information

Contractors shall ensure provision of required supervision for Nurse Practitioner staff or interns. The furnishing law requires that the physician supervise no more than four (4) nurse practitioners at a time. If the nurse practitioners are not furnishing, there are no limitations on the number of nurse practitioners the physician may supervise. (BPC §2836.1 (e)) Nurse Practitioner (ca.gov).

Use of Volunteers and Clinical Trainees

Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to members. Emphasis shall be made to recruit volunteers from diverse communities within program region. Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also

members/caregivers. Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct member care.

Training

An increasing focus and requirements for cultural sensitivity, outcome measures, practice guidelines, electronic health record and evidence-based practices necessitates the need for ongoing training. Many providers have a contractual obligation to participate in identified trainings within 60 days of hire (unless otherwise specified) or when training becomes available.

Trainings for the System of Care

The Quality Assurance Unit provides trainings and technical assistance on topics related to the provision of services in he Systems of Care.

Training and information is disseminated through:

- Basic Medi-Cal/County Standards Documentation Training through CalMHSA LMS
- Root Cause Analysis Training
- SmartCare Health Electronic Health Record User Trainings through CalMHSA LMS
- QA Specialized Trainings
- Regular QA Communications
- Organizational Provider Operations Handbook
- Provider Meetings
- TKC—The Knowledge Center (County staff only)

BHP–MCP Memorandum of Understanding (MOU) Training

In accordance with DHCS BHIN 23-056 and BHIN 23-057, BHS provides training on BHP-MCP MOU requirements to applicable subcontractors, downstream subcontractors, and network providers. This includes provider staff who carry out responsibilities covered by the MOU. The training explains the MOU requirements, the services provided or arranged by the BHP and MCPs, and how Medi-Cal members access and receive coordinated services. Training must be completed before staff perform MOU responsibilities and at least annually thereafter.

MOU responsibilities may include, but are not limited to, helping members access services, making or receiving referrals, coordinating care with an MCP, helping transition a member between the BHP and MCP, and sharing information needed for referrals and care coordination. Providers are responsible for ensuring required staff complete the training and for tracking and reporting completion in accordance with BHS requirements.

Annual Training: Staff may meet the annual training requirement each calendar year by either:

- Attending the Annual Mental Health (MH) Forum or Annual Substance Use Disorder (SUD) Forum, as applicable; or
- Completing the BHP-MCP MOU Resource Training available on the Optum website.

New Staff: New staff, or staff newly assigned MOU responsibilities, must complete the BHP-MCP MOU Resource Training before performing those responsibilities, unless they have already completed the training for the current calendar year. The training is available on Optum's HSD BH Operations webpage.

For information on upcoming trainings or in-services, or if you require technical assistance, please contact QA at: QIMatters.BHS@sdcounty.ca.gov

Electronic Health Record Trainings

Prior to staff obtaining access to SmartCare, they shall successfully complete all applicable SmartCare trainings. Program managers are responsible for registering new and returning SmartCare users for training on the CalMHSA LMS application. Previous users returning to employment (including maternity leave) after more than ninety (90) days of absence will be required to resubmit new paperwork including an updated ARF and be evaluated for a skills assessment or retraining.

Users are required to attend and pass the assigned online LMS trainings with CalMHSA prior to access. Staff will be responsible for trainings according to their Staff Role. The CalMHSA Required Trainings by Role Grid can be found on the Optum Website under the *SOC Resources and Training*. See the following grid for guidelines : SmartCare Trainings by Staff Role. For additional resources, please see: SmartCare User Training Registration and SmartCare Training Tips

CSU and Residential programs must also complete and pass an additional Optum training class. For residential, crisis residential, and crisis stabilization unit users, live in-person training is required for access to SmartCare, also provided by Optum. See the Optum SmartCare Training webpage for training dates and registration. For questions contact: sdu_sdtraining@optum.com.

Information about SmartCare EHR trainings may be found on the Optum website under the "BHS Provider Resources" tab and selecting SmartCare Training. Additional resources can be found on the CalMHSA Knowledge Base website and BHP Provider Documents page under the 'SmartCare' site link also located on the Optum San Diego website

CalMHSA Documentation Trainings

CalMHSA has collaborated with DHCS on the integration of CalAIM requirements and documentation standards. All direct service providers are required to complete the online documentation trainings through the CalMHSA LMS and are encouraged to review and be familiar with the CalAIM Documentation Guides relevant to their credential level. These guides are updated periodically as new requirements are issued. CalAIM Documentation Guides - CalMHSA. Newly hired direct service staff must complete the required documentation trainings within ninety (90) days of hire.
All direct service providers are required to complete the following CalMHSA trainings:

- 01-Foundations of Documentation and Service Delivery
- 02-Access to Services
- 03-Assessments
- 04-Diagnosis, Problem Lists, and Care Planning
- 05-Progress Notes
- 06-Care Coordination
- 07-Screening Tools for SMHS
- 08-Transition of Care Tool
- 09-Discharge Planning
- 10-Effective Administration of Screening Tools
- Coding for DMC and DMC-ODS - Non-CE
- Coding for SMHS - Non-CE

All direct service staff are required to complete the required documentation trainings and review the documentation guides relevant to their credential level to ensure compliance with DHCS BHIN 23-068 which clarifies documentation standards and requirements for all SMHS, DMC and DMC-ODS services. Verification of completed trainings can be viewed within the CalMHSA LMS Portal.

Tracked Trainings

The following trainings are tracked on the MSR/QSR:

1. Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program. Providers shall maintain and submit a Cultural Competence Training Log annually.

2. Transgender, Gender Diverse, or Intersex (TGI) Cultural Competency Training- As of 05/12/2025, All staff who are in direct contact with service recipients are required to complete an evidence-based cultural competency training for the purpose of

providing trans-inclusive health care for individuals who identify as transgender, gender diverse or intersex (TGI). (BHIN 25-019) BHPs shall require that the training is completed by new staff within 45 days of hire and all staff at least every two (2) years or more often if needed. The training is offered via an on-demand webinar series. Please register via Academy LMS.

3. BHS Disaster Support Training e-learning access is available through the BHS Training and Technical Assistance website. A minimum of twenty- five percent (25%) of contracted staff need to be disaster trained.

4. Continuing Education Units (CEUs) -- Contractor shall require clinical staff to meet their licensing requirement. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.

5. Trainings for STRTP staff – See section below "*STRTP Trainings"*

Contractor shall attend trainings as specified in their Contract. Children, Youth and Families Contractors shall obtain training on the *DCR System* for FSP programs. Trainings are available through Child and Adolescent Services Research Center (CASRC).

Family and Youth Support Staff Training Requirements

Minimum Curriculum should include the role and function of the Y/FSP, the role of supervision, basic knowledge of Principles of Family Youth Professional/System Partnership, Pathways to Well Being / Katie A, Children's System of Care (CSOC), community and system resources to which youth/family may be referred. This also includes the safety, cultural competency, boundaries and dual relationships, Systems' Mandate, or introduction to peripheral systems on the child/youth's continuum of care Mandated Reporting confidentiality, documentation requirements, conflict resolution and effective listening. Other training as specified by employer or BHS- Children, Youth & Families. Family and Youth Support Partners trainings are available through NAMI San Diego. Contact the Peer & Family Support Helpline at 1-800-523-5933.

STRTP Training Requirements (Regs. Version II)

All STRTP mental health program staff shall receive a minimum of twenty-four (24) hours per calendar year of ongoing, planned academic and on-the-job in- service education. At a minimum, the in-service education shall cover all of the following topics even if the STRTP mental health program staff must attend more than twenty-four (24) hours of training in a calendar year:

1. Client-centered and trauma-informed approach

2. Suicide prevention techniques;

3. Preventing and managing assaultive and self-injurious behavior (must have at least eight (8) hours of training on this topic or other similar crisis services prior to commencing any employment duties involving direct contact with children.

4. Cultural competence;

5. Interpersonal relationship and communication skills;

6. Confidentiality of member information;

7. Member rights and civil rights;

8. Monitoring and documenting responses to psychotropic and other medications to treat mental illness and recognizing possible side effects in children and youth

9. All approved policies and procedures applicable to the STRTP.

Subdivisions (a), (b), and (e) shall not apply to a psychiatrist or physician, who is not the head of service. Psychiatrists and physicians shall attend a minimum of one training per calendar year on preventing and managing assaultive and self-injurious behavior. The STRTP shall document all trainings by maintaining a record of the training title and date, syllabus or curriculum, and sign-in sheets of attendees

Mobile Crisis Team Training Requirements

All mobile crisis teams shall meet DHCS core and enhanced training requirements before delivering qualifying mobile crisis services, as outlined in BHIN 23-025. The core training curriculum will include crisis intervention and de-escalation strategies, harm reduction strategies, delivering trauma-informed care, conducting a crisis assessment, and crisis safety plan development. The enhanced training curriculum will include~~,~~ but is not limited to, training in provider safety, delivering culturally responsive crisis care, and crisis response strategies for special populations (e.g., children, youth and families, tribal communities, and members with I/DD).

J. Facility Requirements

Programs shall provide all facilities, facility management, supplies and other resources necessary to establish and operate the program. The facility shall meet the BHSA Components and Requirements as described in HHSA-BHS-ADS 1077. Programs licensed and/or certified by DHCS shall notify DHCS of facility relocation, change of ownership, or change in scope of services, and copy their program COR on such correspondence.

Facility Operations

- Accessibility: Program's business shall be accessible by public transportation in compliance with Americans with Disability Act (ADA) and California State Administrative Code Title 24.

- Child Care Space: Programs providing perinatal services shall establish and maintain appropriate space for childcare if serving pregnant and parenting women and their children. The childcare may be state-licensed or parent/childcare cooperative but must be supervised by an individual with at least one (1) year of experience in a state-licensed facility.

- Cultural Competency: In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

- Public Contact: Providers shall have sufficient staff with adequate knowledge, skills and ability available during operating hours specified in their contracts to ensure that all persons who contact the program in person or by phone during operating hours are quickly and appropriately served with information or a referral to appropriate services.

- Voicemail: All providers are required to maintain a functioning voicemail that operates twenty-four/ seven (24/7) for those times when a staff is not available to answer in person. Outgoing voicemail messages should include directions for accessing emergency services, as per community healthcare standards, including directing members to the Access and Crisis Line (888-724-7240) for 24/7 access to a counselor, or if in need of referrals.

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal members must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial members. If the provider serves only Medi-Cal members, the hours-of-service availability must be the same for fee-for-service and managed care members. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities and adhere to the specifics in the Statement of Work. The BHP QA Unit will document program service hours at annual site reviews and/or Medi-Cal Certifications/Recertifications.

For residential programs, services shall be available to residents seven (7) days a week, twenty-four (24) hours a day. Programs shall not change the hours of operation or location from those listed in their County contract without prior written approval from the Contracting Office Representative (COR). Non-residential programs shall be open no less than forty (40) hours per week and five (5) days per week, except County of San Diego Holidays. Weeks where there is a County of San Diego Holiday shall have regular business hours on all days except the County of San Diego Holiday.

When closed, programs shall provide information to members (i.e. outgoing voice mail message, signage on program door, reminders provided during services prior to the closure, etc.) concerning the availability of short-term emergency counseling or referral services, including, but not limited to, emergency telephone services.

Missed Appointment and Follow Up Standard

County of San Diego BHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. "Missed Appointment" policies and procedures shall cover both new referrals and existing members, and at minimum, include the following standards:

For new referrals: When a new member (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

For current members: When a member (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a

"No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For members who are at an elevated risk and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the member's emergency contact, or initiating a welfare check.

Additionally, the policy shall outline how the program will continue to follow up with the member (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the members' whereabouts and admittance to different levels of care throughout the County (e.g., hospital, PERT or jail admissions). All providers shall have policies and procedures in place regarding the monitoring of missed appointments for members (and/or caregivers, if applicable).

All attempts to contact a new referral and/or a current member (or caregiver, if applicable) in response to a missed appointment must be documented by the program. "Elevated risk" is to be defined by the program and/or referral source.

Programs Serving Children, Youth & Families Specific Requirements

- Smoking Prohibition Requirement: Providers shall comply, and require that subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking is not permitted in any portion of any indoor facility owned, leased, or contracted for or by an entity and used to provide services to children under the age of eighteen (18).

- Transportation of Minors: Minors shall always be escorted when being transported by any non-public, private, or commercial transportation service including but not limited to taxi and rideshare services.

Promotional Materials and Advertising Requirements

All promotional materials for BHS-funded programs shall include the BHS logo, defined as the circular County of San Diego logo with "Behavioral Health Services" written underneath. The BHS logo should no longer be paired alongside the Live Well San Diego logo. Promotional materials shall be provided to COR for review before distribution, and are subject to COR approval. For initiatives involving multiple County groups, it is allowable to use the circular County logo without "Behavioral Health Services" written underneath. Promotional materials shall include but not be limited to electronic and printed materials such as brochures, flyers, and other materials.

As described in BHIN 22-022, SB 434 and SB 541 were passed to enhance the advertising requirements for mental health facilities and address certain fraudulent marketing practices. Mental Health facilities have been established by SB 434 - Health and Safety Code (HSC) § 11831.9.

BHIN 23-007 further clarifies these requirements were mirrored in W&I code Division 4, Part 1, Chapter 4, Section 4097. Allegations of violations of Section 11831.9 may be investigated by DHCS. Upon finding a violation of this section or related regulations, sanctions may be imposed by DHCS, as described in HSC Section 11831.7. In addition, DHCS may also investigate allegations of violations of W&I Section 4097c and may impose sanctions described in W&I Sections 4080 and 5675.1.

Licensed mental health facilities shall not do any of the following:

1. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet website.

2. Make a false or misleading statement or provide false or misleading information about medical treatments or medical services offered in its marketing, advertising materials, or media, or on its internet website, on a third-party internet website, or in its social media presence.

3. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.

4. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

Medi-Cal Certification and Recertification

Each County Behavioral Health Plan (BHP) is responsible for enrolling, certifying, recertifying, and monitoring all its Directly Operated Providers as well as Contract Legal Entity Provider. For a Provider to provide and be reimbursed for specialty mental health services delivered to a Medi-Cal member, the Provider must be certified by the Department of Health Care Services (DHCS) and be recertified every three (3) years.

Additional Resources: Medi Cal Provider Certification Re-certification General Overview and DHCS: Licensing and Certification- Applications, Forms and Fees

Requirements for Medi-Cal Certification

- Smartsheet notification
- NPI
- Program Name
- Location/address
- NPPES record matching NPI with anticipated Program Name and address
- Approved MOU with school/district (if applicable)
- Point of contact to work with QA to submit forms and evidence
- Fire clearance (less than 12 months old)
- Head of Service license
- P&P's
- Contract start date
- Site visit by MH QA
- DHCS approval

Site Reviews

Site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, have appropriate fire clearance, and store and dispense medications in compliance with all pertinent Federal and State standards. Providers will typically be recertified every three (3) years**.** For contracted programs, the Site Review is completed by BHS QA staff. For County-operated programs, DHCS will perform on-site reviews. DHCS also performs on-site reviews for the relocation of all County Mental Health staffed programs, and the addition of any Medication Support for County Mental Health staffed provider sites when medications will be stored, dispensed, or administered on-site.

Recertification site visits will be scheduled no less than thirty (30) days before the last Medi-Cal certification date. Providers will be notified of the recertification site visit no less than forty-five (45) days before the last Medi-Cal certification date. Providers must comply with all Federal and State regulatory requirements and BHP contract requirements with DHCS.

Site Visit Review Categories

- Maintenance of current licenses, permits, notices and certifications
- Policies & Procedures or written process
- Compliance with standards in the Mental Health Plan's Managed Care Contract with the State of California.

- Physical facility requirements
- Adherence to health and safety requirements
- Compliance with local fire authority requirements for fire inspections and clearances.
- Required program documents
- Medication services
- Cultural competence
- Consumer orientation
- Staff Training & Education
- Member Rights, Grievance & Appeals Process

Reviewed Policies & Procedures

Programs must submit their most current P&Ps prior to the site visit for review:

- Emergency Evacuation
- Confidentiality and Protected Health Information
- Personnel P&P's specific to screening licensed personnel/providers
- General operating procedures
- Maintenance policy
- Service delivery policies
- Incident Reporting
- Procedures for referring individuals to a psychiatrist, when necessary
- (Effective 1/1/25)- Policy for providing members with a notice that the Board of Behavioral Sciences responds to complaints about licensees and how to contact, prior to the provision of psychotherapy services. (BBS Required Notice- SB1024)

Initial Certification

The steps for initial certification are outlined below:

1. Have an active contract with the county's Behavioral Health Plan.

2. Complete the NPI Application via the National Plan and Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov/ to obtain an Organizational **NPI (Type 2)** that exactly matches the legal entity name and physical site address across NPPES, the county, and DHCS systems.

3. Ensure full ADA compliance (wheelchair ramps, accessible restrooms, parking, and clear signage).

4. Clear evacuation maps, visible emergency exit signage, updated fire extinguishers, confidential record storage, and secure medication rooms (if providing Medication Support Services).

5. Obtain a valid fire safety clearance specifically approving the site for its intended healthcare/mental health occupancy (less than twelve (12) months old).

6. Designate a qualified, licensed mental health professional (e.g., Licensed Psychologist, LCSW, LMFT, LPCC, or Psychiatrist) to serve as Head of Service.

7. Maintain current copies of licenses, registrations, primary source verifications, resumes, and NPI (Type 1) numbers for all clinical staff.

8. Approved MOU for school services within a school district if applicable.

9. Develop written policies & procedures for program operations for the legal entity and site, including:

    a. Confidentiality and Protected Health Information
    b. Emergency Evacuation
    c. Personnel policies and procedures specific to screening licensed personnel/providers and checking the excluded provider lists
    d. General operating procedures
    e. Maintenance policy to ensure the safety and wellbeing of beneficiaries and staff
    f. Service delivery policies
    g. Incident Reporting (CIR & N-CIR) procedures relating to health and safety issues
    h. Written procedures for referring individuals to a psychiatrist when necessary, or to a physician who is not a psychiatrist, if a psychiatrist is not available

i. Policy and procedure for providing clients with a notice that the Board of Behavioral Sciences responds to complaints about licenses and how to contact, prior to the provision of psychotherapy services.

10. Prepare required member informing materials and post in the lobby/waiting areas for:

    a. Grievance & Appeal posters, along with physical copies of Grievance forms and pre-addressed envelopes in English and all county threshold languages.
    b. Member Handbook
    c. Provider Directory

11. Additional requirements may be needed depending on the type of services or level of care. See CSU MC Certification requirements

12. Complete a site visit with COSD QA Specialist

13. Obtain a Provider Number from the State

14. Receive Medi-Cal certification approval and state provider number

Re-certification

For most programs, recertification will occur every three (3) years. For contracted programs, the BHP will contact each provider to initiate the recertification process. For County owned/operated providers, DHCS will contact the BHP to coordinate recertifications.

The steps for re-certification are outlined below:

1. Program will obtain a new fire clearance
2. Program will have a site visit with COSD QA Specialist
3. Program will submit any revised Policies & Procedures
4. Program will submit any new or expired Head of Service Licenses.
5. Receive Medi-Cal certification approval

Program Changes

- Adding or Revising Services: All certification changes must be approved by the program COR. Once approved, BHP needs to report to DHCS for certification changes.

- Location Changes: Re-certification is required for program relocation. Prior to any change in location, the COR reserves the right to conduct a site visit(s), inspect the facility plans, and approve the location and any budget and/or service delivery impact which may result from the proposed move to a new location/facility.

- Remodeling or Change in Ownership: Remodeling should be reported to the program COR and may impact the Medi-Cal certification and fire clearance. All changes in ownership, such as legal entity (LE), should be reported to the COR and BHP. The previous legal entity must be closed with DHCS and the new legal entity/ program needs to be established. This would require a new certification.

Fire Clearance / Fire Safety Inspection

Provider sites are required to have a current Fire Clearance in order to be Certified or Re-Certified by the DHCS, per CCR Title 9, Section 1810.435 (b) (2). A current Fire Clearance is defined by DHCS as occurring "within one (1) year of the onsite review/visit" (DHCS 1735 form). Please note that the date the State utilizes to determine the one (1) year period is the date the Fire Clearance was granted. A valid and appropriate fire clearance is issued from the fire authority having jurisdiction over the area in which the facility is located. Fire clearances must be dated within one (1) year of the scheduled recertification site visit.

Please note that not having an active fire clearance will impact program start date and/or ability to provide direct services at the location.

A new fire safety inspection may be required if the facility undergoes major renovations or other structural changes. Review local fire code requirements to determine reinspection schedule. Any efforts to schedule fire clearances should be maintained. All fire clearance documents must be kept at the program site and be available to reviewers.

New Programs: As part of the Short-Doyle Medi-Cal Certification process for new programs or Recertification of Short-Doyle Medi-Cal programs, the organizational provider will secure a new fire clearance document from their local fire code authority and submit a copy to the San Diego County Mental Health Service's Health Plan Organization Quality Assurance Unit prior to Certification/ Recertification site visit.

Established Programs: At the Short-Doyle Certification/Recertification site visit, the organizational provider must make available to the reviewer the most recent site fire clearance document. Fire clearances must be dated within one (1) year of the scheduled recertification site visit. A new fire safety inspection may be required if the facility undergoes major renovations or other structural changes. Review local fire code requirements to determine reinspection schedule. Any efforts to schedule fire clearances should be maintained. All fire clearance documents must be kept at the program site and be available to reviewers.

School Based Programs: Per DHCS, all services are provided at a public school site and meet school fire safety rules and regulations.

Posted Brochures and Notices

All of the following brochures and notices below must be in all available threshold languages and prominently displayed unless otherwise stated. As of this date, there are ten (10) threshold languages: English, Spanish, Chinese, Tagalog, Vietnamese, Korean, Somali, Arabic, Persian (Farsi/Dari) and Russian. See the Optum website > "*Beneficiary*" tab for most up to date list of threshold languages and obtain information without needing to request from staff. Please use the Behavioral Health Plan Informing Materials" to request hard copies of brochures and posters related to the Member Grievance and Appeal Processes as well as other Member Materials. Electronic versions of all materials are available to print on the Optum Website > BHS Provider Resources > MH & DMC-ODS Health Plans > *Beneficiary* Tab

Size Requirements

Programs may also can print brochures/notices independently, provided they meet any size requirements. Per APL 18-026, all written health education materials must use at least a 12-point font. DHCS encourages MCPs to use a larger point font (20- point font or larger) when doing so is considered best practice. Guidelines for written and alternative formats are described below.

Alternative Formats

Written health educational materials should take into account the specific needs of members such as Seniors and Persons with Disabilities (SPDs) and those who are visually impaired. Upon request by the member, family caregiver, or provider, MCPs are required to provide MCP-produced written health educational materials in alternative formats, including Braille, accessible PDFs, large-sized print, video-or audio-accessible materials online, a CD or DVD that is sent to the member (unencrypted) and/or other appropriate technologies and methods. If providing an alternative format causes undue hardship to the MCP, the MCP can provide the information in another reasonable format, such as by phone or in-person from a qualified health educator.

All of the following brochures and notices must be clearly displayed in all available threshold languages:

- Behavioral Health Plan (BHP) Member Handbook in all threshold languages
- Current Provider Lists with instructions for accessing in all languages
    - An updated *County of SD-HHSA-BHS Provider List* must be available. Updates are generally created monthly. It provides instructions for accessing the guide in all languages.
- Current Limited English Proficiency Posters- in all threshold languages
    - Posters must be displayed so all languages are clearly visible.
- Current Notice of Privacy Practices- in all threshold languages
    - Notices must be posted or displayed so all threshold languages are visible
    - Programs are required to provide members a copy of this document no later than the first date of service.
- Current Problem Resolution Process brochures - in all threshold languages
    - Brochures must be easy for members to see/obtain without having to ask staff.
- Current Problem Resolution Process posters (with fair hearing process)- in all threshold languages
    - Programs may print the posters themselves from Optum if they comply with the sizing requirements (8.5 x 14 paper and 12-point font).
- Current grievance/appeal forms with self-addressed, stamped envelopes available -in all threshold languages
    - Forms must be easy for members to see/obtain without having to ask staff.
    - Self-addressed stamped envelopes addressed to either CCHEA or JFS must be provided by the program.
- Open Payments Database Notice- included on provider/legal entity's website (if applicable).- Currently English is the only threshold language available

- If the program employs/contracts physicians/psychiatrists who prescribe medication, then this statement needs to be posted in a common area that is visible to all members.

- If the program employs/contracts physicians/psychiatrists who prescribe medication at **any** of their programs, the Open Payments Database statement (see above) needs to be posted, at minimum, on the legal entity's website with a link to the database to be in compliance.

- Physician Notice to Patients from the Medical Board of California (with QR Code) - in all threshold languages

  - Programs that have a Physician providing or monitoring services are required to post these statements in the office/area where MD services are provided. They do not need to be posted in the main common area.

- California Board of Psychology Consumer Statement- in all threshold languages

  - Business & Professional Code sec 2936 requires programs that have a Psychiatrist providing or monitoring services post these statements.

  - Statements may be displayed in the office/area where psychiatric services are provided. They do not need to be posted in the main common area.

- BBS Notice Display of License/Registration Notice to Consumers (SB 1024)

  - Effective January 1, 2025, licensees and registrants are only required to display their license or registration in a conspicuous place in their primary place of practice when rendering professional clinical services in person. The license or registration does not need to physically be on display when services are provided via telehealth.

- BBS Notice- Updated Requirement to Provide Notice to Psychotherapy Clients (Notice to Clients- AB 630)

  - Effective 7/1/25- mental health professionals licensed or registered with the Board of Behavioral Sciences (BBS), prior to providing psychotherapy, must give clients a notice in at least 12-point font telling them that BBS receives and responds to complaints about licensees and tells clients how to contact BBS to file complaints. This "Notice to Clients" must contain the licensee or registrant's full name, license or registration number, type of license or registration and expiration date. Licensees and registrants must also display their license or registration in a conspicuous location at your

primary place of practice. It **does not need** to be displayed when providing services via Telehealth.

- Human Trafficking Model Notice (For facilities that provide pediatric care) – At minimum posted in English, Spanish and a 3rd language that is most prevalent in the community being served.
    - More information on this notice can be located on the Optum Website and/or the DOJ Website

Electronic Display Options

Postings may also be displayed using video technology. Compliance will be determined on a case-by-case basis and will be evaluated by criteria including legibility, image size, and image residence time or scroll speed.

Legibility and Size: Documents are required to be printed/posted with at least 12-point font, but if displayed electronically, these documents may need to have a larger font so they can be seen from across the room.

Image Time or Scroll Speed: Images need to rotate at a slow enough speed that people can read everything before moving to the next document.

National Voter Registration Act (NVRA)

Per the National Voter Registration Act (NVRA) of 1993, providers are required to offer voter registration materials at intake (except in a crisis), renewal and anytime a change of address is reported. For Children's programs, voter registration services shall be offered to parents/guardians of members less than eighteen (18) years of age. For TAY and Adult programs, voter registration services shall be provided to members who are:

- A citizen.
- A California resident
- At least eighteen (18) years of age by the date of the next election; and
- Not currently on parole for a felony conviction or formally judged by a court to be mentally incompetent to vote.

Behavioral Health Programs shall have Voter Registration Forms and General Instruction Forms available to members in Spanish, Filipino, Vietnamese, and Chinese as required the County of San Diego Registrar of Voters.

The following shall be included in all intake/admission packets:

- Voter Registration Form
    - Paper Registration - To request a paper voter registration application be mailed to you, please call (800) 345-VOTE(8683) or email Elections Division staff.
    - Online Registration - Applications can also be submitted online: California Online Voter Registration.
- General and State Instructions -PDF instructions on how to complete the Voter Registration in English and other languages are available on Voter Registration.
- NVRA Voter Preference Form

Additionally, the same level of assistance shall be provided to mental health consumers registering to vote as is provided for completing other forms for mental health services. When a member requests a form in a language other than those available from the County's Registrar of Voters, staff shall provide the member with the Secretary of State's toll-free number: 1-800-345- VOTE.

Emergency Critical Services

The Office of Emergency Services (OES) coordinates the overall county response to disasters. OES is responsible for alerting and notifying appropriate agencies when disaster strikes; coordinating all agencies that respond; ensuring resources are available and mobilized in times of disaster; developing plans and procedures for response to and recovery from disasters; and developing and providing preparedness materials for the public.

The County of San Diego, Behavioral Health Services, has identified, at a minimum, residential contracts as Emergency Critical. If designated and informed by the COR, providers must identify the primary program contact for emergency/disaster communication and any succession of authority should the primary contact be unavailable. Emergency/disaster contacts must be made known to the COR within fifteen (15) days of start or annual renewal of the contract, or whenever there is a change in contact person. If the need to evacuate the primary service site arises, residential program providers must have arrangements for either an alternate site to house program participants, or a plan to discharge members back to their own homes. The alternate site or plan to discharge home must be made known to the COR within fifteen (15) days of start or annual renewal of contract.

To minimize disruption to member care and assist with continuity of treatment services during emergency situations, DHCS urges providers to reevaluate their policies and procedures surrounding emergency preparedness to ensure the safe evacuation and/or transfer of members when a situation arises that requires the immediate removal

of members. An important aspect of this reevaluation is ensuring that emergency/disaster preparedness plans are up to date. Providers must follow their own relocation protocols to ensure member safety and to limit the disruption in services when possible. DHCS can assist providers with identifying alternative treatment sites for the relocation of members and will work collaboratively with providers to ensure the continuation of services.

Specific guidance for program types is expanded upon in BHIN 20-055: Disaster Management for Department of Health Care Services (DHCS) Licensed or Certified Behavioral Health Facilities

Disaster Preparedness & Response

In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas. Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a disaster or County emergency state of alert. Contractor shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

Contractor shall identify twenty-five percent (25%) of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. Contractor shall advise COR of subsequent year training needs to maintain twenty-five percent (25%) trained direct service staff in the event of staff turnover. Contractor shall always maintain twenty-five percent (25%) staff deployment capability. In the event that contractor's program site is closed due to disaster or emergency, contractor shall call the Access and Crisis Line and their COR to inform them of this.

Providers shall contact their COR if there is an evacuation or relocation of services during the provision of services. COR must grant approval for any discontinuation of services. Funding sources specify that funding can only be claimed for services in support of contracted activities. Redirection of staff to other non-evacuation/emergency activities during an emergency/disaster may cause their time to be non-reimbursable, depending on funding availability and regulations. Note that discontinuation of outpatient services shall, in cost reimbursement programs, result in staffing and other service costs being ineligible for reimbursement during the period of program closure. Fixed price and pay for performance contracts may also be reduced if pay points are not achieved or deliverables are interrupted.

K. Management Information System

The County of San Diego BHS manages an electronic health record (EHR) for the BHP County and Contracted providers. An electronic health record (EHR) will replace much of what is contained in the hybrid medical record. Many controls are built into the software and hardware to safeguard the security and privacy of member personal health information. The electronic Mental Health Management Information System (MH MIS) utilized by the BHP is Streamline SmartCare. All member information, including clinical documentation, is entered into SmartCare allowing for improved coordination of care across the BHP System of Care. For documentation and user guidance, please reference the CalMHSA Website and the to the Optum Website ('*SmartCare'* tab and '*UCRM'* tab).

SmartCare

User Account Setup and Access

SmartCare Software is a web-based application that is managed by CalMHSA. Access to SmartCare is through a secure portal which requires a user to establish an account in which you must obtain an identification number, menu group, and password. Access to SmartCare is granted through the MIS Unit by completing the appropriate access and security forms.

System Administration for SmartCare is shared between the Administrative Services Organization (ASO) and the County's MIS Unit. The ASO is responsible for other system administration activities such as table management, system maintenance, updates to the application, managing SmartCare environments, producing reports for legal entities, electronic submission of state reporting, coordination with SmartCare Software, and providing the User Support Help Desk (for access issues).

The Mental Health Management Information System (MH MIS) is used by County and contract operated programs for member tracking, managed care functions, reporting and billing. The MIS Unit is responsible for managing access, security, and menu management in SmartCare in accordance with County, State and Federal HIPAA regulations. The MIS Unit is also the gatekeeper who ensures that staff is only given access pursuant to contract agreements. In addition, the MIS Unit is responsible for coordination among the County Technology Office, SmartCare and the ASO.

Technical Requirements to Access SmartCare

Prior to accessing the SmartCare application via the internet, there are some basic technical requirements. For questions about whether an individual user or program site

meets the basic technical requirements, it is recommended that the individual or program contact their company's IT department. The ASO may also be able to provide some technical assistance. Additional support regarding SmartCare's hardware, software and network requirements can be found on the Optum Website.

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded SmartCare as well as those who are authorized to access SmartCare must have a staff account. A "staff" in SmartCare is defined as an individual who is employed, contracted or otherwise authorized by his or her designated legal entity or County business group to operate within the County of San Diego public behavioral health System of Care and whose primary job function may include any one of the following: to provide Behavioral Health Services, Quality Assurance activities, enter data, view data, or run reports. This includes clinicians, doctors, nurses, office support staff, financial/billing staff, research/analyst staff and program managers/administrative staff. All Staff providing services must provide National Provider Identifier (NPI) and taxonomy numbers. All staff will be assigned a username.

User Access requires the following steps:

1. Program manager completes the "SmartCare Access Request Form" (ARF) located on the Optum Website> SmartCare tab.

2. All new users must successfully complete the required SmartCare Training Modules after creating a CalMHSA LMS Account.

3. Contractor employee and employee's supervisor must read and sign the "Staff Electronic Signature Agreement".

4. Contractor employee and employee's supervisor must also read and sign the County's "Summary of Policies" (SOP) form.

5. Email all completed forms to:

MIS Unit
BHSEHRAccessRequest.HHSA@sdcounty.ca.gov
and BHSCredentialing@optum.com

All forms **must** be typed and contain all necessary information. Incomplete forms will be returned to the contact person listed on the form. Once completed correctly, the forms must be resubmitted to the MIS Unit. Please ensure forms are completed correctly to avoid delay in user account setup. All forms with instructions are available electronically on the ASO's (Optum) Public Sector website.

Once all forms have been submitted, the MIS Unit will set up SmartCare User Account with username and password. The user will be provided his/her username and password after completing required trainings. Program managers and other supervisors are responsible for registering new staff who will be users to attend the SmartCare training and confirming that employees have successfully completed SmartCare training.

Staff Assignment to Programs

Staff are given access to specific programs based upon the program(s) where they work. Staff are also given access to specific menus based on their respective job functions. A list and definition of menus is available on the Request Form. Staff authorized to access SmartCare will be given login access and a password and are considered "users". Staff may be assigned to a single or multiple programs. The programs must be reflected on the SmartCare Account Request Form (ARF) completed by the program manager.

The MIS Unit will monitor staff access to programs to ensure that staff has been assigned correctly. Under no circumstances should a staff be assigned to a CDAG or program if that staff person does not perform work for that program. This would constitute a violation of security and member confidentiality.

User Assignment to a Clinical Data Access Group (CDAG)

Each user is granted restricted access to MH MIS based on his/her job requirements. One of the ways that access is restricted is through assignment to programs described above. Access is further restricted by assignment to a clinical data access group or CDAG. A CDAG defines the screens and reports the user will be able to access and whether the user can add/edit or delete for each of those screens. For example, the user may only be able to view but not change data in one screen but may have rights to add data or edit previously entered data for another screen. CDAG groups are created based on multiple criteria such as security, level of access to member information, staff job functions, staff credentials and state and federal privacy regulations.

On the ARF, the program manager or supervisor is responsible for requesting the CDAG assignment for each user based on his/her job functions. A user may only be in one CDAG group at a time. Therefore, it is important for the program manager/supervisor to determine which CDAG group is the best match for the job functions performed by his/her staff. If a person is employed by more than one legal entity, he/she may have different CDAG assignments. The provider will have to select the correct CDAG upon login to SmartCare.

For example, there will be Roles for:

- Data entry staff with full member look up rights
- Data entry staff with limited member look up

- Clinicians
- Program managers and supervisors
- Quality Assurance
- Billing staff
- Billing only (For Billing Purposes Only – It has no views)
- Research and Analysts

Refer to the ARF Instructions for a list and definition of available menus. The MIS Unit will review role group requested by the program manager/supervisor and approve or modify the request.

Guidelines when the EHR is Unavailable

Programs are expected to adhere to County and Medi-Cal Documentation standards, even on occasions when the EHR is temporarily out of operation. When an unplanned disruption occurs, programs will receive an email alert from the CalMHSA Helpdesk. Consider the circumstances and apply best judgement to determine if it is prudent to use paper methods for documentation of services. Review UCRM to determine if the documentation/data is required to be entered manually into the EHR or can be scanned into the EHR/maintained in paper format in the Hybrid Chart. Paper billing records should be given to administrative staff for later entry in the EHR. Services may be claimed after documentation on paper notes or signature in the EHR.

It is strongly recommended that programs Save and Sign documentation as soon as possible within the stated timelines, in order to avoid risk of late entry and being out of compliance. Continued problems with the EHR should be reported directly to the CalMHSA Helpdesk.

Questions about the documentation process may be sent to: QIMatters.BHS@sdcounty.ca.gov.

SmartCare for Prescribers

CalMHSA Rx

Prescribers, and nurses who stage medications for prescribers, will have access to CalMHSA Rx. Prescribers who need to be set up to electronically prescribe controlled substances (EPCS) must additionally go through an identity proofing process and a soft or hard token must be established within their account. Both primary and backup tokens are required in SmartCare. Behavioral Health Services (BHS) will implement a new electronic prescribing (e-prescribing) component with the SmartCare go-live called CalMHSA Rx (previously DrFirst). CalMHSA Rx uses a medication management

software called Rcopia that will seamlessly integrate with SmartCare for e-prescribing, meaning no additional login will be required. Doctors who will use SmartCare to e-prescribe will use CalMHSA Rx. For a step-by-step guide, including the information needed for identity verification, please see the EPCS Invite Guide at: Optum Website> SMH & DMC-ODS- Health Plans> SmartCare> *Training* .

Other Resources for Prescribers

- CalMHSA Home Page > *Prescriber Documentation* and *CalMHSA Rx*
- SmartCare DrFirst Guidance (additional information re. hard and soft tokens)
- Quick Start for CalMHSA RX Users

User Support

Users can obtain support through the CalMHSA HelpDesk. The CalMHSA HelpDesk can assist a user with the MH MIS application (technical assistance), MH MIS password issues, connectivity/access problems, printer problems, data entry questions, special requests, such as reports for contractors.

- SmartCare support for system issues is offered by CalMHSA during normal business hours (M-F 8am-5pm)
- Connect via Live Chat at or Submit a Ticket
- Register for a Customer Ticket Portal Account
- After normal business hours the only support available is for system outages. You can call (916) 214-8348

Numerous SmartCare resources are available to assist you with workflow and documentation questions:

1. Go to the CalMHSA Website
2. Access help from within SmartCare
    a. Once you are logged in to SmartCare, you can access help in the following ways:
        i. Use the CalMHSA AI Documentation chatbot to ask direct questions about workflow and documentation

ii. Click on the black question mark at the bottom of your screen to find “how to” documents on the CalMHSA website.

3. Access San Diego Specific Resources

    a. For resources and guidance specific to San Diego County’s use of SmartCare, go to either the BHP Provider Documents or Organized Delivery System Drug Medi-Cal pages of the Optum website> *SmartCare* tab.

Security and Confidentiality

The County of San Diego is responsible for the protection of County technology and data and to monitor through its own policies and procedures user compliance with state and federal privacy and confidentiality regulations. The County’s Security mandates state that access will be given to a user at the least minimum level required by the user to execute the duties or job functions and that only those individuals with a “need to know” will be given access. Protection of County data and systems is also achieved via the use of unique user identification and passwords as well as other tracking methods.

Limitation of Staff Assignment to “Data Entry – Add New Clients”

Program staff will be allowed to view information about a member currently or previously served by their program. Designated program staff will be given access to the “full client look up” to add new members and assign existing members to their program. These individuals will be allowed to view all members in the system, including those not served by their program. This access allows for data entry, adding new members, full client lookup; entering demographic, diagnosis, insurance, and financial information (UMDAP); opening assignments; and running reports.

Program Manager/Supervisor Responsibility for Staff Access

The program manager/supervisor shall ensure that staff are in compliance with all County, State and Federal privacy and confidentiality regulations regarding security, providers protected health information (PHI). In addition, the program manager shall ensure that their staff are aware of the County’s Security Policy regarding the protection of network/application passwords and use of County systems and data as outlined in San Diego County’s “Summary of Policy”. The program manager shall immediately notify the MIS Unit whenever there is a change in information such as staff demographics, email, job title, credential/licensure, and jobs, or are program assignment. This includes the initial staff setup, modifying or terminating existing staff accounts**.**

Under no circumstances shall a staff person who has terminated employment have access to the EHR through SmartCare. This would constitute a serious violation of security which may lead to disciplinary actions.

Unauthorized Viewing of County Data

All terminals / computer screens must be protected from the view of unauthorized persons. All confidential member information, electronic or printed, shall be protected at all times.

Passwords

The sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. A user's password is his/her electronic signature that is not to be shared or made available to anyone. Programs must ensure that the County's Policy and Procedures regarding security and confidentiality as stated in the Summary of Policies must be complied with at all times. Failure to comply with these policies and procedures can result in the temporary or permanent denial of access privileges and/or disciplinary action.

SmartCare passwords:

- Minimum of eight (8) characters
- At least one (1) numerical digit
- At least one (1) lower case letter
- At least one (1) upper case letter
- At least one (1) special character (* - #)
- Must be reset every ninety (90) days. Users will be prompted at the end of each ninety (90) day period.

Multi-Factor Authentication

To ensure the best possible security of member data, SmartCare will utilize multi-factor authentication (MFA) to all contracted users. This means that after entering user ID and password, users will receive an email with a one-time code that will need to be entered before gaining access into the system. Users will use MFA each time they access SmartCare. The change will not impact users who log in via Akamai with a County email.

- MFA will be required every twenty-four (24) hours to access SmartCare

- Users will need to enter security questions - answers are not case sensitive and autofill will populate incorrect answers for security questions

- The change will not impact users who login via Akamai with a San Diego County email address.

- See the following link for more information: MFA Re-Launch Information Staff Termination Process

User Termination from SmartCare

The MIS Unit is responsible for deactivating SmartCare staff accounts.

- **Routine User Termination –** In most cases, staff employment is terminated in a routine manner in which the employee gives an advanced notice. Within one business day of employee termination notice, the program manager shall email to BHSEHRAccessRequest.HHSA@sdcounty.ca.gov and BHSCredentialing@optum.com a completed ARF with the termination date *(will be a future date).* The MIS Unit will enter the staff expiration date in SmartCare which will inactivate the staff account at the time of termination.

- **Quick User Termination –** In some situations, a staff person's employment may be terminated immediately. In this case, the program manager must immediately email the MIS Unit to request the staff account be inactivated immediately. Within one business day, the program manager shall email a completed ARF to the MIS Unit to BHSEHRAccessRequest.HHSA@sdcounty.ca.gov and BHSCredentialing@optum.com.

Legacy System: CCBH

As of 01/01/2026, the legacy solution, Cerner Community Behavioral Health (CCBH) will be retired Access will no longer be available to this system.

All member demographic information from the legacy systems (CCBH & SanWITS) has been made available in the current SmartCare solution. Pertinent member information was migrated to the new system during the transition. All historic information in the legacy CCBH system has been archived and is accessible with a chart request form through the Optum support desk (1- 800-834-3792).

AI-Assisted Documentation and Audio Processing in SmartCare

Artificial Intelligence (AI) tools integrated with SmartCare may be used to support clinical documentation workflows. These tools may assist with transcription, summarization, compliance guidance, or drafting of clinical documentation.

Some AI-assisted documentation tools may process audio from clinical encounters to generate transcripts or documentation summaries. Audio processing may occur through secure systems integrated with SmartCare and approved by the County.

AI-assisted documentation tools are intended to support Direct Service Provider documentation and workflow efficiency. These tools do not replace clinical judgment or the responsibility of the Direct Service Provider to ensure accuracy and compliance with Medi-Cal and County documentation requirements. For purposes of this guidance, **Eleos** is the AI-assisted documentation tool currently approved by BHS and integrated with SmartCare.

Use of Eleos is governed by Behavioral Health Services (BHS) policies and County requirements related to artificial intelligence, privacy, and data security. Use of Eleos shall comply with County of San Diego Board Policy A-140 (Artificial Intelligence) and any applicable contractual requirements. Eleos-generated documentation is considered draft content and must be reviewed, edited as necessary, and approved by the Direct Service Provider before it is finalized in the medical record.

Direct Service Providers remain responsible for ensuring that documentation:

- Accurately reflects services delivered
- Supports medical necessity when applicable
- Complies with Medi-Cal documentation requirements

Eleos use is intended to support documentation workflows but may not always be available. Direct Service Providers remain responsible for completing timely documentation in SmartCare in accordance with Medi-Cal and County documentation requirements when Eleos is unavailable. Eleos may not be used to generate documentation for services that were not provided or otherwise misrepresent clinical services rendered.

Direct Service Provider Responsibilities

When Eleos is used:

a. The Direct Service Provider shall review all Eleos documentation.

b. The Direct Service Provider shall edit or correct documentation as necessary to ensure the content accurately reflects the service delivered.

c. The Direct Service Provider shall approve the final documentation before submitting the note in SmartCare.

d. The Direct Service Provider remains the author of the finalized clinical documentation.

Audio Processing During Clinical Encounters

a. When Eleos is used during clinical encounters:

   i. Direct Service Providers should inform the member that AI-assisted technology is being used to support documentation during the encounter.

   ii. Consent must be obtained and documented in the clinical record prior to the use of Eleos.

   iii. Direct Service Providers should confirm consent with the member at the beginning of each session for Eleos to be used. This verbal consent at the beginning of each session shall be documented.

   iv. If a member withdraws consent, Eleos shall no longer be used.

   v. For group services, Eleos may only be used if all participating members have provided consent. If any participant declines or withdraws consent, Eleos shall not be used for that group session.

   vi. The member may ask questions about the technology used during documentation.

   vii. Audio processing may occur for the purpose of generating a transcript or documentation summary.

   viii. Audio processed by Eleos is handled in accordance with County privacy, security, and data governance policies.

   ix. Direct Service Providers must ensure that member information is processed only through County-approved systems integrated with SmartCare.

   x. Audio retention and deletion practices are governed by the approved system configuration and applicable County requirements.

xi. Direct Service Providers shall not use external or non-approved recording or transcription tools to document clinical encounters. This includes publicly available, consumer-facing, or non-secure Artificial Intelligence tools or platforms.

Use of AI Documentation Suggestions

a. Eleos may generate documentation suggestions, prompts, or compliance alerts. Direct Service Providers may:

b. Accept suggested documentation.

i. Modify suggested documentation.

ii. Override suggested documentation when the suggestion does not accurately reflect the service delivered.

iii. Direct Service Providers must exercise professional judgment when determining whether Eleos-generated content should be included in the clinical record.

iv. Direct Service Providers must apply clinical judgment and/or consult with a clinical supervisor before making decisions that impact the type or amount of care provided if and/or when Eleos content is used to support clinical decision-making.

v. Eleos-generated content may not replace required clinical supervision, assessment, or clinical decision making.

Documentation Requirements

a. Documentation created with Eleos must:

i. Accurately reflect services delivered during the encounter.

ii. Comply with Medi-Cal and County documentation requirements.

iii. Support medical necessity where applicable.

b. Eleos-generated documentation must be reviewed and edited as needed before it is finalized in the medical record

Privacy and Confidentiality

a. Use of Eleos must comply with all applicable privacy and confidentiality requirements, including:

    i. HIPAA

    ii. 42 CFR Part 2

b. Member information may only be processed through County-approved AI systems integrated with SmartCare, unless otherwise authorized by BHS.

c. Direct Service Providers shall not enter member information into external or non-approved AI tools without prior written approval from BHS. This includes generative AI platforms, transcription services, publicly available AI platforms, or other AI-enabled tools that are not approved by the County.

d. Direct Service Providers seeking to use AI tools that are not integrated with SmartCare must submit a request to BHS at QIMatters.BHS@sdcounty.ca.gov prior to implementation. BHS will review the request and, as applicable, coordinate with DHCS to determine whether the proposed AI tool is permissible. Direct Service Providers must not use such AI tools until approval is confirmed by BHS.

Training

a. Direct Service Providers authorized to use Eleos must complete required training prior to using the system. Training includes:

    i. Appropriate use of Eleos.

    ii. Review and editing of Eleos-generated documentation.

    iii. Medi-Cal documentation expectations.

    iv. Privacy and confidentiality protections.

    v. Member notification and consent requirements related to Eleos.

    vi. Any County-required AI-related training.

Contracted Organization (Legal Entity) AI Policy Requirement

a. Contracted Organizations must develop, implement, and maintain organizational policies and procedures (P&P) governing the use of Eleos that aligns with County Board Policy A-140, the BHS AI Policy, this guidance, applicable laws and regulations, and other applicable BHS requirements.

b. Prior to receiving access to Eleos, Contracted Organizations must provide confirmation, in a form specified by BHS, that the required organizational AI policies and procedures have been developed and implemented and will be made available to BHS upon request. Confirmation may be required from Legal Entity leadership, Program Managers, or other authorized organizational representatives.

c. At a minimum, the Organization's Eleos-related P&P should address:

    i. **Governance and Oversight** Identification of responsible roles for AI use within the organization and processes to ensure alignment with County Board Policy A-140, the OPOH/SUDPOH, and other applicable County and BHS requirements. P&P should address internal oversight, risk mitigation, staff accountability, and processes for responding to concerns related to AI use.

    ii. **Human Oversight and Accountability.** Requirements that Eleos-generated outputs are reviewed, edited as necessary, and approved by the direct service provider, and that the direct service provider remains responsible for the accuracy and completeness of all finalized documentation. Eleos may not replace clinical judgment or required supervision.

    iii. **Privacy and Data Protection.** Safeguards to ensure compliance with applicable privacy and confidentiality laws (e.g., HIPAA, 42 CFR Part 2), as well as County and BHS data protection requirements, including use of only County-approved or otherwise authorized systems.

    iv. **Member Communication and Education.** P&P should address how members will be informed about Eleos, including use of approved educational materials, responses to common member questions, and communication regarding member rights and available alternatives.

v. **Member Notification and Consent.** Processes for informing members when Eleos is used in care, including how notification and consent are obtained and documented consistent with County and BHS requirements. P&P should address:

- notification that AI-assisted technology is being used;
- documentation of consent consistent with County requirements;
- member right to decline participation;
- obtaining and documenting consent prior to the use of AI-assisted documentation tools;
- ongoing notification of AI-assisted technology prior to every use;
- reminding members of their right to withdraw consent at any time;
- procedures for continuing services when a member declines use of AI-assisted tools.

vi. **Appropriate and Prohibited Uses.** Clear expectations regarding permissible uses of Eleos, including the prohibition of use to generate documentation for services not provided or to otherwise misrepresent services. P&P should also prohibit the use of non-approved AI tools, unauthorized recording or transcription applications, and the entry of member information into systems not approved by the County or BHS.

vii. **Staff Training.** Requirements for staff training on appropriate AI use, including responsibilities for review, editing, and compliance with documentation, privacy, and consent-related expectations, as well as completion of all vendor-related training (e.g., Eleos-provided or CalMHSA-provided), County-required AI-related training, and any other training required for the authorized use of AI-assisted tools. Training should address:

- appropriate use of AI-assisted tools;
- review and editing of AI-generated content;

- privacy and confidentiality requirements;
- member notification and consent requirements;
- documentation standards and accountability.

viii. **Monitoring and Compliance.** Processes for monitoring AI use within the organization to support documentation quality, compliance, staff training, and adherence to County and BHS requirements. Monitoring activities should support quality improvement, compliance oversight, staff training, workflow optimization, risk mitigation, and adherence to County and BHS requirements and should not be used for routine employee surveillance.

ix. **Documentation Standards and Accountability.** Requirements that Eleos-generated content be treated as draft content until reviewed, edited as necessary, and finalized by the direct service provider. P&P should clearly state that Eleos does not replace clinical judgment and that staff remain responsible for the accuracy, completeness, and compliance of finalized documentation.

x. **Approved Technology Use.** P&P should prohibit the use of non-approved AI-assisted documentation tools, recording applications, or transcription services for County-funded services unless expressly authorized by BHS.

d. Contracted Organizations must maintain documentation of their AI policy and make it available to BHS upon request.

e. Contracted Organizations must maintain documentation of their AI policy and make it available to BHS upon request.

Quality Oversight

a. BHS may review documentation created using Eleos as part of routine quality assurance and compliance monitoring activities.

b. Monitoring may include:

i. Documentation audits

ii. Review of documentation quality trends
iii. Analysis of system-generated compliance alerts and related documentation trends

iv. Review of findings from DHCS audits or External Quality Review (EQR).

c. Monitoring activities are intended to support quality improvement, compliance oversight, training, workflow optimization, and program evaluation and are not intended for routine employee surveillance.

d. Direct Service Providers may receive feedback or additional training based on monitoring findings.

e. The County reserves the right to review, monitor, and require modification or discontinuation of Eleos use if compliance, privacy, or documentation risks are identified.

Resource Guide

Need	Resource	Contact Information
System Issues (i.e. glitches, functionality issues, pop up errors)	CalMHSA Live Chat	www. 2023.calmhsa.org After normal business hours the only support available is for system outages: (916) 214-8348
SmartCare ARF submission and any access related issues or questions	Email	BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov
Support questions that cannot be addressed by the CalMHSA Support Desk	Email	BHS_EHRSupport.HHSA@sdcounty.ca.gov
Questions related to documentation, guidelines or policy	Email	QIMatters.BHS@sdcounty.ca.gov
Escalation of CalMHSA help desk issues resolved prematurely or not resolved entirely	Email	BHS_EHRSupport.HHSA@sdcounty.ca.gov
Optum Support Desk	Phone Email	1-800-834-3792 sdhelpdesk@optum.com

L. Data Requirements

Data Collection and Retention

The contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of members in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the EHR User's Manual. Service entry shall be kept up to date, and the data shall be entered into the SmartCare Data System within a timely manner.

Data Accuracy

Providers are responsible for ensuring that all member information, including addresses and demographic data, is accurate and meets State reporting requirements for Client Statistical Information (CSI). Providers must have processes for checking/updating member data and following the appropriate procedures when data corrections are needed. In addition, Full-Service Partnership (FSP) programs are required to ensure that all required data is current and up to date in any designated system.

Access Times Monitoring

BHS will monitor program data for compliance with access times standards monthly, that includes a review of NOABD data to ensure NOABD's are issued when lack of compliance is indicated. When non-compliant programs will be notified, technical assistance will be provided. A written report documenting noncompliance will be issued by BHS and providers are required to submit a Corrective Action Plan (CAP) to BHS within thirty (30) days of the report for approval. BHS shall verify corrections as resolved.

Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey

Consumer Satisfaction Surveys are valuable tools for assessing and enhancing client-centered care within the mental health system. By systematically collecting and analyzing consumer feedback, they contribute to improved service delivery, better member outcomes, and greater accountability in mental health care provision. Provider participation in the survey process is critical to get an accurate picture of how well each provider and the mental health system as a whole are meeting member needs. The MHSIP is a tool designed to gather feedback from individuals who have received mental health services. It aims to assess their satisfaction with various aspects of care and their experiences with mental health providers.

On an annual basis, BHS selects a one (1) week time period in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of a Mental Health Statistics Improvement Program (MHSIP) section, which measures member satisfaction with services. This survey should be administered to ***all*** members receiving services during the week, ***including members receiving medications only*****.** UCSD Health Services Research Center (HSRC) is contracted by the BHP to handle the adult survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. Providers will be notified by HSRC of the exact survey period. Survey returns are scanned and then tabulated, therefore, original printed forms provided by the BHP must be used.

Providers are strongly requested to send in completed surveys according to HSRC instructions at the end of the survey period. Each participating provider will receive a report comparing their results on the survey with the average results for their level of care. The criteria and guidelines for the Adult MHSIP Survey are subject to change as determined by DHCS. Providers will be notified of changes affecting them.

Medi-Cal Administrative Activities (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities necessary to properly and efficiently administer a State's Medicaid (Medi-Cal) plan. These Medi-Cal Administrative Activities (MAA) are focused on assisting individuals in accessing the Medi-Cal Program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities, and other designated activities.

Organizational providers may be permitted to provide MAA services and claim them. The BHP requires that each organizational provider have a county-approved MAA Claiming Plan prior to claiming MAA services and that each provider complies with all applicable State and federal regulations. To claim for MAA activities, a provider must follow a set of procedures described in detail in the *MAA Instruction Manual* developed by the State Department of Health Care Services.

The MAA Coordinator provides technical assistance and training on MAA to providers. The coordinator can also assist with claiming and procedural questions or train staff on MAA. There is a Medi-Cal Administrative Activities Procedures Handout for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes. The handout and the MAA Community Outreach Service Record can be found on the Optum website.

Monthly/Quarterly Status Report (M/QSR)

Contracted providers are required to submit a completed Monthly Status Report (MSR) and/or Quarterly Status Report (QSR) within twenty (20) calendar days after the end of the report month. The COR reviews the status report for needed information on compliance and contractual requirements. The Quality Assurance Unit (QA) tracks and trends data, provides analysis and issues reports as needed for the Department of Health Care Services (DHCS), BHS Administration, the Quality Review Council and other groups.

The status report may include:

- A narrative (including General Information, Program Description, Activities/Events, Community Outreach, Emerging Issues, Quality Improvement Activities),
- Outcomes,
- Data Summaries for Units/Subunits
- Staffing & Personnel
- Member Suggestions & Transfer Requests
- Notices of Action
- Additional Information Requested by the COR.

Systemwide State Required Performance Measures

Member outcomes are fundamental measures used to assess the quality and effectiveness of healthcare services. These outcomes provide crucial insights into the impact of interventions, treatments, and overall care delivery on member's health and well-being. Member -reported outcomes (PROs) offer valuable perspectives directly from members regarding their health-related quality of life, pain levels, functional status, and overall satisfaction with the care received. These indicators provide a holistic view of how well healthcare services meet the needs and expectations of members beyond mere clinical effectiveness. Mandated assessments and member-reported outcomes are indicated in the information below.

California's External Quality Review Organization (EQRO) plays a crucial role in monitoring and evaluating the quality of care provided to Medi-Cal members. Cal EQRO is an independent entity contracted by the State to assess the performance of Behavioral Health Plans and ensure compliance with federal and state standards. Requirements include Network Adequacy Validation (NAV), Performance Measure Validation (PMV)- also known as HEDIS, and Performance Improvement Projects (PIP) requirements. The tables below outline the NAV, PMV and PIP for the County of San Diego.

Healthcare Effectiveness Data and Information Set (HEDIS/PMV)

HEDIS is a recognized set of performance metrics in healthcare, standardized by the National Committee for Quality Assurance (NCQA) for evaluating care and service performance. While the NCQA develops and oversees HEDIS, the Centers for Medicare & Medicaid Services (CMS) also manages specific HEDIS measures to promote high-quality, safe and equitable care. HEDIS metrics are updated annually to reflect current clinical guidelines and priorities, providing a framework for assessing healthcare effectiveness, safety, and client-centeredness across various populations. The state-mandated HEDIS metrics for SMHS are detailed in the table below:

EQRO MH Metrics - NAV	Standard
Outpatient Non-Urgent Non-Psychiatry SMHS (BHP Timely Access Standards Selected for Validation)	Offered an appointment within ten (10) business days of request for service
Non-Urgent Psychiatric Services (BHP Timely Access Standards Selected for Validation)	Offered an appointment within fifteen (15) business days of request for services
All SMHS Urgent Appointments (BHP Timely Access Standards Selected for Validation)	Forty-eight (48) hours without prior authorization Ninety-six (96) hours with prior authorization

Performance Improvement Projects	Standard
Clinical	Follow-Up After Emergency Department Visit for Mental Illness (FUM).
Non-Clinical	Improve timely access from first contact from any referral source to first offered appointment for any specialty mental health service (SMHS).

Outcome Mandated Metrics/Assessments	Frequency Standard
Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey	Annually

Member and Performance Outcomes

Measuring outcomes is an integral aspect of the System of Care principles and standard outcomes have been established for all treatment providers. Specialized programs may have individual program outcomes in addition to or in lieu of standard

outcomes measured by all programs. Outcome measures and explanation sheets are located on the Optum Website > *UCRM* tab.

Additional statistical data or outcome requirements may be included in specific program contracts. This may involve using additional tools for Evidence-Based Programs or specific parts of the system. Specific contracts may also require the manual collection of data on certain outcomes from member charts, such as the number of hospitalizations, readmissions, arrests, or changes in the level of placement/living situation. The data collected should be submitted on the QSR or as directed by the program's COR, Health Plan Operations, COE, or the QA unit.

Measures for Programs Serving Adults and Older Adults

The Level of Care Utilization System (LOCUS) is used by programs serving Adults/Older Adults. The LOCUS is a short assessment of member current level of care needs and is completed by program staff with the appropriate training. The Level of Care Utilization System (LOCUS) is available in SmartCare for staff who have completed the five (5) hour initial LOCUS training offered through the American Association of Community Psychiatry (AACP). It is expected that providers completing the LOCUS will do so within their scope of practice, and after completing all necessary training. Providers may access resources on LOCUS training at: AACP- Login.

Program staff should complete a LOCUS for all members within thirty (30) days of their initial intake assessment and every six (6) months thereafter to evaluate level of care as clinically appropriate. Programs utilizing the LOCUS shall enter the information into the EHR in a timely manner. Additional outcome measures may be completed at the program's discretion or instruction of their Center of Excellence (COE) fidelity contractor if delivering an applicable evidence-based practice.

Measures for Programs Serving for Children and Youth

Outcomes measures and data entry trainings are available on the UCSD Children & Youth Outcomes Measures website. Information on CANS certification, a requirement for administration, is available on the System of Care Outcomes for Children, Youth and TAY website. All outcomes' data will be completed within the electronic health record and then entered in the "*Other* "data is manually collected by providers and submitted on a quarterly basis (QSR). The data is useful in determining trends and patterns in service provision and demand, as well as, identifying opportunities for improvement. In conjunction with new State mandates for quality improvement and monitoring member progress, the BHP is extending the Client Outcomes tracking to all programs through data reports and the QSR.

Participating programs shall report their outcomes data according to defined timelines. The Program Monitor/COR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QA unit will track trends for the data provided on the QSR and the quarterly Child, Youth & Families mHOMS DES report produced by CASRC. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor/COR and/or the Child and Adolescent Services Research Center (CASRC).

State Required Outcomes for Programs Serving Children & Youth

Outcome Mandated Metrics/Assessments	Frequency Standard
CANS-Child and Youth: 0-21 years old	Intake, Six (6) months, Discharge (ONLY if discharging from the system of care- the member is NOT enrolled in any other program).
Pediatric Symptom Checklist, Parent/Caregiver (PSC): Three to eighteen (3-18) years of age (Medication-only members excluded)	Intake, Six (6) months, Discharge
Youth Services Survey, Youth (YSS-Y): Thirteen (13) years of age or older	Annually
Youth Services Survey, Family (YSS-F): Caregivers of youth up to age eighteen (18)	Annually
Medication Only Members: Per BHIN 18-048, the CANS and PSC must be completed for all cases, including medication only members.	

The Child and Adolescent Needs and Strengths (CANS)

Per DHCS, the CANS is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. Providers will complete the CANS (California CANS) form through a collaborative process which includes children ages six (6) and youth up to age twenty (20), and their caregivers (at a minimum). The CANS version being used is the CANS Core Item set. The CANS will need to be completed at the beginning of treatment, updated every six (6) months following the first administration, and at the end of treatment. For more information please see: DHCS- Functional Assessment Tools.

The CANS assessment is designed to support decision-making in child and adolescent services, particularly within mental health and child welfare systems. It evaluates the needs of children and youth, determines appropriate services, and monitors progress over time. CANS results shall be used to support medical necessity, treatment planning and clinical progress made in treatment. CANS results are interrelated to the Mental Health Assessment and shall also be utilized as Service Necessity Criteria for Intensive Service Requests (ISR) and Specialty Mental Health DPRs.

There are various versions of the CANS tailored to different populations. With the September 2024 shift to SmartCare, the system transitioned from utilizing the CANS-50 with additional modules to utilizing the IP-CANS which is also the required version through CDSS. Current DHCS guidance shall be followed – (BHIN 25-035)

CANS Completion Timelines and Discharges:

All children, youth, and transitional-age youth ages zero to twenty- one (0 to 21) years old in an outpatient treatment program shall have the CANS completed at:

1. Initial intake at case opening which is beginning of SMHS treatment and may or may not be the intake date to the program

2. Every six (6) months, following first administration

3. Within thirty (30) days of determining occurrence of a significant change or condition

4. At end of SMHS treatment (discharge from the program IF the member is not open to any additional programs)

Data must be entered into SmartCare Electronic Health Record:

- Initial CANS - within thirty (30) days of intake date
- Every six (6) months in a timely manner
- Significant Event – within thirty (30) days when indicated
- Discharge CANS - within seven (7) days from discharge date

The IP CANS replaces the former SD CANS versions (*EC* for ages 0-5, and *50* for ages 6-20). The EC Module will populate in the CA CANS document in SmartCare when being completed for those minors up to five years old (ages 0-5). Adult and Older Adult mental health programs serving TAY will be required to complete a CANS assessment for all TAY-age participants, ages eighteen to twenty-one (18 to 21 years old).

In SmartCare, CANS and PSC are *client-level documents*, they are no longer program-level documents. This means: When a reassessment and discharge is due for a member with multiple serving providers, coordination is required for one submission for the member. For youth in multiple programs, CANS and PSC are streamlined in

SmartCare so that only one set of assessments are due for each youth. Instead of each program completing its own assessment, providers will collaborate to determine the best provider to perform the assessment, thereby reducing redundancies and improving member care.

In SmartCare, outcome measures should only be entered every six (6) months. For UM cycle purposes some programs may have unique/specific requirements for outcome measures (i.e. requiring CANS scores every three (3) months) the most recent measure should be used as long as they have been completed within the past six (6) months. See SmartCare CANS/PSC link on the Optum website 'SmartCare' tab for more information.

For youth open to multiple programs; if the member is still open to another program when discharging, the discharging program will not complete a Discharge CANS. The program that the member remains open to will continue to follow the CANS and PSC reassessment schedule. If the member is not open to any other programs, the discharging program will complete a Discharge CANS**.**

CANS Administrative Close	Discharge CANS
Member is not open to any other program.	Member is not open to any other program.
Previous CANS **was** completed within sixty (60) days of discharge date. The most recent CANS will be accepted as the discharge measure.	Previous CANS **was not** completed within sixty (60) days of discharge date.

CANS Training

The CANS can only be administered by staff who have completed the Certification process. To administer the CANS, you must be certified by the PRAED Foundation. Once you pass the certification test, your certification is valid for one (1) year. You must pass the certification test annually to be certified. Once a practitioner is certified by PRAED, they may complete any version of the CANS. Annual training (and in some cases additional training) and certification is required for providers who administer the CANS as well as their supervisors.

Resources: IP- CANS Manual/Reference Guide & Local Training Process: Outcomes for programs that serve Children, Youth & Families

CANS Exceptions

New admissions to a program who are within six (6) months of turning twenty-one (21) at intake are not required to complete the CANS assessment. Outcome measures identify the effects of mental health treatment. Once members transition from "Meds Plus" to "Meds Only," they will not be required to enter outcome measures in the EHR. Administer and record CANS and PSC as a discharge assessment upon transition to

"Meds Only". Administer and record CANS and PSC as an intake assessment if the member returns to treatment services (Meds Plus) from meds only as a new episode in the EHR.

CANS Discharge Outcomes Objectives

- At discharge, one hundred percent (100%) of members ages six through twenty-one (6-21) shall have at least one actionable need (2 or 3) on the *Child Behavioral and Emotional Needs*, *Risk Behaviors,* or *Life Functioning* domain on their initial CANS.

- At discharge, minimum eighty percent (80%) of members ages six through twenty- one (6-21) with an actionable need (rating of 2 or 3) on the ***Life Functioning*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

- At discharge, minimum eighty percent (80%) of members age 6-21 with an actionable need (rating of 2 or 3) on the ***Risk Behaviors*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

- At discharge, minimum 80% of members ages six through twenty- one (6-21)with an actionable need (rating of 2 or 3) on the ***Child Behavioral and Emotional Needs*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

Pediatric Symptom Checklist (PSC)

Per DHCS, the PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Parents/caregivers will complete the PSC-35 (parent-completed version) for their children ages three (3) and youth up to age eighteen (18). The PSC-35 will need to be completed at the beginning of treatment, every six (6) months following the first administration, and at the end of treatment. For more information please see: Functional_Assessment_Tools

The PSC is provided to caregivers of children and youth ages three through eighteen (3-18) years of age at:

1. Initial intake **at case opening** which is beginning of SMHS treatment and may or may not be the intake date to the program

2. **Every six (6) months**, following first administration

3. At **end of SMHS treatment** (discharge from the program IF the member is not open to any additional programs)

All responses shall be recorded by program staff in the EHR or as otherwise directed by the County:

- Initial PSC - within thirty (30) days of intake date
- Every six (6) months -in a timely manner
- Discharge PSC - within seven (7) days from discharge date

Please note: In SmartCare, outcome measures should only be entered every six (6) months. For UM cycle purposes, some program may have unique/specific requirements for outcome measures and should use the most recent measure for these purposes.

When no parent/guardian is available, an individual in a caretaking capacity (i.e., residential staff, social worker, relative, etc.) may complete the measure. Most current PSC scores above the clinical cutoff should be considered during UM/UR Authorization, supporting medical necessity and clinical effectiveness. See "*PSC Explanation Sheet*" on the Optum *UCRM* tab for further information.

PSC Exceptions

Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

PSC Discharge Outcomes

- At discharge, minimum fifty percent (50%) of members ages three through eighteen (3-18) years old shall show reliable improvement on the PSC by having a minimum six (6) point reduction in symptoms on the total scale score.

- At discharge, minimum fifty percent (50%) of members ages three through eighteen (3-18) shall score below the clinical cutoff on at least one scale (which was elevated on their initial assessment) and have at least a six (6) point reduction on the Parent PSC total scale score demonstrating clinically significant improvement.

- Report the number of discharged members ages three through eighteen (3-18) whose episode lasted sixty (60) days or longer, whose Initial Parent PSC total score was above the clinical cutoff, and whose total score was below the clinical cutoff at discharge, demonstrating improvement.

- Report the number of members ages three through eighteen (3-18) whose episode lasted sixty (60) days or longer, with a three (3) point improvement (reduction in symptoms) between Initial and Discharge assessments, demonstrating improvement.

Youth Services Survey (YSS): Member Satisfaction

A satisfaction survey is conducted annually within all organizational programs (excluding detention programs, medication only cases, inpatient, and crisis services) as required by the State to assess member satisfaction. The Youth Services Survey (YSS) is administered to all members receiving services during the one-week period by the Child and Adolescent Services Research Center (CASRC).

Youth aged thirteen (13) and older complete the Youth Services Survey with the attached comments page. Parents/caregivers of children and youth up to age eighteen (18) complete the Youth Services Survey-Family. Surveys are to be administered to ensure full confidentiality, as directed by the Child and Adolescent Services Research Center (CASRC). The survey returns are scanned to facilitate tabulation; therefore, the original printed forms provided by the BHP must be used. Completed surveys shall be completed via the secure link or delivered by hand to CASRC within three (3) business days after each survey period has been completed, adhering to HIPAA regulations.

YSS Exceptions

Medication-only cases are excluded from the YSS measure.

YSS Satisfaction Outcomes

Submission rate the YSS shall meet or exceed the eighty percent (80%) standard established by the County of San Diego Children's Mental Health. Aggregated scores on the YSS shall show an average of eighty percent (80%) or more respondents responding "Agree" or "Strongly Agree" for at least seventy-five percent (75%) of the individual survey items. Members receiving services from a Substance Use Disorder counselor at an FSP Subunit shall show an average of eighty percent (80%) or more respondents responding "Agree" or "Strongly Agree" on each of the seven supplemental items.

Additional Objectives for Programs Serving Children and Youth

All Providers

- One hundred percent (100%) of all members, ages sixteen (16) and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.

- One hundred percent (100%) of all members shall be assessed for domestic violence issues as evidenced by documentation in the medical record.

- One hundred percent (100%) of all members shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.

- Eighty percent (80%) or more of all members shall receive at least one face-to-face family treatment contact/session per month with the member's biological, surrogate, or extended families (who are able).

Outpatient Providers

- Ninety percent (90%) of members will not require psychiatric hospitalization or re-hospitalization during the outpatient episode.

- Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 54,000 minutes per year (fifty percent (50%) productivity level) for clinic, school, and community-based programs per FTE, unless otherwise specified in the program's Statement of Work.

- Psychiatrist shall maintain a minimum of 75% productivity level.

- RN shall maintain a minimum productivity level of fifty- five percent (55%).

- Case Management services provided by a case manager shall meet or exceed the minimum productivity for annual billable time by providing at least 32,400 minutes per year (thirty percent (30%) productivity level) per FTE, unless otherwise specified in the program's Statement of Work

- Clinical staff shall carry a minimum case load of forty (40) unduplicated members per FTE per year unless otherwise specified in the program's Statement of Work.

- Case Managers shall carry a minimum case load of twenty (20) unduplicated members per FTE per year unless otherwise specified in the program's Statement of Work.

Day Treatment Providers

- The contractor shall ensure that billable days are produced for ninety percent (90%) of the annual client days available, based on five (5) days per week or a two-hundred and thirty (230) days per year.

- Ninety-five percent (95%) of members will be discharged to a lower level of care unless otherwise specified in the contract.

- Ninety-five percent (95%) of members will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

Research Projects Involving Children

Some providers may develop research projects or test additional outcome tools with methods that utilize BHP members. All such projects must be reviewed by the BHP's Research Committee. Approval is required prior to implementation. For more information on BHS research procedures contact BHSResearch.HHSA@sdcounty.ca.gov.

M. BH Connect

In 2025, the County of San Diego opted in to the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), a statewide initiative developed by DHCS as part of California's Behavioral Health Transformation. BH-CONNECT aims to strengthen and expand the behavioral health continuum of care for Medi-Cal members with significant mental health and substance use needs by improving access, coordination, and community-based supports.

The County began phased implementation in 2025, which includes Federal Financial Participation for Specialty Mental Health Services in Institutions for Mental Diseases, Enhanced Community Health Worker Services, and expanded or clarified Medi-Cal coverage for several Evidence-Based Practices (EBPs) including:

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- Coordinated Specialty Care (CSC) for First Episode Psychosis
- Clubhouse Services
- Enhanced Community Health Worker (CHW) Services*
- Individual Placement and Support (IPS) Supported Employment*
- Children's EBPs such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and High-Fidelity Wraparound (HFW)

*Available in SMHS and DMC-ODS delivery systems

Fidelity Assessments & Medi-Cal Fidelity Designation for BH-CONNECT EBPs

When implemented in alignment with evidence-based models, BH-CONNECT EBPs consistently produce positive outcomes for individuals with significant behavioral health needs. Maintaining fidelity through scheduled assessments is a core requirement for each contracted EBP to ensure services are delivered as intended and to identify areas for improvement. To support this effort, DHCS has engaged Centers of Excellence (COEs) to provide counties and behavioral health providers with no-cost training, technical assistance, and fidelity monitoring or accreditation support. COEs will conduct fidelity assessments at regular intervals for each EBP. BHS contractors are required to work within their contract scope of work and involve their COR in all conversations with the designated COE and EBP conversations.

Additional information is available on the DHCS COE website.

Claiming and Medi-Cal Payment for BH-CONNECT EBPs

Providers must adhere to DHCS guidance, including fidelity, documentation, and reporting standards, and maintain coordination with Medi-Cal claiming standards and other funding sources. BHIN 25-009 outlines guidance regarding coverage of EBPs available under Medi-Cal as part of BH-CONNECT including requirements for:

- Medi-Cal Fidelity Designation
- Claiming Requirements
- Bundled Rates
- Full and Partial Rates
- EBP Payment Requirements
- Prior Authorization
- Other Billing Limitations

For more information about BH-CONNECT, please visit: https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

N. Behavioral Health Services Act (BHSA)

Proposition 1, approved in March 2024, modernizes California's behavioral health system by improving accountability, increasing transparency, and expanding treatment capacity. The Department of Health Care Services (DHCS) is implementing these changes through Behavioral Health Transformation (BHT), building on existing statewide initiatives. SB 326 (BHSA) replaces the 2004 Mental Health Services Act (MHSA) and expands services to include substance use disorder (SUD) treatment, housing interventions, and workforce development, with a focus on individuals with the greatest behavioral health needs. For more information, access the BHSA Policy Manual.

BHSA funding may serve children, youth, adults, and older adults who meet BHSA eligibility criteria aligned with Medi-Cal Specialty Mental Health Services (SMHS). County of San Diego BHS contracts that leverage BHSA funding will also include the specific target population for the contract, inclusive of age range. These contracts may also utilize other funding sources to support the contracted services and include additional requirements.

All retained MHSA-funded programs were transitioned into one of three BHSA components and must meet BHSA priorities and DHCS requirements as outlined by DHCS guidance, including the BHSA Policy Manual and county-specific service needs.

1. **Behavioral Health Support Services (BHSS)** – Provides integrated early intervention, mental health, and SUD services for all ages. Includes:

    a. Early Intervention: Prevents serious mental illness and SUD, reduces disparities, and focuses on reducing outcomes such as suicide, school failure, incarceration, unemployment, homelessness, family separation, overdose, and prolonged suffering.

    b. Other Services and Supports (OSS): Includes Children's, Adult, and Older Adult Systems of Care, Outreach & Engagement, and CFTN.

2. **Full Service Partnership (FSP)-** Delivers intensive, team-based, "whatever it takes" services for individuals with significant behavioral health needs. Subcomponents include:

    a. FSP 1: Intensive Case Management for individuals needing moderate to significant support.

    b. FSP 2: Services for the highest-acuity individuals, including ACT, FACT, and High Fidelity Wraparound.

    c. Other EBPs: Programs such as IPS and Clubhouses.

    d. Allowable Costs: Innovative or other DHCS-approved costs.

3. **Housing Interventions (HI)** – Supports a broad range of housing needs, including rental subsidies, operating subsidies, shared recovery housing, family housing, transitional rent (pending federal approval), project-based assistance, and capital projects. As defined in W&I Code section 5830, individuals must meet the BHSA eligibility requirements and meet the definition of:

    a. At-Risk of Homelessness, **or**

    b. Experiencing Homelessness, **or**

    c. Chronically Homeless, with a focus on those in encampments. Of the funding distributed to counties for Housing Interventions fifty (50) percent must be used to support the housing needs of individuals who are chronically homeless, with a focus on those in encampments.

Contracted programs that are expected to support BHS and Managed Care Plans (MCPs) coordination must ensure that HI funding is not used by services that are covered by MCPs. They must also:

a. Support seamless connections from the county to the MCPs for coverage of housing services and vice versa.

b. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet BHSA eligibility criteria.

BHSA funded programs must support BHS in promoting access to care through the efficient use of State and County Resources.

For securing managed care and OHC payments, billing and further documentation resources, see: *BHSA Policy Manual* - Section 6 BHT Fiscal Policies & Section 9 Appendix for helpful process flows and procedures

To access the BHSA Policy manual and find current information, please visit: https://policy-manual.mes.dhcs.ca.gov/

O. Contracting

Note: References to contracting do not apply to County-operated programs.

All contracted providers, including subcontractors, shall adhere to the Behavioral Health Plan (BHP) contract executed between San Diego County and the California State Department of Health Care Services (DHCS). All non-County-operated organizational providers must contract with the County of San Diego to receive reimbursement for Specialty Mental Health Services.

Please read the contract carefully, it contains:

- General terms applicable to all contracts
- Special terms specific to a particular contract
- A description of work or services to be performed
- Payment Schedule and/or budget; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds

Selection and monitoring of organizational agencies are governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, and a proposed staffing plan. All contracted providers will be expected to adhere to these requirements. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Please contact the Behavioral Health Services Contracting Officer's Representative (COR) with any questions regarding the contract.

Provider Orientation

All new agreements require a provider orientation meeting within thirty (30) business days of the agreement's execution or start date, whichever occurs later, and as needed throughout the agreement term. Additional orientations may be required when there are changes to key provider or County staff, operational or fiscal processes, laws or regulations, funding requirements, agreement templates, or unique agreement elements. The CORs and Administrative Representatives, in conjunction with the BHS Contract Support Team, are responsible for leading the provider orientation.

The orientation ensures providers understand their contractual obligations and the County's monitoring activities, and may be conducted in person, virtually, by email, telephone, or any combination, as deemed appropriate by the COR or Administrative Representative.

The provider will designate a contact person to coordinate attendance of necessary provider staff at the orientation. For experienced providers, orientation may be limited to updates on unique agreement requirements or changes to County/BHS processes.

Disclosure Requirements

The Behavioral Health Plan (BHP) providers and contractors shall disclose to the state any persons or corporations with an ownership or control interest that:

- Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Legal Entity's equity;
- Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Legal Entity if that interest equals at least five percent (5%) of the value of the BHP's assets;
- Is an officer or director of a Legal Entity organized as a corporation; or
- Is a partner in a Legal Entity organized as a partnership.
- Any person with a five percent (5%) or more direct or indirect ownership of the Legal Entity's equity must submit to a criminal background check, including submitting fingerprints. (42 CFR 455.434(b)

The contract requires the BHP to submit:

- The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors.
- The addresses for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the BHP and its subcontractors.
- Other tax identification number of any corporation with an ownership or control interest in the BHP and any subcontractor in which the BHP has a five percent (5%) or more interest.
- Information on whether an individual or corporation with an ownership or control interest in the BHP is related to another person with ownership or control interest in the BHP as a spouse, parent, child, or sibling.

- Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the BHP has a five percent (5%) or more interest is related to another person with ownership or control interest in the BHP as a spouse, parent, child, or sibling.

- The name of any other disclosing entity in which an owner of the BHP has an ownership or control interest.

- The name, address, date of birth, and SSN of any managing employee of the BHP.

Disclosure to the State shall be made during the following:

- When the Legal Entity submits a proposal in accordance with the County's procurement process or when the contractor submits a provider application.

- When the Legal Entity executes a contract with the County or when the provider executes a provider agreement with the state.

- When the County renews or extends the Legal Entity contract.

- Within thirty- five (35) days after any change in ownership of the Legal Entity or contractor/disclosing entity.

- Upon request of the state during the revalidation of the provider enrollment.

- Within thirty-five (35) days after any change in ownership of the disclosing entity.

- See 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

Conflict of Interest

Contractor shall not utilize any State officer or employee in the State civil service or other appointed State official for performance of the contract unless specific criteria is met, as per Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2). Contractor shall inform their COR of current and former State employees who are working under a program that is funded by County BHS.

Contractor Compliance Attestation

Contractors shall complete the compliance attestation form attesting to

compliance with all applicable Federal, State, County, and local laws, rules, and regulations and County contract requirements, including those from the County of San Diego Services Agreement and the Organizational Provider Operations Handbook, including but not limited to, the requirements below:

- Prohibition of Political Activities
- Byrd Anti-Lobbying Amendment
- Disclosure Requirements re: five percent (5%) or Greater Ownership and Controlling Interest)
- Conflict of Interest re: current or former State employees working under a program funded by County BHS
- Comprehensive Continuous Integrated System of Care
- Cultural and Linguistically Appropriate Services Standards
- Access to Services for Persons with Disabilities
- National Voter Registration Act
- False Claims Act training and reporting
- Privacy Breach and Suspected Security Incident
- Criminal Background Check & Subsequent Arrest Notification (Both Contractor & Subcontractor staff)

Corrective Action Notice

Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.
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Transportation of Members

Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego. BHS does not limit providers from claiming for services/interventions provided concurrently while transporting members,

however providers should utilize their best clinical judgment in determining if it is safe and appropriate and the intervention is therapeutic/benefits the member; with consideration to safety of member/provider, ability to focus attention on driving.

Verifications

License Verifications

All HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. For county operated programs, license verification is completed by the Human Resource department. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

National Provider Identification Verification

All contractors are required to verify that all clinical staff, licensed or not, have an active National Provider Identification (NPI) number. Contracted programs are to provide new employees with necessary paperwork needed to apply for an NPI number, should they not already have one. If the new employee has an NPI number, the contractor shall verify in the National Plan and Provider Enumeration System (NPPES) for accuracy. Contractors must update the NPPES system as needed when the employee's information changes. The BHP is required to complete the same verification process for the contracted providers. When contractors submit their Access Request Form (ARF) for staff account set up in the electronic health record, the BHP MIS unit preforms validation through the NPPES database. Staff shall not have access to the electronic health record without a valid NPI number.

Disbarment or Exclusion Federal and State Database Checks

During the provider enrollment/reenrollment process, it is required that the BHP checks the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- CMS' Medicare Exclusion Database (MED).
- DHCS' Suspended and Ineligible Provider List

- Restricted Provider Database (RPD)

Providers may be included on these lists for any of the following reasons:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any member, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reasons;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach, verification can be access by clicking on the link.

In addition to checking all the databases upon a provider's enrollment/reenrollment, the BHP will review the SAM, LEIE, and RPD databases on a monthly basis. All databases will be reviewed upon a provider's enrollment/reenrollment to ensure that the provider continues to meet enrollment criteria. An BHP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate as a provider within the BHP's network. Providers will report immediately to their COR any individual or entity that appears on any government excluded list and take the appropriate corrective action.

Provider Credentialing via Optum

San Diego County Behavioral Health Plan (SDCBHP) program for credentialing, re-credentialing and provider enrollment is designed to comply with national accrediting organization standards as well as local, state and federal laws. The process described below applies to all Legal Entities which opted to complete credentialing, recredentialing and provider enrollment using Optum's centralized process. Legal Entities are responsible for ensuring the successful completion of credentialing activities for all new staff upon hire.

Per DHCS BHIN 18-019, credentialing/recredentialing requirements are applicable to Medi-Cal Programs and require Licensed, Registered, Certified or Waivered providers that provide direct billable services to be credentialed and re-credentialed every three (3) years. Billing providers are subject to the rules, processing requirements, and enrollment timeframes defined in Welfare and Institutions Code

Section 14043.26, including the timeframe within Section 14043.26(f) that generally allows DHCS up to one hundred and eighty (180) days to act on an enrollment application.

Consistent with DHCS Information Notice 20-071, Optum will enroll all applicable network providers, including individual rendering providers, through the DHCS Provider Application and Validation for Enrollment (PAVE) portal.

For Applicable Providers, Optum's Enrollment Coordinator will begin an Ordering Referring Prescribing (ORP) Application or an Affiliation Application as applicable in PAVE within five (5) business days from the date the provider returned an application for credentialing complete to Optum. Providers will receive an email from PAVE asking them to log in and respond to the disclosure questions and sign their application. Providers shall respond to the notification email from PAVE and complete their application within five (5) business days.

Initial Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation. Providers are to call Optum's Behavioral Health Services Credentialing Department at (800) 482-7114 or send a notification email to BHSCredentialing@optum.com. Entities can also choose to work with their assigned Optum Credentialing Representative directly by sending timely notice of changes in provider status such as but not limited to terminations, changes in license/registration, new hire notifications, etc.

The credentialing process includes without limitation attestation as to: (a) any limits on the provider's ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner providers, the absence of any current illegal substance or drug use; (c) any loss of required state licensure and/or certification; (d) with respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action; and (f) the correctness and completeness of the application.

Optum will also be conducting primary source verification of the following information:

- Current and valid license to practice as an independent practitioner at the highest level certified or approved by the state for the provider's specialty or facility/program status.

- Professional License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements.

- Clinical privileges in good standing at the institution designated as the primary admitting facility if applicable, with no limitations placed on the practitioner's ability to independently practice in his/her specialty.

- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure.

- Board Certification, if indicated on the application.

- A copy of a current Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) Certificate, as applicable.

- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner, which disclose an instance/ pattern of behavior which may endanger members.

- No exclusion or sanctions/debarment from government programs.

- The current specialized training required for practitioners.

- No Medicare and/or Medicaid sanctions.

SDCBHP also requires:

- Current, adequate malpractice insurance coverage.

- Work history (past five (5) years) for the provider's specialty.

- No adverse record of failure to follow SDCBHP policies, procedures, or Quality Management activities.

- No adverse record of provider actions which violate the terms of the provider agreement.

- No adverse record of indictment, arrest or conviction of any felony or any crime indicating member endangerment.

- No criminal charges are filed relating to the provider's ability to render services to members.

- No action or inaction taken by provider that, SDCBHP's sole discretion, results in a threat to the health or well-being of a member or is not in the member's best interest,

Residential Programs (facilities) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by Optum (currently JCAHO, CARF, COA and Adult/ Older Adult) must have their accreditation status verified. On-accredited Residential Facilities/Sites providers must provide documentation from the most recent audit performed by DHCS, DHS or CMS as applicable.

Re-credentialing via Optum

SDCBHP requires that individual practitioners and Residential Programs Sites undergo re-credentialing every three (3) years. Re-credentialing will begin approximately six (6) months prior to the expiration of the credentialing cycle.

Required documentation includes without limitation attestation as to:

- any limits on the participating provider's ability to perform essential functions of their position or operational status
- the absence of any current illegal substance or drug use with respect to individual practitioners participating providers;
- the correctness and completeness of the application (including without limitation; and
- identification of any changes in or updates to information submitted during initial credentialing).

Failure of a participating provider to submit a complete and signed re-credentialing application, and all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from Optum, may result in termination of participation status with SDCBHP and such providers may be required to go through the initial credentialing process.

Credentialing information that is subject to change must be re-verified from primary sources during the re-credentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

Equipment, Consumable Supplies and Inventory Guidelines for County Contracts

All Capital Assets/Equipment, Minor Equipment, and Consumable Supplies purchases shall be included in Cost Reimbursement contract budgets and shall be

approved by the Contracting Officer's Representative (COR) upon budget submission. The equipment and supplies shall directly benefit members and program's objectives.

County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with contract Agreement funds if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Internal Controls and Procedures below provide guidelines on handling Capital Assets and Minor Equipment.

Definitions

- Capital Assets/Equipment: Tangible non-expendable property that has been purchased with County funds and has a normal life expectancy of more than one year and a unit cost of $10,000 or more. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment. Examples of Capital Assets/Equipment include, but are not limited to: building improvements, vehicles, machinery, furnaces, air conditioners, multifunction copy machines, furnishings, etc.

- Minor Equipment: Any non-consumable implement, tool, or device that has a useful life of more than one year and an acquisition amount of $500 to $9,999. Examples of Minor Equipment include, but are not limited to televisions, video recorders and players, computer monitors, therapy equipment, refrigerators, hand-held electronic devices, electronic games, modular furniture, desks, chairs, conference tables, etc.

- Consumable Supplies: Goods that have a useful life of one year or less and an acquisition value under $500. Examples of consumable supplies include, but are not limited to: pens, pencils, paper, notepads, file folders, Post-it notes, toner or ink cartridges, waiting room supplies, etc.

Internal Controls and Procedures

(Applicable to items acquired prior to 7/1/23 only)

Contractors shall have the following internal controls and procedures in place for managing contract-funded Capital Assets/Equipment and Minor Equipment, whether acquired in whole or in part with County funds**,** for items acquired prior to 7/1/23**,** until disposition takes place:

- Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment through budget development requests or Administrative Adjustment Requests.

- Contractors shall place County of San Diego Property tags on Capital Assets/Equipment and Minor Equipment to identify items purchased with County funds. These tags can be requested through the COR.

- Contractors shall include the expenditure of Capital Assets/Equipment and Minor Equipment on the monthly invoice/cost report that immediately follows the acquisition.

- Contractors shall maintain inventory records that include a description of the item, a serial number or other identification number (if applicable), the acquisition date, the acquisition cost, location of the item, condition of the item, program funding for the item, and any ultimate disposition data including the date of disposal.

- Contractors shall submit an *Inventory Report of Capital Assets/Equipment and Minor Equipment* purchased using County funds annually to the COR no later than thirty (30) calendar days into each new contract year, and when any updates occur throughout the year (e.g., new items charged to the contract or when items are stolen, lost, damaged, missing, and upon disposal completion. The COR will review the Inventory Report to determine if the information is reasonable and complete based on their knowledge of the contract and approval of invoices containing charges for equipment.

- The Inventory Report is to include all Capital Assets/Equipment and Minor Equipment items purchased since inception of the cost reimbursement contract, including all vehicles purchased and/or leased.

- Inventory records on non-expendable equipment shall be retained and shall be made available to the County upon request, for at least 10 years following date of disposition

- Contractors may choose to utilize their own Inventory Report as long as the required information above is included. Otherwise, contractors can utilize the BHS Inventory Form.

- Contractors shall include in the Inventory Report any items that were transferred from one County program to another and note the transfer date and program. A DPC 204 form shall be completed.

- Contractors shall make all purchased items available to the COR (or their designee) for inspection at any time.

- Contractors shall be responsible for accounting of all county-funded items, whether acquired in whole or in part with

- County funds. Contractors that are required to work with computers, laptops, portable devices or media that contain personal information relating to members shall have a duty to protect this data from loss, theft or misuse (refer to Article 14 Information Privacy and Security Provisions in the contract). All electronic property and information technology (IT) related items capable of storing information, regardless of acquisition price and useful life, must be included in the Inventory Report. Examples of electronic property and IT related items capable of storing information include, but are not limited to: cellphones, laptops, tablets, USB memory devices, cameras, etc.

- Contractors do not need to include in the Inventory Report consumable supplies valued under $500 except for electronic property and IT related items specified in item #k above such as cell phones, laptops, anything that hold PII, and items subject to misuse or theft.

Stolen, Damaged or Missing Equipment

Contractor shall inform the COR in writing within 48 hours of any stolen, damaged or missing equipment purchased with County funds. Exception: Any lost or missing item that contains personal information shall be reported in writing to the COR within 24 hours. Article 14 Information Privacy and Security Provisions requirements shall be followed when appropriate. Contractor may be responsible for reimbursing the County for any stolen, damaged or missing equipment at the current book value of the asset.

Vehicles

The preferred method for Contractor(s) to acquire vehicles is through a lease arrangement. COR and County Management preapproval must be obtained for Contractor to acquire a vehicle. Vehicles shall be registered with the Contractor as the lien holder and registered owner. Whether vehicles are leased or purchased, Contractor shall maintain appropriate insurance on vehicles, follow maintenance schedule, as required by the automobile manufacturer. Vehicle(s) usage and insurance requirement language will be included/amended in the contract. If vehicle will be purchased, COR must obtain written pre-approval from ACS Director, and DPC Director. At contract termination, or when the original or replacement equipment/vehicle is no longer needed, or has become obsolete, or is inoperable and impractical to repair, a formal disposition process will be required (refer to BHS Property Transfer/Disposal Process). Contractors shall work with the COR, who will determine the final disposition of the item(s).

Inventory Disposition

Contractors should not remove or dispose the items previously listed on their Inventory Report submitted to the County, unless the COR approved the salvage or

transfer of those items, or a County Behavioral Health Services policy provided such instructions. Minor Equipment not meeting the requirement to be listed on the Inventory Report and Consumable Supplies do not need to be disposed through the County process. Non-expendable property that has value at the end of a contract (e.g., has not been depreciated so that its value is zero), and which the County may retain title, shall be disposed of at the end of the contract Agreement as follows.

At County's option, it may:

1. Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;

2. Allow the Contractor to retain the non-expendable property provided that the Contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or

3. Direct the Contractor to return to the County the non-expendable property.

BHS Property Inventory Form: Available for download from the Optum website > BHS Provider Resources > SMH & DMC-ODS Health Plans > *Forms* tab. As the contractor disposes of equipment the following column on the BHS Inventory form must be completed and a copy provided to the COR. "*Approved Date of Item Transfer or Disposition*." This is the date of the COR approval.

Procedure for Property Transfer to the County of San Diego – Property Disposal or Transfer to another contractor: For purposes of this section on disposal of minor equipment, "contractor" refers to the specific numbered County contract, and that contract's County-owned property, not to the combined County-owned assets of multiple County contracts held by a parent organization/organizational provider.

Versions of the forms, DPC 203, IT Supplemental and DPC 204 can be:

1. Provided to the contractor by BHS staff;
2. Downloaded from the link in the Technical Resource Library (TRL);
3. Downloaded from the Technical Resource Library (TRL) under section 1.2.4 (General Forms and Instructions).

BHS Contract Support administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits. There are three distinct transfer/disposition procedures in place for minor equipment. These are for disposal of Non-IT items that do not have memory, IT items containing memory, and IT Mobile Devices.

All minor equipment salvage requests are to be completed by the contractor on the

appropriate version of the DPC form and forwarded to their Contracting Officer's Representative (COR) who will review, approve, sign and forward the DPC form to the appropriate County staff

Once processed and approved by BHS and/or the Department of Purchasing and Contracting (DPC), the COR will notify the contractor of further steps. All DPC forms must include:

- Program name,
- Contract number,
- COR name,
- Address (with Zip Code) identifying the physical location of the items, and
- full site contact information including name, phone number and email.

Directions for transfers between contracts are included below for each procedure:

- A fillable version of the DPC form is now available for use for Non-IT, IT and Mobile Device disposal. Contractors are not to make changes to the DPC forms, including changing pre-filled wording or making any entries in the forms' boxes #7 through #16. Non-IT equipment, IT equipment and Mobile Devices cannot be listed on the same DPC 203 form

- DPC 203 forms used for minor equipment disposal are located on the Optum Website > BHS Provider Resources > SMH & DMC-ODS Health Plans > Forms tab.

Non-IT Disposal Requests (furniture, office equipment without memory, printers, most copiers, non-memory-containing computer accessories [computer monitors, keyboards, mice], routers, docking stations, wireless access points, DVD players, etc.):

- Requests are to be completed on the *DPC 203* Fillable form, checking the "Non-IT" box, and sent to the COR for review, approval, electronic signature and forwarding.

    - Non-IT requests require the condition of the items to be noted and must be accompanied by photos in .jpg format, (file size must be smaller than 5 MB for posting purposes) preferably with like items grouped but individually identifiable in the photos.

    - The purpose of the condition statement and photos is to give other County departments information useful in deciding if they want to acquire items - photos should provide a clear image of the item(s) and condition should be appropriate for the kind of item – any damage and age issues for

furniture, working and functionality issues for equipment, and any contamination issues for all items.

- Once DPC's approval is final, the COR will provide the program with the approved DPC 203 form (with a Control No.) and directions for delivery by the program, per pre-scheduled appointment, accompanied by the approved DPC 203 form, to the County's disposal contractor.

- Contractors are to retain the disposal contractor's signed proof of delivery and then forward that documentation to the COR team.

Transfers of Non-IT items between contracts/programs require the sending program/COR team to complete the *DPC 204* Fillable form, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form, and secures the receiving COR's approval and electronic signature (if different). The COR then forwards the approved form to BHS staff for further processing. Transfers of Non-IT items do not require photos or condition.]

IT Disposal Requests (those items with memory: computers, laptops, notebooks, servers, zip drives, higher-end copiers with memory, etc.)

- Requests are to be completed on the DPC 203 Fillable form, checking the IT box, and then sent to the COR for review, approval, electronic signature and forwarding. The DPC 203 Fillable form includes a section for Wipe Certification for use with IT disposals. (HHSA only recognizes Department of Defense (DoD) level wiping done by its approved IT Wipe Vendor). IT items must be physically located at the address provided on the DPC 203 and retained at that site for pick up.

- Use DPC 203 form as a cover sheet: no itemizing on the form.

- On the DPC 203, the "Sender Information, Equipment Location and Contract Information" section is to be completed with full contract and contact information.

- The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by Description (brand and model), Serial Numbers (NOT model numbers), "N/A" under Password to Unlock (passwords must be removed on all IT devices), and indicating "N" (for No) in the "Grant Funded" column.

- Group pictures are required for IT items, they do not to be individual.

- Following receipt of the disposal form with COR approval, the contractor will be contacted by CoSD HHSA IT's Wipe Vendor, to arrange for pick up for disposal.

(Include the power cords for all types of computers at point of pick-up. Note the physical location of the serial numbers on each unit, as the Wipe Vendor must verify serial numbers as a condition for pick up).

- The contractor must ensure that the IT Wipe Vendor completes the first box of the Wipe Certification of the DPC 203 form at point of pick-up.

- Once the equipment is picked up, the contractor will send a copy of the form with the completed wipe pick-up confirmation to the COR.

- Transfers of IT items between contracts/programs following DoD wiping, require the sending program to complete the DPC 204 Fillable, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR.

- The sending COR reviews, approves, signs the form and secures the receiving COR's approval and signature (if different), and forwards the DPC 204 form to BHS staff.

- BHS staff then arrange for HHSA IT's Wipe Vendor to pick up the items, do the DoD wipe, and return the wiped items to the contractor at the pick-up location.

- The contractor secures the DoD Wipe Vendor's signature on the DPC 204 at point of pick up (first box of Wipe Certification) and again when wiped items are returned (second box of Wipe Certification).

- Following DoD wiping, the sending program sends the COR the DPC 204 with both sections of the Wipe Certification completed. The sending and receiving programs then coordinate transfer of wiped equipment. Contractors should discuss situations with their CORs when the wiping requirement may potentially be waived, for example certain same provider re-procured (rollover) contracts, or when a new provider will be serving the identical client base and providing identical services. In these situations, a wipe waiver from the HHSA Compliance Office is required.

Mobile Devices Disposal Requests (cell phones, flip phones, smart phones, hotspots, Wi-Fi cards, tablets, etc.)

- Requests are to be completed using, the DPC 203 IT and the DPC IT SUPPLEMENTAL, and sent to the COR team for review, approval and forwarding.

- Use DPC 203 form as a cover sheet: no itemizing on the form.

- On the DPC 203, the "Sender Information, Equipment Location and Contract Information" section is to be completed with full contract and contact information.

- The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by brand model and type, providing serial numbers (NOT model numbers) and "N/A" under passwords (passwords must be removed on IT devices), and indicating "N" (for No) in the "GRANT FUNDED" column. This salvage process requires a group photo, in .jpg format, of the listed Mobile Devices.

- This results in a disposal approval email which must be forwarded by the COR to the contractor along with the approved DPC 203 and IT Supplemental forms. The email includes a FedEx prepaid shipping label that must be printed only by the contractor, attaches it to the package of devices, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental (approval with the Control No.) in the package, writes the Control No. on the outside of the package, and takes the package to the FedEx outlet for shipping to the County's Mobile Devices Salvaging Vendor.

[The contractor packages the devices for secure, cushioned shipping, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental form with the Control No. in the package(s) and writes the Control No. on the outside of the package(s).]

NOTE: DPC requires that all Mobile Devices be reset to their factory default setting prior to shipping.

[Transfers of Mobile Devices are limited to situations where: either the provider, program and services remain the same and only the contract number changes; or where a new provider will be assuming identical services for an identical client population. For Mobile Device transfers where a provider has changed, a wipe waiver must be secured by the COR from the HHSA Compliance Office before the devices can be made available to the new provider.

Electronic Property/IT

Contractors Inventory Minimum Guidelines on A Cost Reimbursement and Fixed PRICE Contract

Inventory responsibility includes these minimum guidelines for the security of member information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions:

Member Data: Any identifying information relating to any individual receiving services from any program.

Portable Devices: Tools such as laptops, external hard drive, PDAs, cell phones, Tablet PCs, other USB memory devices and cameras (digital, non-digital, and video).

Portable Media: Any tool used to transport information any distance such as CDs, DVDs, USB memory sticks, flash drives or smart cards.

Minimum Guidelines

- All Contractors' executives shall be responsible for maintaining a current inventory of all portable devices and portable media in their program.
- All Contractors' electronic devices shall be password protected.
- All member data transported on any portable device or media shall be encrypted and/or password protected.
- Portable devices or portable media shall not be used for routine storage of member data.
- For any privacy incident (e.g., lost or stolen laptop, member files/records accessed, etc.) refer to Serious Incident Reporting to Quality Assurance Unit procedures.

P. Fiscal & Billing

Budget & Fiscal Instructions for Cost Reimbursement- Contracts Only

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining member financial eligibility, billing, and collections. The BHS Billing Guide is FORTHCOMIING. Contractors prepare program budgets for County review and approval. The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate expenditures. The budget guidelines allow for flexibility within specified dollar limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget: The annual contract amount is specified in the contract and supported by an annual budget developed by the contractor. Contractor must obtain written prior approval from the County and a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment. If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and disallowance. Any expenditures requiring written approval must be requested in advance and approved by the COR. Approval is not effective, and contractor should not incur any requested expense, until notified.

Invoice: Where the term "invoice is used in Service Agreement Article 4, "cost report" may be substituted as appropriate.

Total Direct Labor Cost

Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C, Contractor's Budget. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Direct Labor costs is allowed if it

results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

Unexpended Salaries and Benefits (S&B), up to 10% of total annual S&B budgeted amounts with a dollar value up to $100,000, may be applied to Operating Expenses. Budget adjustments greater than 10% to Direct Labor cost; or 10% or less than to Direct Labor but with a dollar value greater than $100,000 require prior approval from the COR. Only budget adjustments up to 10% to Direct Labor cost with a dollar value up to $100,000 do not require prior approval from the COR.

- *Example 1: The total Salaries and Benefits amount for a program budget equals $500,000, and contractor expects to spend less than $430,000. Of the $70,000 in projected unspent funds for this category, up to $50,000 (10% of the $500,000 Total Approved Budget with the dollar value less than $100,000), may be applied to Operating Expenses without requiring prior approval or change to the budget.*

- *Example 2: The total Salaries and Benefits amount for a program budget equals $600,000, and contractor expects to spend less than $570,000. The entire $30,000 in projected unspent funds for this category, which is less than the limit of $60,000 and with the dollar value less than $100,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.*

Unexpended Salaries and Benefits that may be applied to Operating Expenses may be from temporary vacancies of budgeted staff.

Contractor shall not purposefully keep positions vacant for the purpose of accruing savings to be used for Operating Expenses. When staffing levels are reduced due to reduced workloads, then it is expected that operating expenses would be similarly underspent. The intent is to fill all budgeted positions and to provide services to members. Unspent funds due to other reasonable circumstances may be applied to Operating Expenses.

Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior County approval as long as costs do not exceed amounts budgeted for these positions.

Temporary and/or replacement staff should be listed in the Salaries and Benefits category and are not subject to prior approval as long as the total of Salaries does not exceed the budgeted amount plus 10% with a dollar value less than $100,000

Staffing changes, including addition or deletion of budgeted staff, shall require prior COR approval. Individual salaries may be exceeded up to 5% without prior COR approval. Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs)

or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may be exceeded up to 5% without prior written approval by the COR, as long as the overall 10% rule is heeded. NOTE: Bonuses, incentive pay, and other types of special employee pay require prior written approval by the COR and must comply with Office of Management and Budget (OMB) Guidelines

Total Other Direct Cost

Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses in Exhibit C. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Other Direct costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

Unexpended Operating Expenses (OE), up to 10% of total annual OE budgeted amounts with a dollar value up to $100,000, may be applied to Salaries and Benefits. All budget adjustments greater than 10% to Operating Expense cost; or 10% or less than to Operating Expense Cost but with a dollar value greater than $100,000 require prior approval from the COR.

- *Example: If the total Operating Expenses for a program budget equals* $300,000, any unspent amount, up to a maximum of $30,000 (10% of the total budget for this category with the dollar value less than $100,000), may be applied to Salaries and Benefits without requiring prior COR approval.

The budgeted amounts for Operating Expenses line items may be exceeded up to the amount stated in Behavioral Health Services Administrative Adjustment Request (AAR) Guidelines as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits, except for asterisked line items. Overspending by more than the allowable amount per AAR Guidelines on these Operating Expense budget line items will require a one-page Administrative Adjustment Request (AAR) form. The AAR form must be submitted clearly describing the justification for overspending, the budget line items and amounts affected.

- Example: If $1,000 is budgeted for Office Supplies AAR Guideline allowed to exceed up to $5,000, a total expense to date of $1,500, will not require prior approval or change to the budget unless the total Operating Expenses amount exceeds the approved amount in the budget. NOTE: all expenses must be

reasonable and appropriate for the contracted services, and are subject to subsequent review and disallowance.

Consulting expenses shall be budgeted on Agreement Budget and shall not be exceeded without prior COR approval, with the exception of temporary staffing. All other consulting services or Subcontracts not previously budgeted shall require prior written COR approval.

Budgeted amounts for Leasehold Improvements, Consultants, Subcontracts, Interest Expense and Gift Cards and Depreciation shall not be exceeded without prior written COR approval. Budgeted amounts for the member's Flex Funds may exceed up to $1,000. Costs above $1,000 require prior written approval by the COR. No expense shall be allowed for any line item that does not have an amount currently budgeted.

Expenses without a budget require prior COR approval and detailed justification. Additional expenses due to emergencies and/or unforeseen circumstances for line item(s) that have a $0 budget will be reviewed on a case-by-case basis. These expenses are not allowed to be claimed in other line items that were not intended for these types of expenses.

Total Indirect Cost

Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the COR. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost. *If the total budget is underspent, it is expected that Indirect Costs would decrease proportionately.*

Other Costs: Hiring Incentives and Premium Shift Differential Rates

Any contractor that can demonstrate a critical workforce need that is or will imminently negatively impact the delivery of member services and contractual capacity requirements, may consider the following strategies:

Hiring Incentives: Contractor may choose to propose a program for hiring incentives for those positions that are in critical need. Proposed hiring incentive programs must include:

- Identification of the critical staffing needs and potential contractual impact absent any mitigation.

- A documented policy for implementation of hiring incentives to meet the immediate needs of the program and indicates there will be no contract increases that result from the sign-on bonuses.

- Hiring incentive program must be time-bound for immediate recruitment needs.

- Hiring incentive programs may include moving expenses and/or sign-on incentives which must be time bound and include repayment requirements if employment terminates prior to completion of time obligation

- Proposed hiring incentive policy will require the following:

    - Adequate justification

    - COR and program management approval

    - Line-item delineation on budgets/invoices and must properly account for any staff, identification of applicable positions, amount for each position. If cost flow to the next fiscal year – claim to County will only be up to the Contract Max (covered by savings the following fiscal year), or early employment termination implications.

    - Request at the beginning of the Fiscal Year by contractor:

        - Create a new Other line in the Operating Expense tab, label as "Other: Sign-On Bonuses: Max of *$_____". This will have a $1 budget.

        - The amount on the description will be the max amount that is approved for invoicing. If this amount is exceeded, a new AAR will need to be submitted for another approval.

        - For mid-year or end of the year request by contractor:

        - Salaries and Benefits will need to be updated to reflect the number of months the position is vacant creating an unspent amount.
        - Create Other line in the Operating Expense tab "Other: Sign-On Bonuses" and reflect the budgeted amount. Reflect zero bottom net change.

Premium Shift Differential Rates**:** Contractors may wish to consider premium shift differential rates for staff to support shifts that are difficult to recruit, hire, retain or fill. Premium shift rates would be proposed by contractor and require approval from COR. Premium shift differentials would typically be expected for consideration on overnight shifts and 24/7 facilities, but may, upon contractor proposal and approval by management and COR, be approved for certain service settings due to the acuity or high intensity of the setting. Employees receiving Premium Shift Differential Rates would be eligible for hiring incentives outlined above.

Mental Health Providers with Housing Budget**:** (applicable only for contracts that remained at Cost Reimbursement)

Member Housing Line Item: This amount is to be utilized exclusively for the member housing (i.e. 'brick and mortar') paid by the program and does not include Housing Staff and/or related costs. This line item will be reported in the Full Housing cost center. While all Housing Costs must be reflected in the Full Housing Cost Center, there will not be an amount specified in the allocation letter for the Full Housing Cost Center: programs will have the discretion to determine how much of the total program budget to allocate to the Full Housing Cost Center when completing program budgets. The goal is to increase flexibility for programs with regard to costs for Housing Staff (without reducing funding allocated to Member Housing), and to ensure the amount allocated for Member Housing is clear and consistent.

Mental Health Budget Template and BHS Housing Budget Instructions**:** All Housing costs must be reflected in the Full Housing Cost Center. The Operating Expenses budget now have a row labeled 'Member Housing'. This line should match the Member Housing allocation amount and is asterisked. It cannot be changed without COR preapproval. The Operating Expenses budget tab now have a row labeled 'Augmented Member Housing' cost. This line is expected to be blank at the start of fiscal year and will only be filled with COR approval via an AAR when the program receives one-time funding for additional Member Housing funding and/or is approved to move money in an AAR to cover additional Member Housing costs. This line is also asterisked and can't be changed without COR preapproval.

Fixed Assets

All fixed asset expenses shall be budgeted and itemized on the Agreement Budget, and no fixed asset budget line item shall be exceeded without prior written COR approval.

The purchase of fixed assets that are not listed on the budget require prior written approval. Fixed assets include all non-expendable property with a value of $5,000 or more and a normal life expectancy of more than one year. Purchase of fixed assets that are budgeted on the itemized Supplemental A and any assets not currently budgeted require written notification to the COR.

Units of Service

Units of Service are the most critical element of the program budget, and the budgeted units of service may not be changed without prior written approval by the COR. Delivery of service below budgeted levels may be considered a performance matter and subject to corrective action.

Other Revenue Sources

Behavioral Health Services Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to members pursuant to this Agreement and in compliance with all applicable rules and regulations (the current version of which can be found online at the BHS Technical Resource Library

For further guidance, please refer to the "FORTHCOMING-BHS Billing Guide"

Multiple Programs/Cost Centers: In agreements that have multiple programs with separate budgets submitted for each program, any adjustment between individual program budgets shall have the prior written approval of the COR. Any excess funds shall remain and be utilized in the program where originally allocated or may be reallocated by the COR for other appropriate services.

Accounting System**:** Contractor shall use an accounting and timekeeping system for segregating, supporting, controlling, and accounting of all funds, property, expenses, salaries, wages, revenues, and assets for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations. Accounting and timekeeping systems are subject to review during in-depth invoice reviews and audits conducted by the County.

Other Fiscal Instructions**:** Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR.

Budget & Fiscal Instructions for Fixed Price or Fee-For-Service (FFS) Contracts**:** The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate invoicing within the fixed Price or FFS set by the State o contracts as agreed in the Exhibit C of the contract. The Exhibit C provides budget guidelines that may allow flexibility within specified dollar limits, and states conditions when prior written County approval or amendment must be obtained before contractors are allowed to exceed the specified limits from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget: The annual contract amount is driven by the Fixed Price or FFS set by the State or agreed in the contract. If the rate is driven by the State, the rate is automatically adjusted to match the rate. If the rate is based on negotiated rate between the County and Contractor or a Fixed Price, a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

Invoice: The reimbursable invoice submitted to the County includes the agreed rate multiply the units of service or the billing milestone completed.

Ancillary Claims**:** Some contracts may allow ancillary expenses that can be claimed at cost. Please refer to your Exhibit C language for information of the ancillary expenses added to a FFS contracts.

Accounting System: Contractor shall have use of an accounting system for segregating, supporting, controlling, and accounting of all funds, expenses, and revenues for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations.

Other Fiscal Instructions**:** Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR. Contractor must comply with fiscal reporting requirements upon request by County, State, or Federal.

Budget & Fiscal Instructions for Hybrid Contract Only**:** Follow the requirements and guidelines under Cost Reimbursement and Fixed Price/ FFS Contract.

Behavioral Health Services Funding Source Requirements (Contractor Instructions)

Start-Up Funds (for Procurement Budget only)

Start-up funds shall be subject to available funding, negotiations and shall be at the sole discretion of the County. This shall be limited to one-time costs of newly awarded contracts and shall be used for the development and implementation of a new or expanded program or service.

- The budget and timelines for expending start-up funds must be approved by the count.
- Shall not be available for option year

- Shall not exceed 10% of the annual budget of the first year of contract
- A separate cost center for start-up funds shall be included in the proposed budget for the initial contract period and expenditures shall be tracked separately from ongoing expenditures
- If multiple funding sources are identified within the contract, a plan to allocate the start-up costs amongst various funding sources shall be required and budgeted appropriately to reflect the funding ratios amongst the various funding sources
- Start-up costs will be reimbursed based on actual costs (cost reimbursement). Contractor shall comply with Cost Reimbursement Contract requirements.
- At a minimum, submit an acceptable Cost Allocation Plan and keep an Inventory List, according to Article 2.4 of the Service Template

Examples of expenditures that may be approved include:

- Costs of staff hiring
- Initial staff training and development related to a new program or operation (ongoing training and development should be included in the annual operating budget)
- Minor equipment
- Supplies and materials
- Licenses and permits
- Tenant Improvements

Start-up funds shall not be used:

- To supplant or supplement ongoing or routine operating expenses
- For ongoing or routine program activities
- To improve an existing program or service
- At the end of the determined start-up period, an evaluation of the start-up expenditures shall be made and remaining start-up funding may be rescinded at that time. Expenditures that do not meet the start-up criteria may be disallowed and subject to reimbursement.

Claiming to Other Funding Sources

Claiming other funding sources, such as MAA (if included in the contract budget), may be possible for a different set of activities and documentation requirements may also differ. Programs are responsible for knowing the requirements of the specific funding stream if the program receives funding from sources other than Children, Youth & Families SOC. Medi-Cal payments for an eligible member receiving claimable services may not be supplemented by other funding sources except as permitted in Title 9.

Uniform Method of Determining Ability to Pay (UMDAP)

If a Mental Health contractor provides mental health services and is not otherwise excluded from determining the financial eligibility of members they shall request, and assist in processing, UMDAP fees from members as set forth in this Paragraph and this Agreement and comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual. Contractor shall base its fees upon the member's ability to pay for such services. Contractor shall determine the member's ability to pay in accordance with the "Uniform Method of Determining Ability to Pay" (UMDAP) promulgated by the State of California Department of Mental Health.

Contractor shall determine the appropriate UMDAP member fees for its members. In no event, however, shall the fees charged to members (or to other third-party payers) pursuant to this Agreement exceed Contractor's estimated actual cost for such services. No member shall be denied any services offered by Contractor under this Agreement because of inability to pay for such services.

Residency

The Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition and is established by the member's verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any member must be billed at full cost. See *OPOH Section B* for additional information on the provision of specialty mental health services to Children/Youth Out of County Medi-Cal members.

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the BHS Strategy and Finance will process claims (invoice) in accordance with the contract terms.

Budgets, Claims (Invoices) and Supplemental Data Sheets

- Budgets, claims (invoices) and supplemental data sheets must comply with the established procedures and requirements

- Final claim is due by August 31 or as specified on year-end information notice.

- Quarterly claims for MAA, QA and Admin – sixty (60) calendar days after end of each service quarter and actual final actual cost in December which is six months after the end of the fiscal year for QA and Admin. MAA claim is due December 31 of each fiscal year for all quarterly claims.

- Final reconciliation for CalAIM Fee-For-Service contracts shall occur thirteen (13) months after the end of each contract term.

Gift Card Usage

Gift cards may be used to directly benefit members and program objectives (i.e., grocery store vouchers). Gift cards may not be used as an incentive for Drug Medi-Cal billed services (i.e., as prizes for opportunity drawings for group attendance).

Programs with cost reimbursement contracts or with gift cards being reimbursed at cost must comply with the following:

- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards

- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees

- Gift Cards are accounted for by receipts, tracking system, and follow the Contractor's internal purchase policies

- Disbursement of Gift Cards are accounted for by a tracking system that indicates at a minimum:

- Full name of the recipient

- Amount of the Gift Card

- Date disbursed

- Two full signatures (one of which must be a Contractor employee). If both signatures are those of contract employees, one must be a supervisor.

In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence. Gift card purchase

receipts, tracking log and internal polices shall be available to COR or Designee for review and inspection at any time. Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract years. Bus passes that are purchased in advance will follow the gift card policy requirements.

Financial Eligibility and Billing Procedures for SOC Providers

Each provider is responsible for specific functions related to determining member financial eligibility, billing, and collections. The BHS Billing Guide is FORTHCOMING on the Optum Public Sector website for providers as a guide to determine financial eligibility, billing, and collection procedures. This manual includes the following procedure categories:

- Determining financial eligibility
- Billing, collections and payment procedures
- Corrections, adjustments and special requirements

This manual is not intended to replace the EHR User's Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Claiming and Reimbursement of Mental Health Services

All rendering providers of specialty mental health services shall have a National Provider Identification (NPI) number prior to claiming for services. All providers are required to obtain NPI numbers as part of their staff account set up in the electronic health record. Providers may contact the MHMIS unit for questions.

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many members have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility of each program to appropriately bill and collect reimbursement from primary and secondary insurance sources.

For all members receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

FORTHCOMING- BHS Billing Guide

Coding and Billing Requirements

The Health Insurance Portability and Accountability Act (HIPAA) include requirements regarding transactions and code sets to be used in recording services and claiming revenue. UCRM forms reflect the required codes, and County QA staff provide training on the use of the Service Record forms. Additional requirements come from the State Agreement; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers.

The following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with the Management Information System User Manual, Organization Provider Operations Handbook (OPOH) and the Financial Eligibility and Billing Manual.

Diagnoses must be coded using the International Classification of Diseases (ICD-10). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, and "cross-walked" to the correct service code for SmartCare by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.

Services are recorded in the EHR through service note entry or if done on paper on the corresponding downtime form and maintained in the hybrid chart If completed on paper, the document may be scanned into the EHR and viewed on the "Documents (Client)" page but is not required. The program should follow the Administrative Service Entry instructions.

Documentation standards associated with coding and billing requirements can be found in the OPOH, *Section G*, UCRM, Financial Eligibility and Billing Manual, and the CPT Crosswalk, all located on the Optum website > BHS Provider Resources> *SMH & DMC-ODS Health Plans* page.

Medi-Cal Billing to the State

Direct service claims can be submitted to the State up to a year from the date of service. Replacement of the denied service can be submitted up to fifteen (15) months. If the service was denied and the error is with the State's system, services can be replaced up to thirty-six (36) months with a DRC 9. Errors can be process at any time and no limitation.

Please submit all claims (invoice) for payment and questions regarding claims to:
Email: BHSClaims.HHSA@sdcounty.ca.gov / Fax: (858) 999-8929

Overpayment: In the event of overpayments, excess funds must be returned or offset against future claim payments.

Short- Doyle Medi-Cal

Definitions

- *Provider* means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.
- *Federal Financial Participation* per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

Medi-Cal Revenue

The Fiscal Services Unit will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. The State will deny services that do not clear the billing edits, programs have 15 months from the date of service to fix denied services. Once the program has fixed the error, in order to rebill for the service, the program must complete the current Replace Service Request form located on the Optum Website at and email the form to the email addresses stated on the form.

After the form has been received and the replace processed, the program will be faxed back the form, this serves as notification that the replace was processed. If the reason for the denial is for Other Health Coverage or Medicare, the explanation of benefits (EOB) must be faxed to the billing unit with a copy of the denial report – fax to BHSBU/F (858) 467-9682.

County of San Diego– Mills Bldg.
Behavioral Health Services Billing Unit Fiscal Services (BHSBU/F)
1255 Imperial Ave. San Diego, CA 92101
Attn: Fiscal Services 6th Floor Rm. 633

Medi-Cal Requirements

Invoices for Payment of Medi-Cal Services. Contractor shall enter required data based on eligibility and services rendered to each Medi-Cal member into the appropriate County- designated County Data System. Contractor shall enter data on each member or group within the time required by the County.

The validity of Contractor's data input is subject to State, County, Federal or other funding source review and approval. County will make payments in advance of the State, Federal or other funding source review and approval, and in advance of the reimbursement by the State, Federal or other funding to County for sums expended

thereunder. In the event the State, Federal, other funding source or County disapprove any billing, whether previously paid to Contractor, Contractor shall take all necessary actions to obtain approval of the disallowed billing. If Contractor is unsuccessful, Contractor shall reimburse County in the full amount of the disallowed billing within thirty days of County's request or, at the sole discretion of County, County may withhold such amounts from any payments due under this Agreement or any other agreement, including successor agreements, County has entered into or will enter into with Contractor.

Penalty for Failure to Qualify Short-Doyle/Medi-Cal & Drug Medi-Cal Visits

If County experiences a payment reduction in a Short Doyle/Medi-Cal & Drug Medi-Cal claim due to Contractor's failure to qualify the visit under Short- Doyle/Medi-Cal & Drug Medi-Cal program (failure to claim or failure to respond to inquiry) then County will reduce Contractor's reimbursement by an amount commensurate with Contractor's budgeted unit cost and the prevailing Federal Financial Participation (FFP) of Medi-Cal and EPSDT for the Agreement period.

MH UMDAP Requirements Paragraph

Behavioral Health Services, Mental Health Requirements: Mental Health contractors who utilize the electronic Mental Health Information System shall comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual.

Billing for Peer Support Services

Certified Medi-Cal Peer Support Specialists may only submit claims to Short Doyle Medi-Cal (SD/MC) for Medi-Cal Peer Support Services: Self-Help/Peer Services and Behavioral Health Prevention Education Services (H0038 and H0025). Beginning July 1, 2022, per BHIN 22-019, peer support services provided by a Certified Peer Support Specialists must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the member's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

Biling for Crisis Stabilization Services

The maximum number of hours for claimable for Crisis Stabilization in a twenty- four (24) hour period is twenty-three (23) hours. CCR Title 9 1840.368

Medi-Cal Recoupment and Appeals Process

DHCS Requires overpayments to be reported within 60 days of being identified as a disallowance to be recouped. The Payment Recovery Form (PRF) is required for reporting overpayments identified in various reviews (QAPRs, internal/peer reviews, etc) to BHS QA and the BHS Billing Unit to initiate the recoupment. Programs should fill out

the PRF located on the Optum website > *Billing* tab. A tip sheet on how to use the form is on the second tab of the PRF excel form.

In alignment with DHCS Compliance Monitoring requirements and CalAIM Medi-Cal Transformation initiatives, recoupment shall be focused on identified overpayments and patterns in documentation suggestive of fraud, waste or abuse. Fraud and abuse is defined in CFR, Title 42, section 455.2. W&I, section 14107.11, subdivision (d) also addresses fraud. Definitions for "fraud," "waste," and "abuse," as those terms are understood in the Medicare context, can also be found in the Medicare Managed Care Manual.

Evidence of fraud, waste, abuse may include but is not limited to:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing
- Overpayment may include but is not limited to:
    - Missing documentation of allowable service
    - Services not billable under Title 9
    - Medical Necessity
    - Claims submitted for service during a lock out

For disallowances during the QAPR process, the programs will complete the PRF with the QA identifying all disallowed billings based on the DHCS reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, QA has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the QA Unit within required timelines. The appeal process is described in the final Quality Assurance Program Review (QAPR) Report received by the program.

Billing Disallowances – Provider Self Report

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup payments for disallowed units identified and reported to the SDCBHS by the Contracted Organizational Providers in accordance with documentation standards as set forth in the current California State Department of Mental Health "*Reasons for Recoupment of Federal Financial Participation Dollars*."

Provider Requirements

Providers are required to conduct internal review of medical records including paid service verifications, on a regular basis (i.e., monthly) in order to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated. If the review of a Medi-Cal member's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Health "FY 24-25 Reasons for Recoupment SMHS" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with San Diego County BHS. To file a self-report of billing disallowances request, providers should fill out a PRF and reach out via QI Matters. If claims have already been paid and invoiced to the County, further coordination with the billing unit is needed.

Services requiring corrections because of clerical errors including but not limited to start date/time, program selected, location, , procedure codes, etc, may be self-corrected within SmartCare in some instances. If unable to be self-corrected, or progress note status has moved to "complete" the provider should follow the current processes as indicated on the Optum Website SmartCare Tab.

BHS Strategy & Finance (S&F) Procedure

On a monthly basis, BHS S&F staff process invoices based on Year-To-Date units. Any disallowances adjusted out from the Electronic Health Records will automatically reduce the payment to the providers. In any circumstances that disallowance can't be adjusted out from the Electronic Health Record, a manual disallowance calculations will be prepared and will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.

Within thirteen (13) month after end of the fiscal year, S&F staff will reconcile units to ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.

Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments. If the contractor pays by check, the check is received by S&F Fiscal Team staff and will forwarded to S&F Budget Team staff for deposit. The payment is logged in the contract file along with a copy of the payment. If no check is received by S&F within fifteen (15) business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Q. Quick Reference

EHR Contacts	
SmartCare ARF Submissions & Access related issues	Email: BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov
CalMHSA Help Desk (SmartCare System issues)	Live Chat & Submitting Tickets: https://2023.calmhsa.org/live-chat-support/ After-Hours Support (only for system outages): Phone: (916) 214-8348
EHR Support (SmartCare support questions that cannot be addressed by the CalMHSA Support Desk)	Phone: (619) 584-5090 Email: EHRSupport.BHS@sdcounty.ca.gov
Data Science – (Reports and Data Questions)	Email: BHS-DataScience.HHSA@sdcounty.ca.gov
COSD BHS Contacts	
BHS Email Communications & Meeting Invitations	Specialty Mental Health Services Communications SmartCare Communications & Mtg Invites
COSD Ethics and Compliance Hotline	Phone: (866) 549-0004
County Health Information Management Dept. (HIMD)	Phone: (619) 692-5700 Option #3 (Medical Record Requests)
COSD BHS Administrative Office	Phone: (619) 563-2700 Address: 3255 Camino del Rio South, San Diego, CA 92108
Director of Behavioral Health Services	Phone: (619) 563-2700
Medical Director	Phone: (619) 563-2700

Mental Health Billing Unit	Phone: (619) 338-2612 Email: MHBillingUnit.BHS@sdcounty.ca.gov Fax: (858) 467-9682
Quality Assurance Unit (Questions related to documentation guidelines, DHCS regulations or policy)	Email: QIMatters.BHS@sdcounty.ca.gov Fax: (619) 236-1953
OPTUM (Administrative Services Organization)	
Optum San Diego	www.optumsandiego.com BHS Provider Resources - SMH & DMC-ODS Health Plans
San Diego Access and Crisis Line (ACL)	Phone: 1-888-724-7240 TDD/TTY: 711 English TTY/Voice: 800-855-7100 Spanish TTY/Voice: 800-855-7200 7 days a week/24 hrs a day
Optum Support Desk	Phone : (800) 834-3792 Email: SDHelpdesk@optum.com
Optum Provider Line	Phone: (800) 798-2254 Option #7
Member Advocacy Organizations	
Consumer Center for Health Education and Advocacy (CCHEA)	Phone: (877) 734-3258 TTY 1-800-735-2929
Jewish Family Services Patient Advocacy Program (JFS)	Phone: (800) 479-2233
Interpreter Services	
Deaf Community Services – Videophone	Videophone: 619-550-3436
Interpreter's Unlimited	Phone: (800) 726-9891

Internet Resources	
County of San Diego	www.sdcounty.ca.gov
CalMHSA	https://2023.calmhsa.org/
California Board of Behavioral Sciences	www.bbs.ca.gov
California Board of Psychology	http://www.psychology.ca.gov
CA Code of Regulations	www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx
California Department of Health Care Services (DHCS)	www.dhcs.ca.gov
California Medi-Cal Website	www.medi-cal.ca.gov
California Welfare & Institutions Code	leginfo.legislature.ca.gov/faces/codes.xhtml
Center for Medicare and Medicaid Services	www.cms.hhs.gov
Community Health Improvement Partners	https://www.sdchip.org/
Disability Benefits 101	https://www.db101.org/
211 San Diego (Social Services Database)	www.211sandiego.org
Intentional Caregiver Website	https://intentionalcaregivers.com/
Psychiatric Rehabilitation Association	https://www.psychrehabassociation.org/
Joint Commission on Accreditation of Healthcare	https://www.jointcommission.org/en-us
National Institute of Mental Health (NIMH)	https://www.nimh.nih.gov/
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	https://www.gsa.gov/
Social Security Online	www.socialsecurity.gov
Ticket to Work Program	https://www.dor.ca.gov/Home/TTW
Voter Registration Services – Secretary of State	Email: www.sos.ca.gov/elections/elections_vr.htm Phone: (800) 345-VOTE

F. Accessing Services

Consistent with the Health and Human Services Agency's "No Wrong Door" policy (BHIN 22-011), members may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

MCPs are required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies, and supplements.

The County BHP shall provide or arrange for clinically appropriate covered SMHS to include prevention, screening, assessment, treatment services. These services are covered and reimbursable even when:

- Services were provided prior to determining a diagnosis, during the assessment, or prior to determining whether SMHS access criteria are met.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
- The member has a co-occurring mental health condition and substance use disorder; or
- NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

For more information about all the subsections below, please visit the following DHCS FAQ page: CalAIM Behavioral Health Initiative FAQS

Screening for Access to Specialty Mental Health Services

All referrals shall be screened by a clinician for access criteria for specialty mental health services and appropriate level of care. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Depending on screening information obtained and the level of care to which the member is referred, additional screening may be required by the receiving program prior to offering the member an appointment.

Timely Access Data Standards (TADT)

In accordance with BHIN 24-020, Behavioral Health Plans (BHPs) are required to have a system in place for tracking and measuring timeliness of care. To align with the Department of Health Care Services (DHCS) documentation requirements recorded inquiries should be documented within three (3) business days of the request for services in the electronic health record, with the exception of emergent or urgent type which shall be completed within one (1) calendar day. To see a step by step guide for documenting timely access to services refer to the CalMHSA website.

BHPs must use the TADT to report on new members who request a non-psychiatry SMHS, and any new or established member requests for psychiatric services. BHPs are required to submit timely access data for the following:

- An urgent or non-urgent appointment with a non-physician mental health provider of an outpatient SMHS;
- An urgent or non-urgent appointment with a provider of psychiatry;
- Non-urgent follow-up appointments with a non-physician mental health provider;
- Appointments with OON providers in cases where appointments with network providers are not available within timely access standards.

DHCS calculates compliance using the Date of First Contact to Request Services and the number of business days between that date and the date of the first **available** appointment that qualifies as a billable service. For a BHP to be in compliance with the timely access standards, eighty percent (80%) of members must have been **offered** an available appointment within the applicable time frame. Programs shall issue a Notice of Adverse Benefit Determination (NOABD) when the access standard in the table below

is not met. The access times listed below apply for all members (Adults and Children/Youth) accessing care under the BHP:

Urgent Condition: The County further refers to an "Urgent" as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Urgent Psychiatric Condition: Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Non-Urgent (Routine) Condition: A "Non-Urgent (Routine) Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services (SMHS).

Service Type	Standard
Outpatient non-urgent with nonphysician (routine) – Adults and Children/ Youth	Offered an appointment within ten (10) business days from request for services
Psychiatric Services - Adults and Children/ Youth	Offered an appointment within fifteen (15) business days of request for services.
SMHS Urgent Appointments- Adults and Children/ Youth	Forty-eight (48) hours from request for services
Children and adolescents requiring emergency services	Seen within one (1) hour of contact with program- They may be seen at the program or referred to the Children and Youth Crisis Stabilization Unit (CYCSU).
Children and adolescents being discharged from acute psychiatric hospital care	Assessed by program within seventy-two (72) hours