*April 2023*

# QRTips

**Mental Health & Recovery Services (MHRS)**
**Quality Management Services (QMS)**
**Quality Assurance & Quality Improvement Division**
**AOA-Support Team / CYP-Support Team / Managed Care / Certification and Designation**


Authority and Quality Improvement Services (AQIS) has a new name. We are now known as:

**Quality Management Services (QMS)**

For the moment, our support teams' mailboxes continue to be:

AQISCalAIM@ochca.com
AQISCDSS@ochca.com
AQISDesignation@ochca.com
AQISGrievance@ochca.com
AQISManagedCare@ochca.com
AQISmccert@ochca.com
AQISSUDSupport@ochca.com
AQISSupportTeams@ochca.com

Please continue to send in your questions and requests to those email mailboxes


**The first week of May 2023**

This year the APT will begin with a common core section addressing the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) and then the training will break out into the separate areas of CYP, AOA, and SUD. In this APT, you will learn relevant information about the work you do and this APT will serve the purpose of providing your annual training on the requirements of the MHP. If there are any questions who in your program should take the APT, please refer to the current Policies and Procedures at https://ochealthinfo.com/sites/hca/files/import/data/files/70039.pdf link. Providers will have a 30-day window to complete the APT once released, so please make sure to plan accordingly.

## TRAININGS & MEETINGS

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### AOA Online Trainings

*New Provider Training (Documentation & Care Plan)*

*2021-2022 AOABH Annual Provider Training*

**MHRS-AOA MHP QI Coordinators' Meeting**

**Teams Meeting: 4/6/2023**

**10:30- 11:30am**

### CYS Online Trainings

*2021-2022 CYPBH Integrated Annual Provider Training*

**MHRS-CYS MHP QI Coordinators' Meeting**

**Teams Meeting: 4/13/2023**

**10:00-11:20am**

**More trainings on CYS ST website*

## HELPFUL LINKS

• • •

QMS AOA Support Team

QMS CYS Support Team

BHS Electronic Health Record

Medi-Cal Certification

# STANDARDIZED SCREENING & TRANSITION OF CARE TOOLS

Previously, multiple behavioral health screening and transition of care tools were in use for Medi-Cal beneficiaries across the state, leading to inconsistencies for when beneficiaries were referred to mental health plan networks versus managed care plan networks. CalAIM seeks to streamline this process and improve patient care by creating standardized statewide tools.

DHCS is requiring MCPs and MHPs to use the Screening Tool and the Transition of Care Tools for beneficiaries under age 21 (youth) and for beneficiaries age 21 and over (adults).

The Screening and Transition of Care Tools for Medi-Cal Mental Health Services consist of:

- The Adult Screening Tool
- The Youth Screening Tool
- The Transition of Care Tool

The adult and youth screening tools determine the appropriate mental health delivery system referral for beneficiaries who are **not** currently receiving mental health services when they contact the MCP or MHP seeking mental health services.

The screening tools are not required or intended for use with beneficiaries who are currently receiving mental health services.

The screening tools are also not required for use with beneficiaries who contact mental health providers directly to seek mental health services.

Mental health providers who are contacted directly by beneficiaries seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the screening tools, consistent with the No Wrong Door for Mental Health Services Policy.

The Transition of Care Tool ensures that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when:

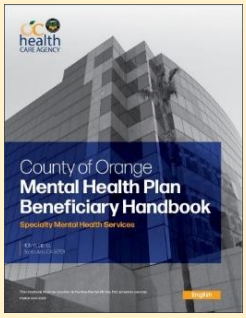
- their existing services need to be transitioned to the other delivery system, or
- when services need to be added to their existing mental health treatment from the other delivery system.

The MHP's Administrative Services Organization (ASO) will be administering the screening tool and all providers will be utilizing the Transition of Care Tool when referring clients who are appropriate for mild to moderate mental health services to the Managed Care Plan: CalOptima.

Trainings and materials will be made available soon. If you have any questions, please direct them to: AQISSupportTeams@ochca.com

## Announcement: Mental Health Plan Beneficiary Handbook Update

The Mental Health Plan Beneficiary Handbook has been updated in all six threshold languages and is available for download via the following link https://www.ochealthinfo.com/providers-partners/county-partnerships/medical/mental-health-plan-and-provider-information. Please ensure any old version of the handbook are replaced with the 2023 updated version.



# Frequently Asked Questions about the BH Assessment downtime form and TCM Care Plan Progress Note

**(County Clinics Only)**

**Which forms need a FIN?**

**The BH Assessment downtime form does not require a FIN.** The time spent working on the BH Assessment downtime form should be captured in an Assessment progress note or multiple Assessment progress notes in EHR.

**The TCM Care Plan Progress Note requires a FIN since the form is a type of progress note.** The original workflow for the TCM CP PN is for the providers to turn the form into the front office staff. At that time the front office staff create, check in, and check out a FIN before scanning the document into EHR. *Please consult with your Service Chief if your program does not follow the original workflow as this may result in the providers being responsible to create, check in, check out and write the FIN on the downtime form, before turning it into the front office staff.*

**Is the "Date of Service" different from the "Date of Documentation" on the TCM Care Plan?**

The "Date of Service" and the "Date of Documentation" on the TCM Care Plan Progress Note should match since the "service" represents the time it took to work on the TCM Care Plan fields in the PN and the "documentation" refers to the time that all other fields on the PN are completed.

**Do I need separate Scan Cover Sheets?**

Yes! The BH Assessment downtime form should be scanned as "BH Assessment" under "Eval (Downtime)" as indicated on the Scan Cover Sheet.

The TCM Care Plan Progress Note should be scanned as "Care Plan – TCM CP PN" under "Care Plans."

**Which date do I write on the Scan Cover Sheet?**

The "Date to use in IRIS" on the Scan Cover Sheet for the BH Assessment downtime form should be the date you completed the BH Assessment.

The "Date to use in IRIS" for the TCM Care Plan Progress Note should be the "Date of Service" on the TCM Care Plan Progress Note.

**What is the difference between Service Minutes and Documentation Time on the TCM Care Plan?**

"Service Minutes" accounts for the time it took to complete the portion of the TCM Care Plan Progress Note that reflects the actual TCM Care Plan starting with "Date this plan was developed/discussed/agree upon with Client" ending with the Provider's Signature. "Documentation Time" accounts for the time spent completing the Progress Note portion of the TCM Care Plan Progress Note starting with "Client Name" and ending with "Purpose of Service."

If you continue to have questions about the BH Assessment, Problem List, and/or TCM CP Progress Note downtime forms, please send your questions to AQISSupportTeams@ochca.com or call (714) 834-5601

## Pathways to Well-Being/Intensive Services Requirements Reminder

QMS wants to provide a friendly reminder to our providers about the service requirements if a beneficiary meets Pathways to Well-Being (PWB) or Intensive Services (IS).

For beneficiaries that meet **PWB criteria**, a CFT meeting needs to occur **no less frequently than every 90 days** with a review of the CFT Plan. The mental health representative assumes the role of the ICC Coordinator and completes/updates the CFT Plan. The provider must document this in a progress note, check off the CFT modifier, AND complete an entry in the PWB/IS 90-Day Review Form.

For beneficiaries that meet **IS criteria**, the ICC/IHBS Care Plan needs to be reviewed in a meeting with the clinician, beneficiary, and parent/caretaker no less frequently than every 90 days. The clinician must document this in a progress note AND complete an entry in the PWB/IS 90-Day Review Form.

## CYS Support Team Site Visits

Currently, CYS Support Team (CYS ST) is conducting site visits with various county community provider partners and county providers. It has been exciting to see familiar and new faces in addition to getting to know more about your unique programs and how you are implementing CalAIM requirements. To further support your program in having a productive visit and leaving with a better understanding of CalAIM, CYPST has come up with some possible subjects/materials to discuss during the upcoming visits.

Possible topics you might want to discuss (but not limited to) are the following ideas:

- Problem list and SNOMED codes
- Care plan progress notes
- 7 domain assessment
- Progress notes documentation
- Access criteria vs medical necessity
- Discussing a case example and how CalAIM might apply to the case
- Sharing samples of your program's CalAIM documentation (please send your samples to CYS ST ahead of time)

We continue to look forward to our collaboration as we work together and appreciate your willingness to share your questions with us during your site visits. Should you need further assistance or need clarification at any time, please send them our way to AQISSUPPORTTEAMS@ochca.com.

# MANAGED CARE SUPPORT TEAM

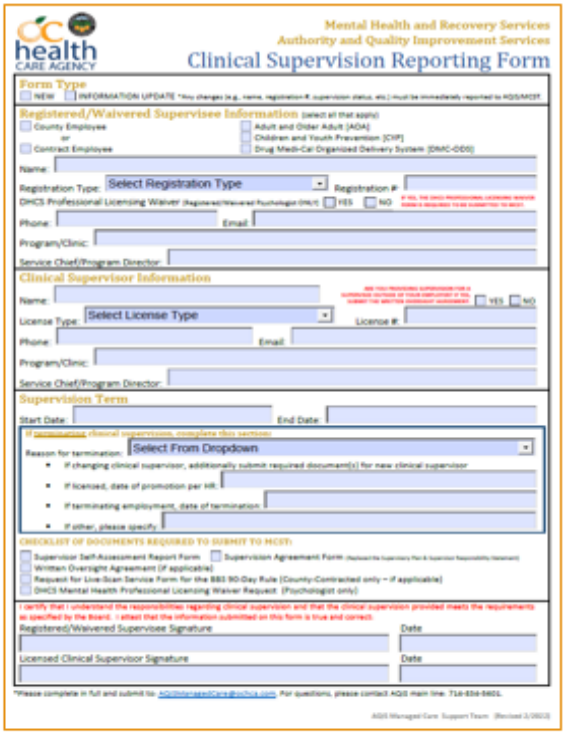
## MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- PAVE ENROLLMENT FOR COUNTY DMC-ODS CLINICS & PROVIDERS
- PAVE ENROLLMENT FOR MHP PROVIDERS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- COUNTY CREDENTIALING
- CAL-OPTIMA CREDENTIALING
- ACCESS LOGS
- CLINICAL/COUNSELOR SUPERVISION
- MHPS/DMC-ODS PROVIDER DIRECTORY

## REMINDERS, ANNOUNCEMENTS & UPDATES

### CLINICAL SUPERIVSION

- Registered, waivered, intern or volunteer collecting clinical hours towards licensure must be assigned to a clinical supervisor.
- Clinical Supervision Reporting Form (CSRF) and the Board of Behavioral Sciences (BBS) Supervision Agreement form must be submitted to the MCST upon commencement (e.g., hire date).
- Any status change requires an updated CSRF to be submitted to the MCST (e.g., separation, change of Clinical Supervisor, etc.).
- Clinical Supervision is required at least once a week until the supervisee becomes licensed.
- Supervisees must **NOT** deliver any Medi-Cal covered services without having an assigned clinical supervisor. Not adhering to the clinical supervisor requirement will result in a compliance issue and be subjected to disallowance.
- Refer to the hyperlink below for the Health Care Agency (HCA)/Mental Health and Recovery Services (MHRS) Policies and Procedures on Clinical Supervision Requirements:
  Clinical Supervision Requirements (ochealthinfo.com)


Mental Health and Recovery Services
Authority and Quality Improvement Services
Clinical Supervision Reporting Form
Form Type
Registered/Waivered Supervisee Information
Clinical Supervisor Information
Supervision Term
CHECKLIST OF DOCUMENTS REQUIRED TO SUBMIT TO MCST:

### COUNTY CREDENTIALING

- All **new providers** must submit their County credentialing packet within 5-10 business days of being hired to the MCST. The newly hired provider must **NOT** deliver any Medi-Cal covered services under their license, waiver, registration and/or certification until they obtain a letter of approval confirming they have been credentialed by the MCST. The IRIS team will not activate a new provider in the IRIS system without proof of the credentialing approval letter. It is the responsibility of the direct supervisor to review and submit the new hire credentialing packet to the MCST.
- New providers must **NOT** provide any direct treatment or supportive services to a beneficiary until they have officially received a credentialing approval letter.

## REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

### EXPIRED LICENSES, CERTIFICATION AND REGISTRATION

- As of January 2023, the MCST has been tracking and monitoring programs with three (3) or more providers who have failed to renew their license, registration or certification on time and began issuing a formal Corrective Action Plan.
- Programs are strongly encouraged to have their providers renew their credentials with the certifying organization at least 2-3 months prior to the expiration. It is not appropriate for a provider to continue delivering Medi-Cal covered services while a registration or certification has lapsed on the assumption that the certifying organization will renew the credential retroactively, as this may not always be the case and can potentially lead to a disallowance.
- When the provider's credential has expired the MCST and IRIS immediately takes action to deactivate the provider in the County system. The provider must petition for their credentialing suspension to be lifted and e-mail proof of the license, certification and/or registration renewal to the MCST and IRIS in order to reinstate their privileges to begin delivering Medi-Cal covered services.

### PROVIDER DIRECTORY

- New providers need to be credentialed or in the process of being credentialed before being placed on the Provider Directory spreadsheet.
- If a provider is credentialed or in process of being credentialed at the time of submission of the Provider Directory, the program will enter the provider's name on the Provider Directory spreadsheet and select "new" from the drop-down menu.
- If a provider is not credentialed and not yet in the process of being credentialed, then the provider is not to be placed on the Provider Directory. Exceptions include MHW, MHS and student interns.

### DISCRIMINATION GRIEVANCES

- The plan provides information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation (WIC §14727 (a)(4-5)).
- The beneficiary can file a Discrimination Grievance at any time without being required to file with the Health Plan before filing the compliant with the other entities listed below. The Discrimination Grievance may be filed via phone, writing, in person and/or electronically to:
    1. Quality Management Services (QMS) Discrimination Grievance Coordinator/Representative
       Phone: (714)834-5601 or (866)308-3074 or TTD: (866)308-3073
       Mail: P.O. BOX 355, Santa Ana, CA 92702
    2. HCA County Civil Rights Coordinator - Office of Compliance
       Phone: (714)568-5787 or 711 (TTD)
       Mail: 405 5th St., Suite #212, Santa Ana, CA 92701
       Fax: (714)834-6595
       E-mail: officeofcompliance@ochca.com
    3. U.S. Department of Health and Human Services - Office of Civil Rights
       Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
       Phone: (800)368-1019 or TDD: (800)537-7697
       Mail: 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
       E-mail: OCRComplaint@hhs.gov

# MANAGED CARE SUPPORT TEAM

## REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

**NOABDS**

- NOABD Terminations are no longer required for beneficiaries who have successfully completed the program, even if they are not moving onto a lower level of care.
- All NOABDs must be e-mailed to AQISGrievance@ochca.com upon mailing it within 2 business days to the beneficiary. The MCST tracks and logs all NOABDs being issued by the providers to report out and assist beneficiaries with any questions they may have upon receiving the NOABD.

**MCST TRAININGS ARE AVAILABLE UPON REQUEST**

If you and your staff would like a specific or a full training about the MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com or Service Chief II, Dolores Castaneda at dcastaneda@ochca.com.

**GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER**

Leads: Esmi Carroll, LCSW Jennifer Fernandez, MSW

**CLINICAL SUPERVISION**

Lead: Esmi Carroll, LCSW

**ACCESS LOGS**

Lead: Jennifer Fernandez, MSW

**PAVE ENROLLMENT FOR MHP & SUD**

Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Martinez, Staff Specialist

**CREDENTIALING AND PROVIDER DIRECTORY**

Credentialing Lead: Elaine Estrada, LCSW
Cal Optima Credentialing Lead: Sam Fraga, Staff Specialist
Provider Directory Lead: Paula Bishop, LMFT

**CONTACT INFORMATION**

400 W. Civic Center Drive., 4th floor
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480-0775

**E-MAIL ADDRESSES**

AQISGrievance@ochca.com (NOABDs/Grievance Only)
AQISManagedCare@ochca.com

**MCST ADMINISTRATORS**

Annette Tran, LCSW
Health Services Administrator

Dolores Castaneda, LMFT
Service Chief II

**Steps for Discharging a Client:**

1) Treatment team member reviews chart.
2) Treatment team member documents reason for closing case on the Discharge Form.
3) Treatment team member writes a corresponding Case Management progress note. (Should be the last FIN created in client chart. No other services should be provided thereafter).
4) Treatment team member notifies Service Chief or Program Director of case to be closed.
5) Service Chief or Program Director reviews discharge and notifies office support that a case needs to be closed.
6) COUNTY ONLY: office support will follow steps on the Office Discharge Checklist.
   CONTRACT PROVIDER/PARTNER ONLY: Office Support confirms discharge note includes discharge date, discharge reason and any other information needed to discharge client.
7) Office support ensures the date of discharge matches the encounter or registration date of the last FIN in the client's Episode of Care (EOC).
8) Office support closes the client's EOC in IRIS.

NOTE: If clinic/program has a paper chart for the client, please follow your program's guidelines.

**Service Chiefs and Supervisors:**

Please remember to submit monthly program and provider updates/changes for the Provider Directory and send to: AQISManagedCare@ochca.com and BHSIRISLiaisonTeam@ochca.com

Review QRTips in staff meetings and include in meeting minutes.

***Disclaimer**: The Quality Management Services (QMS) Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly QRTips newsletter to all MHP providers as a tool to assist with various QA/QI regulatory requirements. It is NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.*

## QMS, Quality Assurance & Quality Improvement Division

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**Division Manager, QMS**

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