Annual Quality Assurance Mental Health Knowledge Forum FY 2025-26

County of San Diego Health and Human Services Agency

Behavioral Health Services
Health Plan Operations Unit
Mental Health Plan – Quality Assurance Unit

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

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Welcome! FY 25-26 Annual Forum Reminders

- Participants are muted upon entry
- Questions will not be answered during the training, but please put any questions you have regarding the presented info in the chat
  - QA will include all Q&As within the final slide publishing
- All information presented is accurate as of August 22, 2025
- For all future updates, please reference communications from BHS, including the monthly ‘Up To the Minute’ (UTTM)

FY 25-26 QA MH Annual Knowledge Forum Agenda

- BH-CONNECT- The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
- QA Analysts & QA MH Team Unit Introductions
- 274 Expansion and The System of Care Application
- DHCS BHIN's in-Review – 2025 Key Updates
- Break- 10 min
- Quality Assurance Performance Review – FY 25-26 Updates
- Beneficiary Rights - NOABDs and Grievances & Appeals
- MHP/MCP MOU Annual Training
- 2025 Incident Reporting Updates
- Updated Resources on Optum

BH-CONNECT

The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment

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What is BH-CONNECT?

A transformative initiative to improve Behavioral Health services for Medi-Cal members

Three Key Authorities:

- 1115 Demonstration
- State Plan Amendment (SPA)
- Existing Medicaid Authorities

Goals of BH-CONNECT Demonstration

Required by CMS

- Reduce utilization and lengths of stay in EDs among Medi-Cal members with SMI and SED
- Reduce preventable readmission to acute care hospitals and residential settings
- Improved availability of crisis stabilization services (e.g., mobile crisis intensive outpatient)
- Improved access to community-based services
- Improved care coordination following episodes acute care

California-specific

- Expand community-based services and availability of evidenced-based practices
- Improved outcomes for Medi-Cal members, including child welfare involved, justice-involved, and experiencing or at risk for homelessness
- Improved availability of TA and incentives to support implementation of high-quality services
- Expand behavioral health workforce

Goals of BH-CONNECT Demonstration, cont.

San Diego – Specific:

- Expand community-based services in alignment with Optimal Care Pathways (OCP) vision
- Improved outcomes supporting our work as a Health Plan
- Supports Behavioral Health Services Act (BHSA/Prop 1) efforts to advance system integration
- Expand behavioral health workforce and support Network Adequacy

Eligibility and Populations of Focus

Individuals with significant mental health and substance use disorders

- Including individuals with justice-involvement
- Youth in or at risk of child welfare involvement
- Individuals and families experiencing or at risk of homelessness

Key Features

Workforce Support	**Support for Children and Youth**	**Transitional Rent Assistance**	**Performance-based Incentives**
Community Transition Services	**Short-term Inpatient Psychiatric Care**	**New Evidence-Based Services**	**Clarified Existing Evidence-Based Services**

New Medi-Cal EBP Coverage

Assertive Community Treatment (ACT)

- Comprehensive, community-based, interdisciplinary team-based service model to help individuals with serious mental illness cope with the symptoms of their mental health condition and develop or restore skills to function in the community.

Forensic ACT (FACT)

- Tailored for individuals who are involved with the justice system.

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

- A comprehensive, community-based, interdisciplinary team-based service model to help individuals cope with the symptoms of early psychosis and remain integrated in the community.

New Medi-Cal EBP Coverage, cont.

Individual Placement and Support (IPS) Model of Supported Employment

- Community and team-based services that help individuals with behavioral health conditions to lead functional and productive lives in the community, including acquiring and/or maintaining competitive employment. (*SMHS and DMC-ODS*)

Clubhouse Services

- Services offered within rehabilitative programs that provide a physical location for people living with significant behavioral health needs to build relationships, engage in work and education activities, and receive supportive services. Utilizes Clubhouse International Standards for fidelity and Work-ordered day.

Community Health Worker Services

- Preventive services delivered through the specialty behavioral health delivery systems by trusted community members to provide health education, advocacy, and navigation services to support members with accessing need health care and community resources to address social drivers of health (*SMHS and DMC-ODS*)

Access, Reform, and Outcome Incentives

- **Statewide Proposed Measures**
  - Improve access to behavioral health services
    - Improve penetration & engagement in services and improve performance on timely access standards
  - Improve health outcomes and quality of life
  - Targeted behavioral health system reforms
    - Reduce infrastructure gaps identified in NCQA assessment completed by Plans in Sept 2024
    - Improve data sharing

- **EBP Proposed Measures**
  - Improved outcomes and quality of life among members receiving BH-CONNECT EBPs

County Participation Requirements

- **DHCS publishing Information Notices in Phases**
  - Evidence Based Practices Policy Guide available
  - To opt in, BHPs are required to submit a letter to DHCS stating which EBP's they intend to cover and the dates that coverage will take effect

- **BHPs that intend to draw down Federal Financial Participation for care provided during short-term stays in Institutions for Mental Diseases (IMDs) must cover the full array of BH-CONNECT EBPs on a timeline specified by DHCS.**

Demonstration Timeline

Demonstration Year 0
MCP Foster Care Liaison
Effective January 2024

January 2025

Demonstration Year 1
- Workforce Initiative
- COE
- Access, Reform, and Outcomes Incentive Program
- Clarification of EBPs for youth
- Activity stipends
- Initial child welfare/SMH assessment

Demonstration Year 2
- Cross-sector incentive program
- Evidence-based tools to ensure appropriate level of care/services

Rolling Basis
- County option to opt-in to any new community-based services
- County option to opt-in to full demonstration, receiving FFP for short-term stays in IMDs

Phased-In Approach for Opt-In Counties

January 2025
Demonstration goes live

Upon IMD Opt-In County Go-Live *(rolling basis)*
- Participate in the incentive program and meet accountability requirements
- Begin providing Peer services with justice involved specialization and CHW services
- Begin TA for ACT/FACT through COEs, completing preliminary fidelity assessment

Demonstration Year 2
- Cross-sector incentive program
- Evidence-based tools to ensure appropriate level of care/services

Within 2 Years of Go-Live
Begin providing FACT and CSC for FEP

Within 3 Years of Go-Live
Begin providing IPS Supported Employment

Quality Assurance Analyst Team

County of San Diego Health and Human Services Agency

Behavioral Health Services

Health Plan Operations Unit

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HPO Quality Assurance Analyst Team

Erin Shapira
Program Coordinator

Malisa “Mali” Touisithiphonexay
Analyst Supervisor

Lorena Gonzalez-Fabiny
Analyst Supervisor

Phyllis Robinson Nana Phengratsamy Miriam Parson Nolan Bunyi Kevin Harrison

Quality Assurance Mental Health Team

County of San Diego Health and Human Services Agency

Behavioral Health Services

Health Plan Operations Unit

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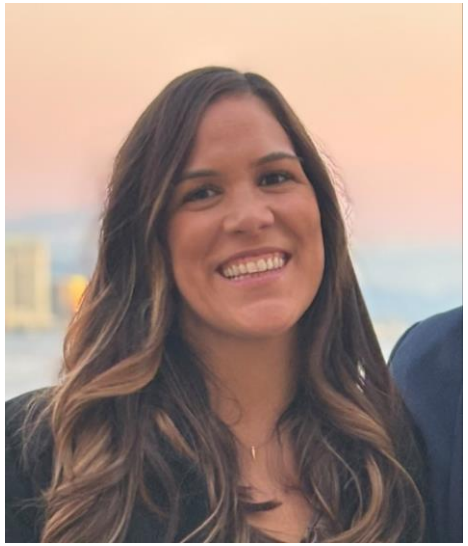
HPO MH Quality Assurance Team

QA LEADERSHIP			
Makenna Lilya, LMFT	**Kristi Jones, LMFT**	**Elaine Mills, LMFT**	**Rachel Fuller, LPCC**
Behavioral Health Program Coordinator, MH QA Team	**QA Supervisor-** BHIN reviews, LPS Lead Supervisor, CAPS QA/UR Supervisor, IMD/FFP Lead, CAPS Inpatient Manual	**QA Supervisor-** Grievances/Appeals, CCHEA/JFS Appeals & State Hearings, STRTP SME, Conlan Claims, LTC Appeals, Presumptive Transfer	**QA Supervisor-** OPOH, Unit Ops, Incident Reporting, Form Development, UTTM, IOP/PHP Day Treatment SME, Justice Involved Program SME, MMOC

HPO MH Quality Assurance Team



QA SPECIALISTS			
Liliana Cerrillo, LMFT	**Emily Duval, Psy.D.**	**Brianna Gilbert, LPCC**	**Michelle Hemmings , Psy.D.**
Rady's CAPS UR Lead	Suicide Dashboard Mgmt	Grievance/Appeals	LPS Certification Review
CAPS MCE/URC Meeting Rep	Clinical Case Review	CCHEA/JFS Reviews	LPS Meeting Rep
Optum UR	RCA Trainer	Conlan Claims	ACL Test Calls

HPO MH Quality Assurance Team





QA SPECIALISTS				
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Incident Reporting Lead	Incident Reporting	Incident Reporting	Incident Reporting	Justice Involved Programs SME
RCA Trainer	Medication Monitoring Oversight Committee			License Waivers
Clinical Case Review				

HPO MH Quality Assurance Team

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County CM/ICM QA	Grievance/Appeals	LTC Appeals	Inpatient Handbook
	LTC Appeals	Conlan Claims	ACL Test Calls

HPO MH Quality Assurance Team





QA SPECIALISTS & QA SUPPORT				
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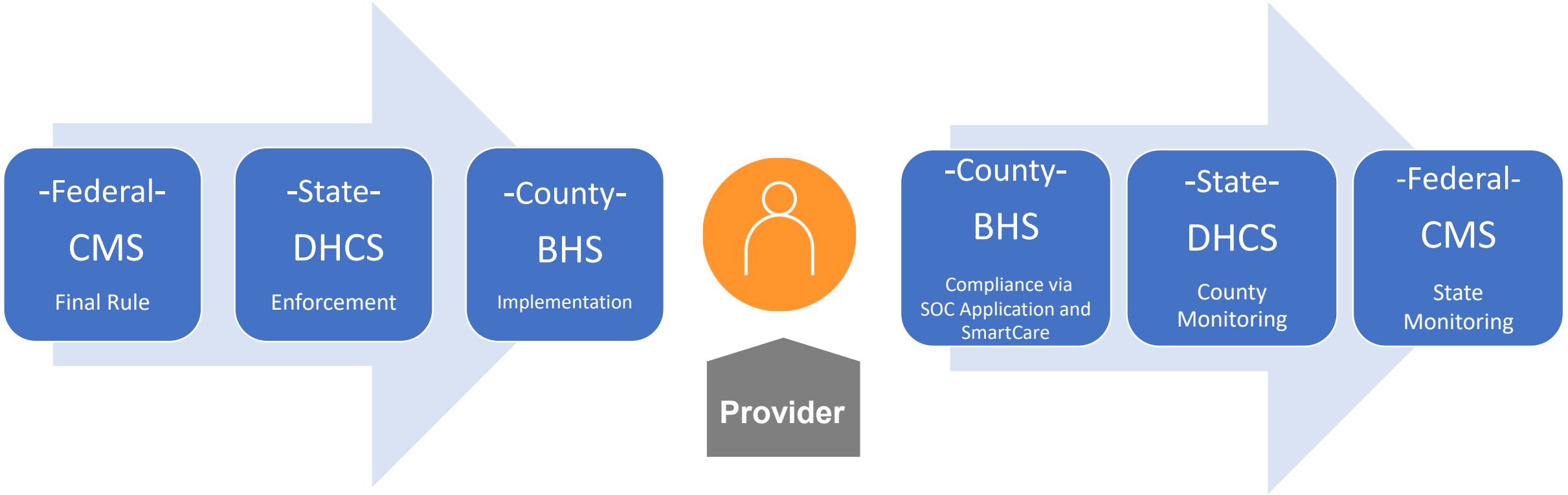
Rady's CAPS UR	Optum UR	Rady CAPS UR	HPO- QA Office Support Specialist	HPO- QA Office Assistant
Optum UR	Claim It Anyways			
	Rady CAPS UR			

274 Expansion and The System of Care Application

274 Expansion (previously NACT) Background and Flow of Data



CMS – Centers for Medicare and Medicaid Services
DHCS – Department of Health Care Services
MHP – Mental Health Plan (County of San Diego)
SOC – System of Care

Reporting Standard

274 Expansion Project

- Based on X12 274 Health Provider Directory standard selected by DHCS to ensure all provider network data is consistent, uniform, and aligns with national standards. (BHIN 22-032)

- DMC-ODS Providers
  - 274 reporting requirements for DMC-ODS have been deployed into production since October 2023. (BHIN 23-042)

Reporting Standard

- Registration
  - New hires and program transfers are required to **register promptly and** attest to information once registration is completed.

- Monthly attestations
  - Effective immediately, Staff/Providers and Program Managers are required to attest to all SOC information **monthly**.
  - Program Managers are expected to visit the SOC app to review their programs' information and attest to information **monthly**.
  - Providers are expected to update their current profile in the SOC app **as changes occur** to show accurately on the provider directory.

Monthly SOC Attestation Process

Go to **www.OptumSanDiego.com**

Log in with **OneHealthCare ID** username and password

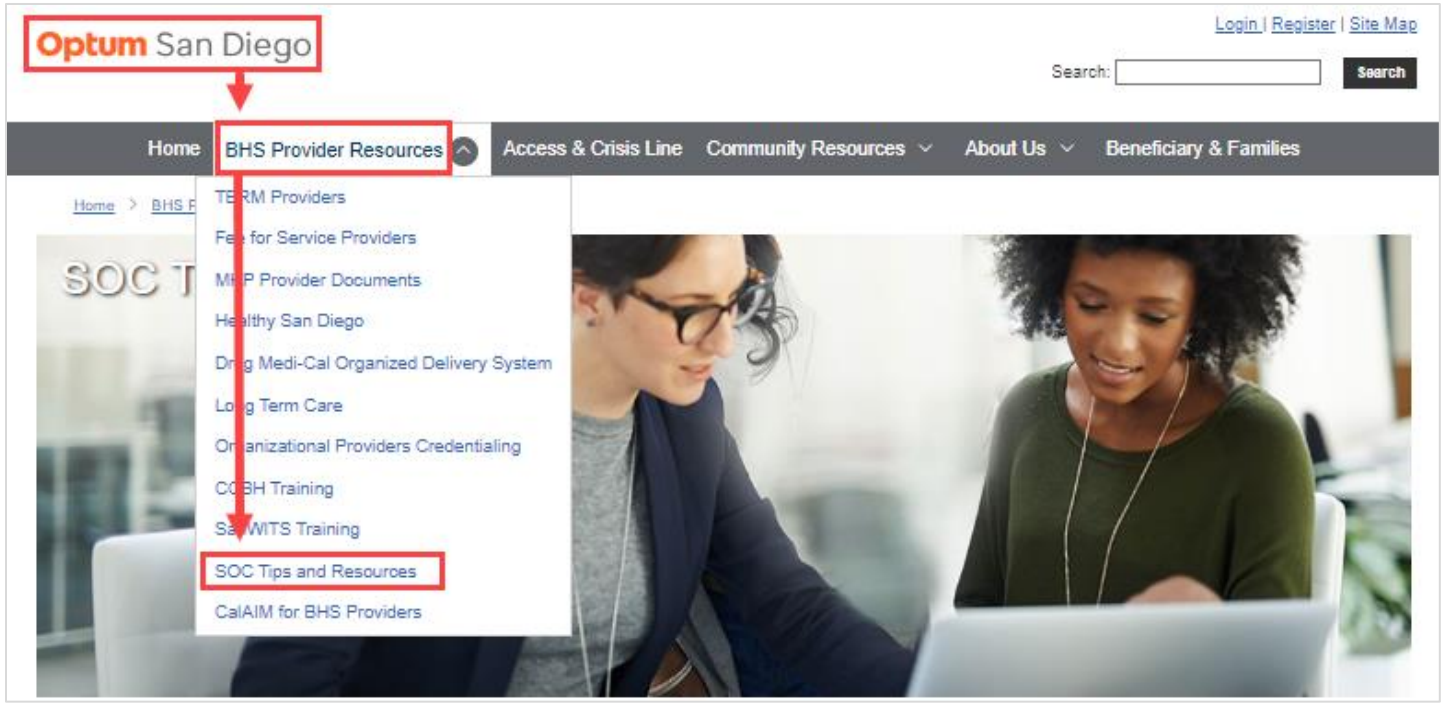
Click on the **SOC** link

Roles: Provider, Manager, Manager with provider update

Review information on **EACH** tab/subtab

Click on the **Save and Attest** button per tab/subtab

Tips and Resources



OptumSanDiego.com

Optum Support Desk

- 1-800-834-3792
- sdhelpdesk@optum.com

2025 Key Behavioral Health Information Notices

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

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DHCS BHIN 25-006

- The purpose of this Behavioral Health Information Notice (BHIN) is to provide guidance to behavioral health plans (BHPs) regarding the opportunity for participation in an incentive program available as part of BH-CONNECT.
- Effective January 1, 2025, BHPs that meet the participation requirements have the option to participate in the Incentive Program to earn incentive payments for demonstrating improvements in access to behavioral health services; outcomes among Medi-Cal members living with significant behavioral health needs; and delivery system capabilities.
- BHPs have the option to cover one or more of the following EBPs under Medi-Cal as part of BH-CONNECT
  - Assertive Community Treatment (ACT) and Forensic ACT (FACT)
  - Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
  - Individual Placement and Support (IPS) Supported Employment
  - Clubhouse Services
  - Enhanced Community Health Worker (CHW) Services
  - Peer Support Services

DHCS BHIN 25-006 Continued

- Participating BHPs have the opportunity to earn incentive payments across 15 measure areas, organized by three major areas of focus:
  - **Improved Access to Behavioral Health Services**
    - Increasing utilization of specified behavioral health services: ACT, FACT, CSC for FEP, IPS Supported Employment, Peer Support services, Enhanced Community Health Worker Services, Clubhouse Services, Multisystemic therapy, Functional Family Therapy, Parent Child Interaction Therapy and Enhanced Care Management.
  - **Improved Health Outcomes and Quality of Life**
    - Improving health outcomes by improving performance on selected CMS Core Set Measures, improving member reported quality of life and improving health and wellbeing among members receiving Key EBPs.
  - **Targeted Behavioral Health Delivery System Reforms**
    - Reducing BHP specific gaps in quality improvement capabilities, making other targeted behavioral health delivery system reforms, enhancing data sharing capabilities and improving outreach and engagement.

DHCS BHIN 25-009

- The purpose of this BHIN is to provide guidance regarding coverage of EBPs available under Medi-Cal as part of BH-CONNECT, including Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), Individual Placement and Support (IPS) Supported Employment, Enhanced Community Health Worker (CHW) Services and Clubhouse Services.

- **Assertive Community Treatment (ACT)**
  - ACT is 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 supports recovery through an assertive, person-centered approach that 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. ACT is delivered by a multidisciplinary ACT team, and includes a full range of clinical treatment, psychosocial rehabilitation, care coordination, and community support services designed to support recovery.

DHCS BHIN 25-009 Continued

- **Forensic ACT (FACT)**
  - 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.
- **Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)**
  - CSC is a community-based service designed for members experiencing FEP. Person-centered team-based services.
  - By providing timely and integrated support during the critical initial stages of psychosis, CSC reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness.
- **Clubhouse Services**
  - Clubhouses are intentional, strengths-focused community-based environments rooted in empowerment that support recovery from a mental health condition.
  - Clubhouses provide opportunities for employment, socialization, education, and skill development to improve members' physical and mental health and overall quality of life and wellbeing.

DHCS BHIN 25-009 Continued

- **Enhanced Community Health Worker (CHW) Services**
  - Enhanced CHW Services are preventive services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and behavioral health. Ensure executive participation in MOU quarterly meetings from both parties.

- **Supported Employment**
  - The IPS model of Supported Employment is a community-based intervention that supports members living with significant behavioral health needs to find and maintain competitive employment.

- BHPs and DMC programs can use the BH-CONNECT EBP Policy Guide as a key resource for implementation and administration of each EBP.

- Fidelity Assessments & Medi-Cal Fidelity Designation for BH-CONNECT EBPs
  - Monitoring fidelity through regular fidelity assessments is a key component of each EBP to ensure members are receiving the EBPs as designed and to identify where improvements can be made.

DHCS BHIN 25-010

- The purpose of this BHIN is to provide the requirements and standards for implementing the Medi- Cal Peer Support Services benefit, Medi-Cal Peer Support Specialist provider type, and Medi-Cal Peer Support Specialist Certification Programs.

- Medi-Cal Peer Support Services
  - Medi-Cal Peer Support Services are defined as “culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.
  - Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery.
  - Medi-Cal Peer Support Specialists shall use their personal lived experience of recovery to assist individuals with their recovery from a mental illness or substance use disorder.
  - Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting.
  - Medi-Cal Peer Support Services shall be based on an approved plan of care that includes specific individualized goals.

DHCS BHIN 25-010 Continued

- Medi-Cal Peer Support Services Three Service Components:
  - **Educational Skill Building Groups**
    - Providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. Groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
  - **Engagement**
    - Medi-Cal Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment.
  - **Therapeutic Activity**
    - A structured non-clinical activity provided by a Medi-Cal Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities.

DHCS BHIN 25-011

- The purpose of this BHIN is to inform behavioral health plans (BHPs) of requirements to receive Federal Financial Participation (FFP) for short-term Specialty Mental Health Services (SMHS) delivered in Institutions for Mental Diseases (IMDs)

- Effective January 1, 2025, BHPs may opt in to the MH IMD FFP Program, which will authorize them to receive reimbursement, including FFP, for Medi-Cal-covered SMHS provided to adult Medi-Cal members ages 21 to 64 during short-term stays in residential or inpatient psychiatric settings classified as IMDs if they meet specified requirements.

- BHPs that opt in to the MH IMD FFP Program must cover and implement all of the following BH-CONNECT EBPs as SMHS:
  - Enhanced Community Health Worker (CHW) Services
  - Peer Support Services, including the Forensic Specialization
  - Assertive Community Treatment (ACT) and Forensic ACT (FACT)
  - Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
  - The Individual Placement and Support Model (IPS) of Supported Employment

DHCS BHIN 25-012

- The purpose of this BHIN is to provide guidance to counties and facilities on the referral procedures and form for the CARE Act.

- This BHIN provides guidance on procedures, a form for facilities to refer an individual to the CARE Act as part of discharge planning, and requirements for county behavioral health agencies to complete an assessment upon receipt of facility referrals.

- A facility that provides assessment, evaluation, and crisis intervention, pursuant to W&I Code section 5150, subdivision (a) or a designated facility as defined in W&I Code section 5008, subdivision (n) may refer an individual who is being treated under an involuntary hold pursuant to the LPS Act for assessment to determine if the individual qualifies for the CARE process.

- A facility or a county behavioral health agency may adopt the CARE Act referral form published on the DHCS website or develop and use its own form. DHCS encourages the use of the referral form published on the DHCS website.

- Within 14 business days of receipt of a CARE Act referral, a county behavioral health agency shall complete an assessment of the referred individual and shall file a petition if the county behavioral health agency determines that the individual meets or is likely to meet criteria to qualify for the CARE process and the individual does not engage in voluntary treatment.

DHCS BHIN 25-013

- 2025 Network Certification Requirements for MHPs and DMC-ODS Plans

- The purpose of this BHIN is to expand and clarify network adequacy certification submission requirements for the FY 2025-26 certification period.

DHCS BHIN 25-014

- The purpose of this BHIN is to provide Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties (hereafter collectively referred to as Behavioral Health Plans (BHPs)) with updated clarification and guidance regarding the application of federal regulations and state law for processing grievances and appeals.

- This BHIN also encloses several notice templates, including the Notice of Grievance Resolution (NGR), Notices of Adverse Benefit Determination (NOABD), Notices of Appeal Resolution (NAR), a “Your Rights” attachment, a member non-discrimination notice, and language assistance taglines. These notices provide members with required information about their rights under the Medi-Cal program.

- Ensures members are provided information of their rights, protections, and access to specialty mental health and substance use disorder services.

DHCS BHIN 25-019

- The purpose of this BHIN is to notify all Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) counties regarding the transgender, gender diverse, intersex (TGI) Cultural Competency Training program required by Senate Bill (SB) 923 (Chapter 822; Statutes of 2022) for the purpose of providing trans-inclusive health care to Medi-Cal members.

- BHPs shall require all subcontractors, downstream subcontractors2 (excluding network providers), and all its staff who are in direct contact with members whether oral, written, or otherwise in the delivery of care or member services, including providers directly employed by the BHP (staff working in county owned and operated facilities), to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as TGI.

- BHPs shall require that the training is completed by all staff at least every two years or more often if needed.

- BHPs must ensure that members are made aware of all their grievance and appeal rights, including their right to submit grievances to BHPs for failure to provide transinclusive health care as defined in W&I sections 14197.09(d)(5).

DHCS BHIN 25-026

- The purpose of this BHIN is to provide Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties with guidance on updated provider directory requirements.

- Effective July 1, 2025 Each Medi-Cal behavioral health delivery system must make available in paper form upon request and in searchable electronic form on the Medi-Cal behavioral health delivery system's public website, information about its network providers.

- The Medi-Cal behavioral health delivery system shall include the following provider types covered under the MHP contract, DMC-ODS Intergovernmental Agreement, or the DMC contract:
    - Physicians, including specialists
    - Hospitals
    - Pharmacies, if applicable
    - Behavioral health providers, i.e. mental health or substance use disorder providers, as applicable

DHCS BHIN 25-027

- The purpose of this BHIN is to establish the statewide minimum standards to be certified to provide family-based aftercare services.

- To become a certified provider of aftercare services, providers must agree to use the California High Fidelity Wraparound Model ("CA HFW Model"), approved by the California Department of Social Services (CDSS) and based on the updated California Wraparound Standards.

- DHCS and CDSS continue to collaborate to minimize duplication and administrative complexity and align the High Fidelity Wraparound (HFW) requirements applicable to family-based aftercare, Medi-Cal, the Immediate Needs program, and Behavioral Health Services Act (BHSA) Full Service Partnerships (FSPs).

- BHIN provides detailed information regarding:
  - Overview of the Provision of Aftercare Services Utilizing California's High Fidelity Wraparound Model
  - High Fidelity Wraparound County Plan Approval and Provider Certification Portal
  - County Requirements
  - STRTP Provider Requirements
  - Community Treatment Facility Provider Requirements

DHCS BHIN 25-028

- The purpose of this BHIN is to provide guidance regarding coverage of Enhanced Community Health Worker (CHW) Services available under Medi-Cal as part of BHCONNECT.

- Effective April 11, 2025, behavioral health plans have the option to cover Enhanced CHW Services within the Specialty Mental Health Services (SMHS) and/or DMC-ODS systems.

- Enhanced CHW Services are tailored preventive services for members living with significant behavioral health needs, defined as members who meet the access criteria for SMHS and/or DMC-ODS services.

- Enhanced CHW Services include:
  - Health education to promote the member's health or address barriers to physical and mental health care, including providing information or instruction on health topics.
  - Health navigation to provide information, training, referrals, or support to assist members access health care, understand the healthcare system or engage in their own care as well as connect to community resources to promote health.
  - Screening and assessment to identify the need for services.
  - Individual support or advocacy that assists a beneficiary in preventing a health condition, injury, or violence.

DHCS BHIN 25-028 Continued

- Enhanced CHW Services must be delivered by practitioners that meet the following qualifications:
  - CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served.
  - CHWs must demonstrate minimum qualifications through the Certificate Pathway and/or Work Experience Pathway defined in the California Medicaid State Plan.
  - CHWs must complete a minimum of 6 hours of continuing education training annually.

- Enhanced CHW Services are distinct from Peer Support Services. CHWs are community members who typically act as a bridge between members and the healthcare system and provide system navigation and health education support. Peer Support Specialists use their personal lived experience with behavioral health and recovery to support members in their recovery from a behavioral health condition and provide skill-building, coaching and other therapeutic activities.

- Enhanced CHW Services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law. The recommending provider must ensure that the member meets eligibility criteria for Enhanced CHW Services.

- BHPs shall not claim for Enhanced CHW Services if the member is already receiving CHW Services or Enhanced Care Management (ECM) through their MCP.

Break Time

Please return in 10 minutes

COUNTY OF SAN DIEGO
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FY 25-26 Quality Assurance Program Reviews QAPR

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QAPR Revision FY 25-26

Sections

- Program Compliance Attestation

- Charts 1, Chart 2, Chart 3 etc.
  - Assessment/ Diagnosis
  - Problem List
  - Care/ Treatment Plans
  - Progress Notes
  - Quality of Care

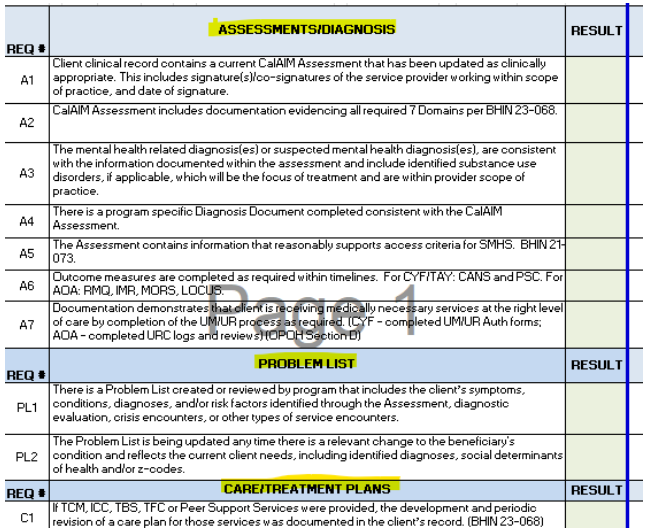
Service Changes Summary

Self Correction Resolve Date	"My Reported Error" Correction Date Submitted	"My Reported Error" Correction Date Resolved

QAPR Revision FY 25-26

FY 25-26

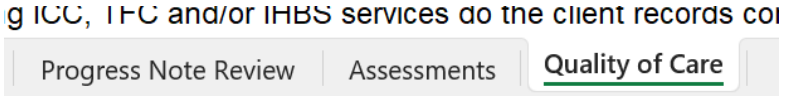
- Reviewing charts for all programs
- Min. 50 services/ Max. 20 charts- 10% of services
- All subsections are on the same tab for each chart.



REQ #	ASSESSMENTS/DIAGNOSIS	RESULT
A1	Client clinical record contains a current CalAIM Assessment that has been updated as clinically appropriate. This includes signature(s)/co-signatures of the service provider working within scope of practice, and date of signature.	
A2	CalAIM Assessment includes documentation evidencing all required 7 Domains per BHIN 23-068.	
A3	The mental health related diagnosis(es) or suspected mental health diagnosis(es), are consistent with the information documented within the assessment and include identified substance use disorders, if applicable, which will be the focus of treatment and are within provider scope of practice.	
A4	There is a program specific Diagnosis Document completed consistent with the CalAIM Assessment.	
A5	The Assessment contains information that reasonably supports access criteria for SMHS. BHIN 21-073.	
A6	Outcome measures are completed as required within timelines. For CYF/TAY: CANS and PSC. For AOA: RMQ, IMR, MORS, LOCUS.	
A7	Documentation demonstrates that client is receiving medically necessary services at the right level of care by completion of the UM/UR process as required. (CYF - completed UM/UR Auth forms; AOA - completed URC logs and reviews) (DPOH Section HD)	
REQ #	PROBLEM LIST	RESULT
PL1	There is a Problem List created or reviewed by program that includes the client's symptoms, conditions, diagnoses, and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters.	
PL2	The Problem List is being updated any time there is a relevant change to the beneficiary's condition and reflects the current client needs, including identified diagnoses, social determinants of health and/or z-codes.	
REQ #	CARE/TREATMENT PLANS	RESULT
C1	If TCM, ICC, TBS, TFC or Peer Support Services were provided, the development and periodic revision of a care plan for those services was documented in the client's record. (BHIN 23-068)	

FY 24-25

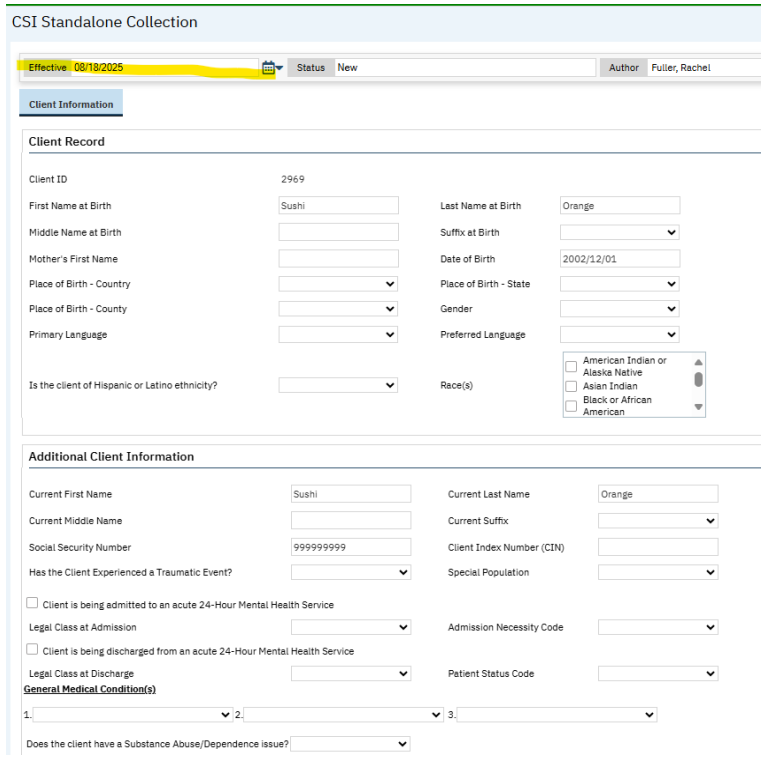
- Reviewing providers
- Every provider is reviewed
- Subsections are on separate tabs



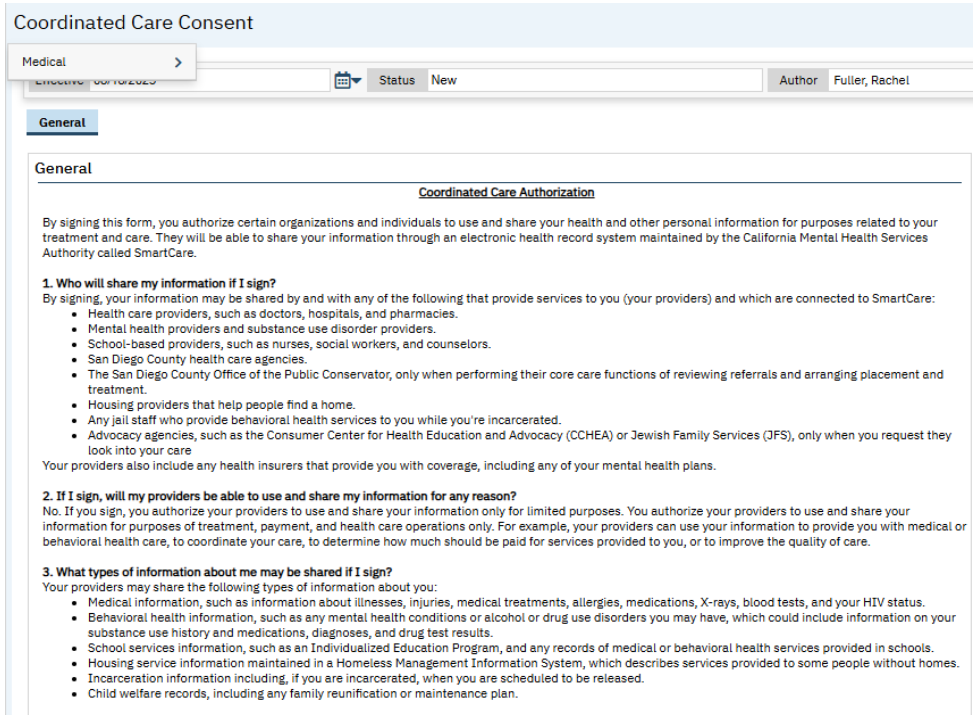
QAPR Revision FY 25-26

New Questions - Attestation

CSI Standalone Collection



Coordinated Care Consent



QAPR Revision FY 25-26

New and/or Revised Questions

- Outcomes measures
- Diagnosis Document
- UM/UR
- Care Plan
- Risk assessment and follow up appt
- Program has a P&P for telehealth
- Preference/ sensitivity to: language, sociocultural hx, religion, gender, sexual orientation
- Transition of Care tool
- Sensitivity to disabilities

Grievances & Appeals
NOABDs

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Advocacy Agencies

- Jewish Family Services – JFS
  - All grievances and appeals for hospital and residential treatment (including STRTP an CRTP)
- Consumer Center for Health Education and Advocacy – CCHEA
  - All grievances and appeals for outpatient programs

Grievances

- BHIN 25-014 Supersedes BHIN 22-070
- Grievances must now be resolved within 30 days without extensions
- Programs may not require members to go through the program's own grievance process prior to filing an official complaint or grievance

Notice Of Adverse Benefit Determination Notices (NOABD)

What is a Notice of Adverse Benefit Determination?

Denial or limited authorization of a requested service, including determinations based on:

- Type or Level of Service Provided or Authorized
- Medical Necessity Requirements
- Appropriateness of Services- additional or general
- Effectiveness of a covered benefit.
- Reduction, Suspension, or Termination of a previously authorized service
- Failure to provide services in a timely manner
- Failure to act within the required timeframes for standard resolution of grievances or appeals
- Denial of beneficiary's request to dispute financial liability.

NOABD Notice Types & Timelines for Issuing

Denial of Authorization	Within 2 business days of decision	Issued when a request for a service is denied- whether due to medical necessity, appropriateness, setting, level of effectiveness
Delivery System Notice	Within 2 business days of decision	The Plan determined beneficiary does not meet criteria for SMHS and refers them to MCP or other appropriate system of care.
Modification Notice	Within 2 business days	Issued when a provider's request for services is modified or limited- for example, reduced frequency/duration services, or, approving of alternative services
Termination Notice	At least 10 days before the date of Action	Termination, reduction, or suspension of a previously authorized service. Includes AWOL, client unwilling to continue, termination AMA.
Authorization Delay Notice	Within 2 business days	Issued when there is a delay in processing a provider's request for authorization- either due to need for more information or an extension granted in member's interest
Timely Access Notice	Within 2 business days	Issued when requested services cannot be provided within the required timelines (i.e. a delay in providing timely access)
Financial Liability Notice	At the time of the action	The Plan denies a request to dispute financial liability.
Payment Denial Notice	At the time of the action	The Plan denies a provider's request for payment for a service already delivered to the beneficiary.

NOABD: Choosing the Correct Notice

- **The Termination Notice**
  - Most used notice
  - When a provider terminates, reduces, or suspends a previously authorized service for a beneficiary (i.e., crisis residential treatment)
  - Must be sent to the beneficiary when provider discharges for any reason other than successful completion of treatment.
- **The Timely Access Notice**
  - When a plan cannot provide requested services within the required timelines
- **Delivery System Notice**
  - The Plan/Program has determined the beneficiary does not meet criteria for SMHS and is referred to the MCP or other appropriate system of care
- **Financial Liability Notice**
  - The Plan denies a beneficiary's request to dispute financial liabilities.

NOABD: Choosing the Correct Notice

- **The Denial of Authorization Notice**
  - The Plan denies a request for service.
  - Based on type/level of service, medical necessity, appropriateness, setting, or effectiveness of the service
- **Modification Notice**
  - Issued when a service request is modified or limited- for example reduced frequency/duration of services counter to client request
  - Example: Member requests 5 group sessions per week, provider only offers 3 per week; A request for residential treatment is modified to intensive outpatient services, based on medical necessity.
- **Payment Denial Notice**
  - When the Plan denies, in whole or part for any reason, a provider's request for payment for service that has already been delivered to a client.
- **Authorization Delay Notice**
  - When requested service authorization cannot be provided within timelines.

Appeals

- When an adverse determination is made, a member may appeal the decision
- BHIN 20-014 eliminated the ability to file an extension by the County or the member
- Aid Paid Pending may be requested and financial liability no longer falls to the client if the appeal is not upheld.

State Fair Hearing

- If an appeal is denied, the member has a right to file a request for a state hearing.
- The County and Advocacy Agency, if involved make every effort to resolve the issue before going to a hearing
- Our G&A staff attend the hearing, and the program is not required to attend in most cases.

MOU Requirements Between Medi-Cal SMHS/DMC-ODS and Medi-Cal Managed Care Plans

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DHCS Behavioral Health Information Notice 23-056 and 23-057

- The purpose of this Behavioral Health Information Notice (BHIN) is to clarify the responsibilities of Medi-Cal Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) when entering into a Memorandum of Understanding (MOU) with Medi-Cal Managed Care Plans (MCPs).

- The BHIN also issued the MOU Template that is required to be utilized for MOU's between MHPs/DMC-ODS and MCPs.

- The BHIN documents the oversite and compliance requirements as well as reporting requirements to the Department of Health Care Services (DHCS).

- The MOU is intended to clarify roles and responsibilities between MHPs/DMC-ODS and MCPs and support local engagement, care coordination, information exchange, mutual accountability and transparency.

MOU Between MHP or DMC-ODS and MCP Requirements

▪MHPs/DMC-ODS are responsible for providing medically necessary covered Specialty Mental Health Services and Drug Medi-Cal services to beneficiaries set forth in the State Plan and the DMC-ODS Intergovernmental Agreement, MCP Boilerplate Contract, including the coordination of a beneficiary's care.

▪The MOU between the MHP or DMC-ODS and MCP ensures coordination of medically necessary services, including health-related social service needs, when beneficiaries are accessing services from both systems.

▪Describes the services that each party must coordinate for beneficiaries and each party's provision of services and oversight responsibilities.

▪Requires each party to provide educational materials to beneficiaries and network providers about accessing medically necessary services. Train network providers, subcontractors and downstream subcontractors on MOU requirements and services provided by each party. Education resources for beneficiaries can be found on Optum Website under Health San Diego page.
https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/healthy-san-diego.html

MOU Between MHP or DMC-ODS and MCP Requirements

▪Describes required policies and procedures covering beneficiary screening and assessment, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services and administering Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) to DMC-ODS beneficiaries ages 11 and older. The MOU requires each party to refer beneficiaries to the other party as appropriate and describes each party's referral process.

▪Describes the requirements for coordinating beneficiary access to care and describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improvement of care coordination. Requires parties to coordinate provision of medically necessary services, treatment planning, clinical consultation, Enhanced Care Management (ECM), Community Supports, and prescription drugs.

▪Requires parties to have policies and procedures to ensure the continued care coordination for services in the event of a disaster or emergency.

MOU Between MHP or DMC-ODS and MCP Requirements

- Describes the parties' quality improvement (QI) activities to ensure oversight and improvement of the MOU requirements.

- Describes the minimum data and information that the parties must share to ensure the MOU requirements are met and describes the data and information the parties may share to improve care coordination and referral processes, and requirements for parties to share information about beneficiaries as set forth in the MHP-MCP MOU and DMC-ODS-MCP MOU template and in accordance with federal and state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2.

- Describes the policies and procedures for resolving disputes between the parties and the process for bringing the disputes to DHCS when the parties are unable to resolve disputes between themselves.

- Describes additional general contract requirements.

MOU Compliance and Oversight Requirements

- The MHP and DMC-ODS County compliance officer must designate a responsible person(s) for overseeing MHP's and DMC-ODS compliance with the MOU.
  - Conduct regular meetings, on at least a quarterly basis, to address policy and practical concerns that may arise between MOU parties.
  - Ensure executive participation in MOU quarterly meetings from both parties.
  - Report on the party's compliance with the MOU to the Compliance Officer no less frequently than quarterly.
  - Ensure there is sufficient staff at the MHP and DMC-ODS to support compliance with and management of the relevant MOU and it's provisions.
  - Ensure subcontractors, downstream subcontractors, and network providers, as applicable, comply with any applicable provisions of the MOUs.
  - Serve as or designate a person at the MHP and DMC-ODS to serve, as the day-to-day liaison with the MCP or MCP programs.

MOU Compliance and Oversight Requirements

- MHPs and DMC-ODS Counties must work collaboratively with MCPs to establish dispute resolution processes and timeframes within the MOU.
  - Includes how the MHP or DMC-ODS County will work with the MCP to resolve issues related to coverage or payment of services under conflicts regarding respective roles for case management for specific beneficiaries, or other concerns related to the administered services to beneficiaries.

- MHPs and DMC-ODS Counties and MCPs must complete the plan-level dispute resolution process. If the parties fail to resolve the dispute, either party must submit a written “Request for Resolution” to DHCS.

- MHPs and DMC-ODS Counties must provide training and orientation of MOU requirements with subcontractors, downstream subcontractors, and network providers, as applicable, on an annual basis, at a minimum. The training must include information on MOU requirements and the services that are provided or arranged for by each party and how those services can be accessed or coordinated for the beneficiary.

- Starting January 1, 2025, MHPs and DMC-ODS Counties must submit an annual report that includes updates from the quarterly meetings with the MCP and the results of their annual MOU review to DHCS.

Healthy San Diego Managed Care Plans (MCP)

Healthy San Diego

Medi-Cal Managed Care Plan Contact Card

Health Plan	Member Services/Transportation	Behavioral Health	Telephone Medical Advice Line	Vision Services	Medi-Cal RX	Denti-Cal
Blue Shield CA Promise Health Plan	1-855-699-5557	(855) 321-2211	1-800-609-4166	1-855-699-5557	(800) 977-2273	(800) 322-6384
Community Health Group	1-800-224-7766	(800) 404-3332	1-800-647-6966	Vision Service Plan 1-800-877-7195	(800) 977-2273	(800) 322-6384
Kaiser Permanente	1-800-464-4000	(833) 579-4848	1-800-290-5000	1-800-464-4000	(800) 977-2273	(800) 322-6384
Molina Healthcare	1-888-665-4621	(888) 665-4621	1-888-275-8750	March Vision Services 1-888-463-4070	(800) 977-2273	(800) 322-6384

County Mental Health Plan To access Specialty Mental Health and the Drug Medi-Cal Organized Delivery System 1-888-724-7240	**Jewish Family Service** Patient Advocacy Program Complaints & Grievances/Inpatient & Residential 1-800-479-2233	**Consumer Center for Health Education & Advocacy** Patient Advocacy Program Complaints & Grievances/Outpatient services 1-877-734-3258

Pharmacy benefits for all Medi-Cal recipients are covered by the State's Medi-Cal Rx. Program (800) 977-2273

05/2024 Medi-Cal Managed Care Plans cover transportation to all Medi-Cal covered services including Specialty Mental Health, Drug Medi-Cal Organized Delivery System and Denti-Cal

Healthy San Diego Drug Medi-Cal Managed Care Plans (MCP)

Drug Medi-Cal Quick Guide

Health Plan	Medi-Cal Specialty Mental Health and Drug Medi-Cal Services	Medi-Cal Managed Care Plan Behavioral Health Services (For Mild to Moderate Mental Health Conditions)
Blue Shield CA Promise Health Plan Blueshieldca.com/promise	San Diego Access & Crisis Line (888) 724-7240	Blue Shield CA Promise Health Plan (855) 321-2211
Community Health Group Chgsd.com	San Diego Access & Crisis Line (888) 724-7240	Behavioral Health Services (800) 404-3332
Kaiser Permanente KP.org	San Diego Access & Crisis Line (888) 724-7240	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare MolinaHealthcare.com	San Diego Access & Crisis Line (888) 724-7240	Molina Healthcare (888) 665-4621

Optum San Diego Website
Healthy San Diego

- Optum San Diego Website houses resources/educational materials for Medi-Cal Specialty Mental Health Service Providers and Drug Medi-Cal Organized Delivery System Providers.
  - https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/healthysandiego.html

- The MHP-MCP MOU and the DMC-ODS-MCP MOU will be posted on the Optum San Diego Website-Healthy San Diego Page.

Incident Reporting Updates as of January 2025

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

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Changes to Incident reporting

Effective January 1, 2025

- All Incidents must be reported within 24 hours of knowledge

- Naming conventions:
  - Previously 'SIR Level 1': **Critical Incidents**
  - Previously 'SIR Level 2', Unusual Occurrences: **Non-Critical Incidents**

- SIR Phone Line has been eliminated
  - Can consult with QA at any time

- Incident Reports are required for all BHS contracted programs, treatment and non-treatment, including clients in active treatment.

Critical Incident Reporting

Critical Incidents

- Who: Any clients in active treatment;
  - Or, who were discharged within the last 30 days related to client deaths
- Email (secure) or fax completed Critical Incident Report (CIR) form within 24 hours of knowledge of the incident
- Form **must** be typed
- Report of Findings (ROF) must be submitted within 30 days from the date the program was made aware of the critical incident

Critical Incident Categories

- 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)
Death/Natural Causes (Confirmed)
Death/Overdose (Confirmed)
Death/Suicide (Confirmed)
Death/Homicide (Confirmed)
Suicide Attempts
Non-Fatal Overdose
Medication Error
Alleged abuse/inappropriate behavior by staff
Injurious assault by a client resulting in hospitalization
Critical Injury on site (MH/SUD related)
Adverse Media/Social Media Incident (only; no leading incident)

Non-Critical Incident Reporting

Non-Critical Incidents

- An adverse incident that may indicate potential risk/exposure for the County operated or contracted provider, client, or community.
- 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 Non-Critical Incident.
- COR or QA staff may request an ROF at any time, but they are not automatically required for Non-Critical incidents
- Reported via an online submission form
  - Sent directly to the COR, Program Manager and QA (QI Matters)
  - Reported within 24 hours of knowledge of the incident
  - **No** PHI is entered on this form

Non-Critical Incident Categories

- Non-Critical Incidents may include but are not limited to:

Client AWOL
Contract/Policy violations by staff (unethical behavior)
Loss or theft of medication from the Facility
Physical Restraints (prone/supine)
Tarasoff Reporting
Non-critical injury onsite
Adverse Police/PERT Involvement onsite
Property destruction onsite
Other*

Report of Findings

- Report of Findings (ROF) is the review and investigation of an incident
  - Interventions
  - Findings
  - Policy/Procedure
  - Trainings
- ROFs are required for all Critical Incidents, unless waived by either QA or COR.
  - Due 30 days from date of incident
  - If a CME is requested, an extension of 6 months may be granted, or they may submit without the CME.
- ROFs are not *automatically* required for Non-Critical Incidents, however, can be requested by COR or QA for any program incident.
- Root Cause Analysis (RCA)
  - Required for deaths by suicide, alleged homicide by client, or as requested by County QA or COR

Resources and Tip Sheets

- **OPOH Section G**: CIR/N-CIR Categories and Reporting Processes

- Next RCA Live Training: **September 15, 2025**

- Optum Page: SMH & DMC-ODS Health Plans
  - "Incident Reporting" Tab
    - BHS Communication Memos
    - CIR Tip Sheet and Forms
    - N-CIR Tip Sheet and Link
    - ROF/RCA Tip Sheet and Forms

Recently Updated Resources on the Optum San Diego Website

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Recently Updated/Uploaded Forms

- **Clearing CoSD Service Error Report** as of 7/15/25
  - Within 'Workflows and Documentation' in the "SmartCare" Tab

- **Billing Unit Payment Recovery Form** - 7/28/25
  - Within "Billing" in "SMHS & DMC-ODS

❖ Not yet posted to "Billing" tab but available on the DHCS MED CCC site:

- **Specialty Mental Health Services Billing Manual-***July 2025 Version*
  - MHBU has requested summary of changes from DHCS

- **Medication Monitoring Tool- Adult** as of 8/15/2025
  - Within the "Monitoring" Tab

Recently Updated/Uploaded

- **Inpatient Operations Manual**: as of 7/15/25
- **CAPS Inpatient Operations Manual**: as of 07/01/25
  - Both located in the “Manuals” Tab

- New **Beneficiary Handbook** in all threshold languages- effective as of July 2025
  - San Diego threshold languages now include Russian

- **ECHW vs PSS Comparison Grid** as of 08/01/2025
  - Within the ‘MH Resources’ Tab

Recently Updated/Uploaded

- Recent Communications:
  - **Enhanced Community Health Worker (E-CHW)** BHS Communication- published as of 7/30/2025
  - **Certified AOD Counselors for SMHS Information Notice-** published as of 07/03/2025

- All SmartCare User Group slides are posted and up-to-date within the 'Townhall and User Group PowerPoints' within the 'SmartCare' tab

***Reminder:** The 'QA Updated' CPT Crosswalk is no longer in use- Please reference CalMHSA site & DHCS for most up to date Service Codes and definitions

COSD Reports Available & Pending

SmartCare Report Name	Status
CoSD Active Clients Report	Completed
CoSD Admissions Morning Report	Completed
CoSD Admissions, Discharges, and Census Report	Completed
CoSD Authorizations Report	Completed
CoSD Bed Management Report	Started
CoSD CANS Assessment Summary	In UAT
CoSD Charges/Claims Report	In UAT
CoSD Client Demographic Breakdown	Started
CoSD Client Insurance & Date Span Report	Completed
CoSD Client Services Report	Completed
CoSD Consent Documents Report	Completed
CoSD Missing Diagnoses by Program Report	In UAT
CoSD Open Enrollments and Last Date of Service Report	Completed
CoSD Program Invoicing Report	Completed
CoSD Progress Note Timeliness Report	Completed
CoSD Service Error Report	Completed
CoSD Staff Licenses and Expiration Dates Report	In UAT
CoSD TADT Report	Completed
CoSD Unsigned Documents Report	Completed

Q&A's From Live Forum

Q: Are the diagnosis forms that were transferred over by county from Cerner to prepare for the Sept 1st SmartCare opening valid as the program's diagnosis document or do we need to update the Diagnosis forms?

The diagnosis document is a client specific document. Every program needs to open their own diagnosis form. If your program has a diagnosis document that was migrated into SmartCare, this is a valid document for providing services.

Q: With the new CalAIM trainings updated in July. are staff required to go back and retake them? I noticed my completion of CalAIM no longer shows on my dashboard

No, Staff do not need to re-take the CalAIM trainings if they have previously completed them. If they have not completed new modules, these will need to be completed.

*Continued on next slide **

Q&A's From Live Forum

Q: We have multiple programs and our staff lost some of their access to attest to all programs with the latest update to the SOC in July. Is there an update of when access will be reinstored?

Please contact the Optum Support Desk or email them with the names of the providers and the programs they should be associated with. Optum will update the connections on the back end so that the correct programs are seen in the SOC. If providers need assistance with registering or logging on to the SOC application, please have them contact the Optum Support Desk.

Q: Is there an update on the SOC attestation for Smartcare as most people aren't able to attest monthly because signing up required a CCBH #?

The SOC attestation process no longer requires a CCBH account. With the update of SmartCare connections, providers could log into the SOC application and see their profiles. If they are missing programs or need updated program associations, please reach out to the Optum Support Desk to correct that.

Another asker: Same questions here. I was recently advised not to start SOC applications for new staff due to this issue.

The SOC application had been "under construction" and is now re-opened for attestations to begin again.

Participant answer: We were informed to use Smart Care ID numbers

SmartCare IDs can now be used to register for the www.OptumSanDiego.com

Thank you

Looking forward to a great year ahead!

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

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