MEDI-CAL PROVIDER GUIDE

Ventura County Behavioral Health

Effective Date: July 1, 2026

Updated: June 30, 2026

The Ventura County Behavioral Health Medi-Cal Provider Guide covers the operations of the Behavioral Health Plan's Provider Network.

Section 1 – Introduction

1.1 Welcome – About this Guide

Welcome to Ventura County Behavioral Health Plan's **Provider Guide**. We are grateful for your participation as a contracted provider serving Ventura County Behavioral Health Plan members. This Guide is designed to assist you in delivering high-quality, accessible, and culturally responsive care as well as outline operational requirements, policies, and procedures for all contractors providing services under the Ventura County Behavioral Health (VCBH) DHCS Integrated Agreement (Contract 24-40149). This Guide is incorporated by reference into all service provider contracts and compliance with its requirements is mandatory.

In the event of a conflict between this Provider Guide, the Provider Services Agreement, applicable federal or state law, DHCS guidance, Behavioral Health Information Notices (BHINs), or the DHCS Integrated Agreement, the stricter or more recently controlling authority shall govern.

Contractors are responsible for monitoring and complying with applicable laws, regulations, BHINs, DHCS guidance, and other regulatory requirements, including updates issued between revisions of this Provider Guide.

1.2 Purpose of the Guide

The Plan Provider Guide serves as a reference for clinical and administrative requirements. It provides:

- Expectations for providers
- Eligibility and Covered Services
- Information on member rights and responsibilities
- Guidance on billing, claims, and utilization management
- Clinical practice guidelines and quality standards
- Other Provider Resources
- Operational Information

1.3 How to Use This Guide: Required vs. Best Practice

This Guide serves two distinct purposes that are important to understand. Certain sections set forth binding contractual requirements that are incorporated by reference into your Provider Services Agreement (PSA) with Ventura County Behavioral Health (VCBH). Other sections provide operational guidance, clinical best practices, and VCBH recommendations that, while not contractually enforceable, represent the standard of care and operational expectations that VCBH encourages all providers to meet.

To make this distinction clear, the following terminology is used consistently throughout this Guide:

> **REQUIRED —** Language using "shall," "must," or "is required" denotes a contractual obligation. These provisions are incorporated into your Provider Services Agreement and non-compliance may result in payment delay, corrective action, or contract remedies. Sections and provisions containing mandatory obligations are highlighted in red callout boxes like this one.

BEST PRACTICE — Language using "should," "VCBH recommends," or "it is recommended" denotes a best practice or VCBH recommendation. These provisions are not contractually required but reflect the standard of quality care and operational performance VCBH expects providers to strive toward. Best practice guidance is highlighted in blue callout boxes like this one.

Where a section contains both mandatory requirements and best practice guidance, mandatory language will appear first, followed by best practice guidance clearly labeled. Informational and operational content (e.g., system navigation instructions, reference links, background context) is presented in plain text and does not carry independent compliance obligations beyond what is stated in the contract.

The terms "Contractor" and "Provider" will be used somewhat interchangeably throughout this Guide, however, most language pulled from the PSA Contract will reference "Contractor" as the entity, whereas the more general term used throughout refers to a "Provider" as the entity.

1.4 Guide Updates

VCBH will update this Guide as needed to reflect changes in DHCS requirements, state and federal regulations, and/or VCBH policies. Contractors will be notified of material changes at least 30 days prior to implementation. The current version of this Guide will always be available on the VCBH website. All documents referenced within this Guide can be located on the VCBH website by clicking on the following link Provider Resources - Ventura County Behavioral Health or found within the Policy Library

1.5 About the Plan

The Ventura County Behavioral Health (VCBH) Plan is responsible for administering Specialty Mental Health Services (SMHS), Substance Use disorder Services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) and Substance Use Block Grant (SUBG) programs for Medi-Cal plan members. The Plan's mission is to ensure that all Medi-Cal beneficiaries have access to effective, person-centered behavioral health services that support recovery, resilience and wellness. VCBH employs both evidence-based practices (EBP) and community-driven evidence practices (CDEP) supporting the needs of our plan members.

1.6 Mission, Vision, and Values

- **Mission:** Ventura County Behavioral Health is committed to reducing stigma and discrimination. We promote wellness through a whole-person care approach where clients and families are empowered by appropriate, accessible, timely, culturally sensitive, and collaborative behavioral health services.
- **Vision:** Ventura County Behavioral Health envisions a community where our diverse residents are respected and empowered so those impacted by mental health and substance use can heal, thrive and lead a healthy, engaged life.
- **Values:** Respect, Equity, Integrity, Compassion, Collaboration and Quality

Section 2 – Provider Responsibilities

2.1 Becoming a Contracted Provider

How do I contract with the County?

Website - Become a Provider - Ventura County Behavioral Health

- A potential provider may click on the link above and email: PNMRelations@venturacounty.gov to contact the VCBH Provider Relations Team.
- Upon receipt of your email, VCBH Provider Relations will forward your request to the Division Chief responsible for oversight of the requested services. The Division Chief will assess service need and determine whether the services meet applicable standards.

How do I apply for a National Identifier Provider (NPI) number for my organization?

An entity (organization) applies for an NPI through the **National Plan and Provider Enumeration System (NPPES)**, which is managed by the Centers for Medicare & Medicaid Services (CMS).
Here's a summary of the process:

- The organization completes an online application in the NPPES system, selecting the option for an **Organizational NPI (Type 2)**. The application requires basic business information such as the legal entity name, Employer Identification Number (EIN), address, taxonomy (provider type/specialty), and authorized official details. The authorized official must attest to the accuracy of the information and has the legal authority to act on behalf of the organization.
    - Please click on Taxonomy to find more information about Health Care Provider Taxonomy Codes and identify the most appropriate Code for your agency.
- After submission, CMS reviews the application. In most cases, if the information is complete and valid, the NPI is issued within a few days, though it can take longer if additional verification is needed.
- The application can be completed online at the official NPPES site:
  NPPES NPI Application

How do I obtain required Licensure and Certification?

To provide services to Medi-Cal beneficiaries and receive reimbursement, Substance Use Services Providers (DMC-ODS) and/or Specialty Mental Health Service (SMHS) Providers must be licensed and certified by the Department of Health Care Services (DHCS), Licensing and Certification Division.

VCBH Provider Relations is responsible for monitoring and verifying the License and Certification as well as certifying, recertifying and monitoring all contracted organizational providers.

- *Mental Health Providers*
    - To provide and bill for SMHS, Specialty Mental Health Services Provider Medi-Cal Certification and Recertification is required for facility types: Short-Term Residential Treatment Program (STRTP), Outpatient, Adult Residential Services (ARS), Crisis

Residential Treatment (CRT), Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU)
        - how to become site certified is referenced in 2.4 Site Certification
    - The California Department of Social Services (CDSS) is responsible for monitoring and issuing licenses to residential and care programs that fall under California Title 22 regulations.
        - CDSS Programs
    - DHCS provides oversight and determines compliance with State law, regulations and other governing requirements for residential mental health treatment programs that serve children and adults. The Mental Health Program Certification Section (MHPCS) is responsible for approving and/or certifying the mental health programs of licensed residential facilities on an annual basis.
        - Mental-Health-Program-Certification-Section
    - The Mental Health Licensing & Certification (MHLC) Branch of DHCS is responsible for the licensing of psychiatric and rehabilitation care facilities, and the approval and/or certification of mental health programs on a statewide basis, ranging from acute to long-term programs.
        - Mental Health Licensing Branch
- *Substance Use Service Providers*
    - Information on obtaining your DHCS License, Certification and Level of Care: Licensing and Certification Applications Forms and Fees
    - Alcohol and Other Drugs (AOD) Standards: Licensing and Certification Program Certification
    - Provider Application and Validation for Enrollment (PAVE) for Drug Medi-Cal Certification (DMC Clinic): DMC Application Information
    - Reference: Department of Mental Health Information Notice 10-04

Clinical Laboratory Improvement Amendments (CLIA) Certification (optional) - CDPH Lab (California Dept of Public Health)

- Only applicable to certain Providers who will be testing human specimens **onsite**.
    - To determine whether this applies to your site, please go to: How to Apply for a CLIA Certificate, Including International Laboratories | CMS

How do I renew my contract with the County?

- Your (Provider's) insurance must be in good standing with no identified performance issues and the agency is in good standing with the state (DHCS)
- You (Provider) are willing to and want to extend services
- Subject to approval by VCBH Operations and Fiscal Departments
- Medi-Cal Contracts – annual renewal reports as requested per service type

How do I expand or modify my contract with the county?

- Modifying – modifying an existing agreement to align with the request of the Provider
    - Example: insurance language – the contract says $2 million coverage; however, the Provider would like it to say $1 million based on their insurance coverage
- Scope of Work Modification – modifying language to align with service goals
    - Example: increasing number of referrals
- Standard Modification – can always be negotiated directly with VCBH Contracts Department Contracts.vcbh@venturacounty.gov if it doesn't result in budget change
    - Example: name changes, modification of language within the contract
- Expanding an Existing Contract within Behavioral Health – Provider reaches out to Manager Liaison and explains the services they would like to add to their contract
    - Example: Provider has a contract for Wellness centers to high school students and now the same Provider would like to provide services to middle school and elementary school students.
- Developing Additional County Contracts with County Agency or Department - Provider would have to reach out to other county entities and follow their process for onboarding new providers
    - Example: Provider has a contract for interpretation services and now the same Provider would like to provide additional services to other departments within the county for the same service.
- Increasing contracts with the County
    - AP06 or Mid-year projection
- Invoicing (Fiscal subcommittee)
- Review of Budget (Fiscal subcommittee)

2.2 Site Certification

Required Notices to be posted in Agency Lobby - VCBH provides a list of required postings on our website (https://hca.venturacounty.gov/behavioral-health/provider-resources); however, please note that the information is subject to change is alignment with regulation updates. Please ensure your agency displays the proper signage based on your level of care and services provided.

Mental Health Providers

Medi-Cal Site Certification – Required for Billing Medi-Cal

- How to Prepare for Medi-Cal Site Certification or Recertification:
    - Submit to PNMRelations@venturacounty.gov
        - VCBH Application – Please see document titled "**Fillable VCBH MC Site Certification Application**" via the following link Provider Resources - Ventura County Behavioral Health
        - Policies and Procedures
        - Head of Services (HOS)– Professional License or Resume (if not licensed)
        - NPPES/NPI information – legal name and information must match information listed on NPPES website.

- Fire Inspection/Clearance – dated within 1 year of Site Visit
- Department of Social Services License – submit if a Residential facility

- For Initial Medi-Cal Site Certifications, the Provider Relations team will schedule a meeting with the Provider to review the process and workflow.
- For Re-certification, the Provider will be notified by email of their upcoming certification around 60 days prior to the certification expiring.
- **Your site must be operational prior to scheduling the initial Medi-Cal Site Certification Visit**
    a. Site visits and certifications may be retroactively dated up to six months from the start of services at the site.

Certification Process

- Certification is completed every 3 years and/or whenever an entity moves to a new location, changes names, or Modes of Service/Service Functions change
    - You must notify your VCBH Contract Liaison as well as Provider Relations PNMRelations@venturacounty.gov
- If HOS changes you must notify Provider Relations PNMRelations@venturacounty.gov as soon as reasonably practicable

DMC-ODS - DHCS License and Certification Division

Standards for all Substance Use Service Programs: Department of Health Care Services Certification for Alcohol and Other Drug Programs

- *Submit paperwork to Provider Relations at* PNMRelations@venturacounty.gov

Renewal Process

- *Certification renewal is completed every 2* years and/or whenever an entity moves to a new location, changes names, or Modes of Service/Service Functions change
    - You must notify your VCBH Contract Liaison as well as Provider Relations at PNMRelations@venturacounty.gov
- If HOS changes you must notify Provider Relations PNMRelations@venturacounty.gov as soon as reasonably practicable

2.3 Network Adequacy Requirements

DHCS Network Adequacy Requirements establish standards for the Behavioral Health Plan (BHP) related to provider capacity, provider qualifications and capabilities, staffing ratios, and geographic time and distance standards to ensure members have adequate access to behavioral health services. Providers are considered an entity within the Plan's network. As such, Providers are required to submit information related to site, program and staff in order for the Plan to demonstrate Network Adequacy. Additional information regarding Network Adequacy standards can be found here: 2026 Behavioral Health Network Adequacy Certification Requirements

As part of the overall Network Certification process, Providers are required to support this process by submitting accurate and timely information to VCBH, such as, but not limited to:

- Submission of program and staff information to VCBH on a monthly basis, as requested.
- Ensuring all submitted information is accurate, complete, and current, as VCBH is required to certify the accuracy of all data submitted to DHCS.
- Notifying VCBH promptly of any updates or changes to provider, program, or staffing information.
- Providing demographic, credentialing, specialization, language capacity, and other staff information as needed.

Information gathered for Network Adequacy reporting is also used to meet the DHCS Provider Directory requirements, produced by VCBH. Processes described in Section 2.4 below, and responsibilities described above, support the collection and maintenance of accurate, updated Provider (site) and Practitioner (staff) level information the feeds into monthly production of the Provider Directory which can be found here: Client Resources - Ventura County Behavioral Health

2.4 Onboarding, Reporting and Tracking Data

Entity/Provider Level

To support DHCS Network Adequacy requirements, providers must submit onboarding information and report any ongoing changes at the entity level throughout their contract with VCBH.

- The Provider/Community Based Organization (CBO) representative will be required to submit "**274 - New Site Info Template**," which collects the site and organizational information needed to establish and maintain the provider profile in SmartCare for DHCS 274 reporting requirements.
    - Providers are responsible for ensuring all information is kept current, reported to the VCBH Plan and updated in accordance with applicable regulatory requirements.
- **Ongoing changes:** Provider/CBO representative must also report any Entity/Provider level or Individual/Practitioner level changes on the **monthly 274 spreadsheet**.
- Providers/CBOs are also responsible for accurately reporting completion of all required trainings. Please refer to **Section 13 Training and Education,** for additional information.

Individual/Practitioner Level

In addition to information submitted at the Entity level, there are also requirements for all Practitioners to provide information to the VBCH Plan during onboarding as well. DHCS requires that VCBH regularly submit information regarding the demographics and practice profile of practitioners in the VCBH network.

- The Individual Practitioner will be required to complete a "**VCBH Provider Information Form**". Within this form Practitioners are responsible for reporting accurate information in accordance with applicable regulatory requirements.

2.5 EHR (Electronic Health Record) System

Providers will be onboarded into the VCBH Plan EHR system, SmartCare, and will utilize SmartCare for either Billing Purposes ONLY or as their EHR.

Entity/Provider Level

If utilizing SmartCare for Billing Purposes ONLY, the Provider representative should request SmartCare accounts for ALL their staff and note that the accounts are for "Billing Purposes Only".

- There are two ways to go about entering billing information into SmartCare
    a. *Guide Entry:* A representative will enter the service information into SmartCare under each staff member and the VCBH Billing team will submit a claim to Medi-Cal for payment.
    b. *Batch Entry:* A representative will provide a service data populated *Batch Service Upload template* to the VCBH Billing team, VCBH Billing team will upload into SmartCare.

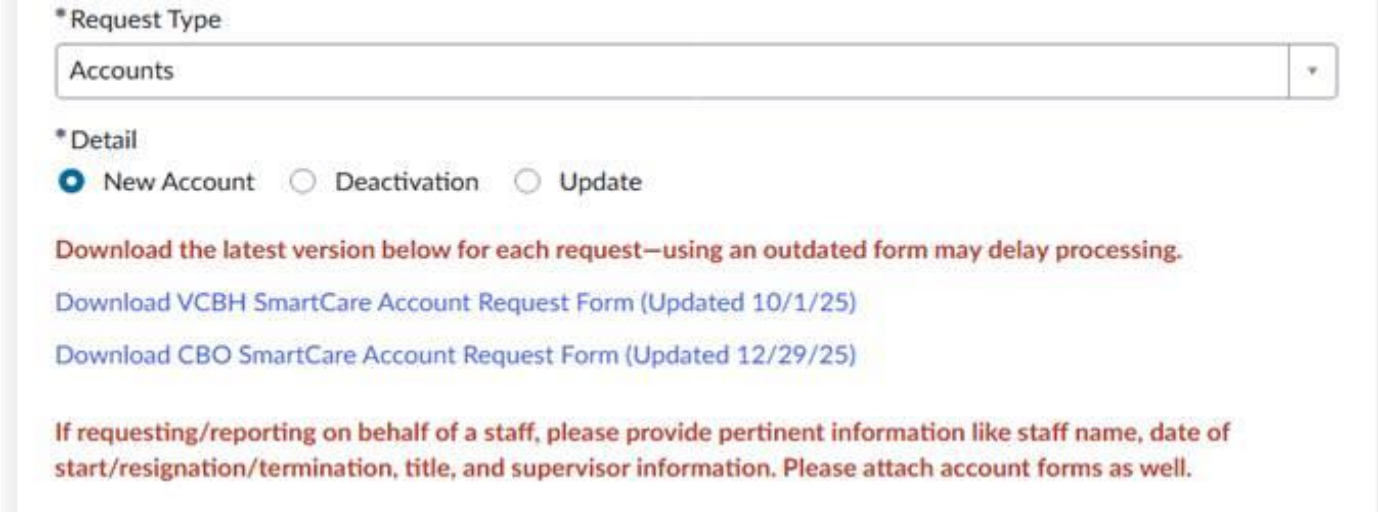
All SmartCare Users (Primary EHR or Billing Purposes Only):

- Ensure you or your manager has access to the SmartCare ServiceNow Ticket system
    - If **you are not a manager**, please provide your manager with the necessary information and they will request access to the SmartCare (EHR) system for you via the ServiceNow Ticket System.
    - If you do not have access to this system and **you are a manager**, to request access please email the following information to your Manager Liaison (VCBH Representative).

        Last Name:
        First Name:
        Email:
        Organization:

Individual/Practitioner Level

If utilizing SmartCare as your EHR system, Providers will need to request accounts for all Practitioners/service providers who will render services using the EHR system.



- If you would like to view Step by Step instructions, see ***"CBO-How to Submit a New Account Ticket for SmartCare in ServiceNow"*** via Forms & Documents section of the VCBH Provider Resources website: https://hca.venturacounty.gov/behavioral-health/provider-resources/

How to request a new SmartCare account

During Onboarding: *CBO representative submits the Smart Care Account Request via a ServiceNow ticket.*

- For external SmartCare users please use: https://vchca.service-now.com/sc
- Login to the site
- Click on: "SmartCare Request"

BEST PRACTICE — VCBH recommends always using the newest SmartCare Account Request form within the ServiceNow system. Do not download and save the form, as saved versions may be outdated.

  - Documents to provide with your Account Request Form include:
    - NPPES PDF Print-out – to confirm NPI number, Taxonomy Code, and Mailing/Practice Address
    - Proof of Licensure, Registration Status, Certification – confirms Credentials and needs to match NPPES information
- When setting up accounts for Psychologist Clinical Trainee, Master Students and Community Health Workers, Supervisor information must be provided which includes
  - Supervisors Name
  - Supervisors NPI Number
  - Start Date of the Supervision Relationship

2.6 Credentialing and Re-Credentialing

Individual/Practitioner Level

Credentialing verifies the qualifications, training and experience of licensed and unlicensed mental health practitioners to ensure safe, effective care. It also approves practitioners to bill insurance, maintaining quality standards and protecting clients.

National Plan & Provider Enumeration System (NPPES) - National Provider Identifier (NPI) Registry

NPPES (hhs.gov) – find information and instructions on the site as well as the answers to frequently asked questions

- A NPI number is a permanent identifier that stays with you throughout your health care career, similar to a work-related Social Security number.
- Update your NPPES information when your Primary Practice Location changes or you obtain a new license or certification (ie. Taxonomy Code update)

  NPI Application

  NPPES FAQs
  - If you would like to view Step by Step instructions see the document titled **"CBO_How to update NPI Taxonomy Code, Practice Address & Contact Info."** via the following link Provider Resources - Ventura County Behavioral Health

Taxonomy Code

Taxonomy (nucc.org) – find information about Health Care Provider Taxonomy Codes and determine the most appropriate Taxonomy Code for your education and area of specialization.

> **BEST PRACTICE — VCBH recommends using the "CBO Taxonomy Code List 12.23.25" document via the following link** Provider Resources - Ventura County Behavioral Health **for guidance regarding appropriate Taxonomy Code usage per education, training and experience.**

Practitioner Responsibilities - Enrollment

- *Individual Practitioners for Mental Health:* PAVE - Provider Application and Validation for Enrollment
    - **"AD78 PAVE Enrollment Instructions"** document can be located via the VCBH Policy Library.

Routine Maintenance

Maintain accurate and up-to-date information on NPPES - NPPES (hhs.gov)

- If you work at multiple locations, you can add various practice addresses to NPPES
- Update Taxonomy Code upon obtaining additional education, certifications and/or licensure

Maintain active licensure/certification/registration related to your position

- The California Department of Consumer Affairs (DCA) oversees over 280 license types through its 36 boards, bureaus, commissions, and other entities. The licenses cover a vast range of professions from healthcare (MDs, NPs, RNs, LCSWs, LMFTs) to skilled trades, cosmetology and private security.
    - You can search the DCA by name to ensure a license/registration is currently active without restrictions - Search - DCA
- Peer Support Specialist Certification Registry - Welcome - CalMHSA Peer Certification Portal
- California Association of DUI Treatment Programs (CADTP)
    - Link to: Verify Credentials • CADTP Counselors
- California Association for Alcohol and Drug Educators (CAADE)
    - Link to: Verify – Addiction Counselor Certification Board of California
- California Consortium of Addiction Programs and Professionals (CCAPP)
    - Link to: Verify a Credential :: CCAPP Credentialing
    - Certified Community Health Worker (CCHW) | CCAPP Credentialing

Notification of Renewal of Registration/License/Certification

Update SmartCare system:

- Ensure you or your manager has access to the SmartCare ServiceNow Ticket system
    - **If you are not a manager**, please provide your manager with the necessary information and they will request access to the SmartCare (EHR) system for you via the ServiceNow Ticket System.

- Update license/registration in SmartCare by completing the following steps: SmartCare ServiceNow Request Cheat Sheet v1.0 1.pdf
  - For external SmartCare users please use: https://vchca.service-now.com/sc
  - Login to the site
  - Click on: "SmartCare Request"
  - Select "Update License Information in SC" as the Request Type
  - Fill out required fields and attach a copy of your renewed license/registration
  - Click on the "Submit" button
  - Note: **You may not be able to access documents or have the ability to enter notes in SmartCare if your license information is not current in the SmartCare system.**

Entity/Provider Level

Entity-level credentialing information includes legal entity identification, ownership disclosures, certification/licensure status, service locations, organizational NPI, tax identification information, and Medi-Cal enrollment data.

Credentialing/Re-credentialing – Requirements for Providers

- **Credentialing/Re-credentialing Attestations will be required to be completed at least every 3 years**. Upon start of a contract and every third year from when the credentialing process was completed, the CBO Provider must ensure that required CBO staff complete the required attestation form: Individual. Group, Organization Provider Credentialing and Re-Credentialing and Attestation form to be Re-Credentialed (can be located within the VCBH Policy Library).
  - In accordance with regulatory requirements, VCBH must maintain signed forms on file. Updated forms are required every three years and **must be submitted to VCBH** during the audit period.
  - Required verifications include both primary and secondary sources.
  - Re-credentialing may include a review of other sources of information, such as quality improvement activities, plan member grievances, quality of work and medical record reviews.
  - Any deviations or concerns are identified for further evaluation prior to contract execution or renewal and prior to the processing of provider claims.
  - Audit tool document titled "**Ventura County Behavioral Health Medi-Cal and DMC-ODS Contractor Credentialing Audit Form**" can be found via Provider Resources - Ventura County Behavioral Health

Non-licensed Practitioner "Credentialing"

Alcohol and Other Drug (AOD) Counselor Educational Requirements AB 2473 BHIN July 31 2025 (003)

New AOD counselors must complete 80 hours of core training within 6 months of registering, plus 50 hours of education every year. This training includes topics like ethics, documentation, MAT, and co-occurring disorders.

- If registering after July 1, 2025: Be prepared to complete the 80-hour core training within your first 6 months.
- **Counselors registered before July 1, 2025, or with a related master's degree are exempt.**

Community Health Worker

Contracted providers may utilize the Community Health Worker taxonomy code and discipline, provided all DHCS requirements are met. Please review the following DHCS information and guidance Community Health Workers.

Summary of basic requirements

- CHWs must have "lived experience" relevant to the community/population they serve - that connection is a core requirement.
- To bill CHW services under Medi-Cal, a CHW must either: (a) hold a certificate of completion for a training program covering required core competencies and including field experience, or (b) meet the "work-experience pathway."
    - If using the work-experience pathway, an uncertified CHW can deliver services temporarily — but they must earn an acceptable certificate within 18 months of first providing/billing CHW services.
- CHWs must complete at least 6 hours of additional relevant training annually. The supervising provider must document this and make records available for audit or upon request from DHCS.
- CHWs must be supervised by an enrolled Medi-Cal provider (e.g. a licensed provider, clinic, hospital, community-based organization, local health jurisdiction, or similar).
- Credentialing process to become a Certified CHW - Certified Community Health Worker (CCHW) | CCAPP Credentialing

Peer Support Specialist

A Peer Support Specialist is a trained professional who uses their own lived experience with mental health or substance use recovery to support, guide and encourage others on their recovery journey.

Summary of basic requirements

- **80 hours of state-approved training** (CalMHSA-approved)
- Must cover core peer support skills (recovery principles, ethics, boundaries, communication, trauma-informed care, etc.)
- **Eligibility:** 18+, high school diploma/GED, lived experience with mental health and/or substance use recovery (self or family)
- Certification exam required after training to become a Medi-Cal Certified Peer Support Specialist
- Ongoing education: 20 hours every 2 years to keep certification
    - DCHS information: Peer Support Services
    - CalMHSA information: Peer Certification - California Mental Health Services Authority California Mental Health Services Authority

90 Day Rule

The 90-day rule allows recent master's degree graduates who have applied for their associate registration number with the BBS to work and gain hours toward licensure while waiting for their associate number. However, they must adhere to BBS guidelines (see number 1 below for direct link to the regulations).
Instructions and Guidelines for Contracted Providers utilizing "90-day rule"

1. Please refer to Don't Lose Your Hours: Know the 90-Day Rule (updated 9/2025)
2. Finger Printing must be done by the Contracted Provider (Employer) and be **in addition** to the Finger Printing submitted to the state for an Associate Number and prior to beginning to bill as an "associate".
3. Contracted Providers (Employers) and employees are responsible for ensuring these rules and regulations are upheld.
4. Contracted Provider Director or Designee will sign and maintain a copy of the "Contracted Provider 90-day Rule Verification" form in the employee's file.
5. Contracted Provider will email the completed form to: BHCredentialing@venturacounty.gov.
    a. "**Fillable Attestation for Contracted Providers"** - 90-day Rule form can be found via Policy library, policy Provider Enrollment and Credentialing, Supporting Forms

[Corrective Action Plans (CAPs) may be issued to Providers for not complying with Credentialing and Re-credentialing Requirements]

2.7 Practitioner Termination (Offboarding) and Staffing Changes – Significant and Routine

Significant Staffing Changes — Required Notification to VCBH
Contractors must notify VCBH **in writing within five (5) business days** of any **significant** staffing change that may affect service delivery. Significant staffing changes include, without limitation:

- Departure or loss of any key clinical staff member (e.g., Clinical Director, Program Manager, Lead Clinician, or other staff whose role is specifically identified in Exhibit A of the Agreement).
- Any reduction in staffing levels that brings the Contractor below the minimum staffing levels specified in Exhibit A or required by applicable DHCS regulations.
- Departure of any licensed clinician, psychiatrist, or prescribing practitioner that reduces clinical capacity or creates a gap in required service coverage.
- Any event that may prevent the Contractor from meeting access and timeliness standards during the staffing transition period.

Written notification must be sent to the Contractor's assigned VCBH Operations Manager and to Contracts.VCBH@venturacounty.gov . The notification must describe: (a) the nature of the staffing change; (b) the expected impact on service delivery; and (c) the Contractor's plan to maintain continuity of services to Members during the transition.

This contractual notification requirement is separate from, and in addition to, the SmartCare ServiceNow access deactivation process and the technology separation form described below. Both the VCBH contractual notice and the operational IT offboarding steps are required for all departing staff. (PSA §2.9)

Routine Staffing Changes – Required Notification to VCBH
Contracted Providers must notify VCBH when an employee is no longer employed in their agency, is on a LOA, or has a change in their job duties that does not necessitate having access rights. This notification should be completed as soon as reasonably possible. Contracts.VCBH@venturacounty.gov

All staffing changes must also be kept current in the monthly 274 Network Adequacy Provider Report through the process facilitated by the Quality Improvement team.

Routine and Significant Changes:

- The CBO representative submits a ServiceNow ticket for any SmartCare update.
- *Required Service Now updates/changes*:
    - Classification – Case Manager to Clinician
    - Worksite – moving to a new location
    - Clinical Supervisor – change in supervisory relationship
    - License and/or Taxonomy – registered associate to licensed clinician, completion of degree or certificate or related to years of experience

Offboarding:

- Please follow the 2 steps outlined below.
    1. The CBO representative submits a SmartCare ServiceNow ticket as shown below and selects the appropriate reason for account Deactivation as well as any other pertinent information.

*Request Type

Accounts

*Detail

New Account Deactivation Update

*Reason for Deactivation

Resigned
Retired
Terminated
Other

If requesting/reporting on behalf of a staff, please provide pertinent information like staff name, date of start/resignation/termination, title, and supervisor information. Please attach account forms as well.

*Description

2. The CBO representative ***Technology Separation MS Form*** to BH Credentialing
    a. Form can be accessed here: CBO Contracted Staff Separation Form

SmartCare ServiceNow Tickets

- Service now tickets for external SmartCare users (those without a venturacounty.gov email address), please use:
    - https://vchca.service-now.com/sc
- Access to submit ServiceNow ticket will be granted to 1-2 reps per agency.
- If you do not have access to this system and you are a manager, to request access, please email the following information to your Manager Liaison (VCBH Representative)
    - Last Name:
    - First Name:
    - Email:

- Organization:
- "**SmartCare ServiceNow Request Cheat Sheet**" can be found via Provider Resources - Ventura County Behavioral Health

2.8 Subcontracting

Subcontractor Approval

Purpose

Contractors are required to obtain prior written approval from VCBH before subcontracting any portion of services under their Agreement. This section of the Provider Guide establishes the procedure for requesting and obtaining that approval, describes the standards a proposed Subcontractor must meet, and explains VCBH's review and decision process.

This policy applies to all Contractors executing a Provider Services Agreement with VCBH, regardless of contract type, funding source, or service category.

Definitions

Contractor	The legal entity that has executed an agreement with VCBH and is the primary party responsible for performance under that Agreement.
Subcontractor	Any individual, group, or organization with whom Contractor enters into an agreement to perform any portion of the services required under the Contractor's Agreement with VCBH.
Subcontracting	Any arrangement by which Contractor delegates, contracts out, or otherwise transfers responsibility for any part of the contracted services to a third party.
VCBH Contracts Department	The VCBH administrative unit responsible for receiving, reviewing, and processing subcontractor approval requests.

When Approval Is Required

Prior written approval is required before a Contractor may engage any Subcontractor to perform any portion of the services covered by the Agreement. This requirement is audited annually and applies to:

- All new subcontracting arrangements, regardless of dollar value or scope.
- Renewals or material amendments of existing subcontracts where the Subcontractor, scope of services, or contract terms have changed.
- Arrangements where a third party will deliver, bill for, or otherwise fulfill any portion of the Contractor's contracted obligations.

Approval is not transferable. Each proposed Subcontractor must be individually approved by VCBH. Approval of one subcontract does not constitute approval of subsequent or different subcontracts with the same entity. Additionally, sub-contractors and independent contractors are legally the same under the PSA.

NOTE	Engaging a Subcontractor prior to receiving written VCBH approval is a material breach of the Agreement and may result in immediate termination, withholding of payments, and/or corrective action. VCBH approval may be granted or withheld at VCBH's sole and absolute discretion.

Subcontractor Eligibility Standards

To be approved, a proposed Subcontractor must demonstrate compliance with all standards applicable to the Contractor, including but not limited to:

- Valid licensure, certification, or registration as required by California law and DHCS for the services to be performed.
- Registration with the California Secretary of State to do business in California and good standing with the California Franchise Tax Board.
- Current enrollment with DHCS through the PAVE system (or other DHCS-designated enrollment process) if providing Medi-Cal covered services.
- Non-inclusion on the OIG List of Excluded Individuals/Entities (LEIE), the SAM.gov exclusion database, and the DHCS Suspended and Ineligible (S&I) Provider List.
- Insurance coverage at the levels required under the Contractor's Agreement.
- Willingness and capacity to comply with any DHCS flow-down requirements identified in the Agreement.

For a full list of sub-contractor requirements contact PNC.Compliance@venturacounty.gov
VCBH reserves the right to conduct credentialing, background review, or any other verification it deems necessary before approving a Subcontractor.

How to Submit a Request

To request approval of a Subcontractor, the Contractor must complete the VCBH Subcontractor Approval Form (see Appendix D.9) and submit the completed form, together with all required supporting materials, to the VCBH Contracts Department.

Required supporting materials include:

- A copy of the proposed Subcontractor's current license(s) or certification(s).
- Evidence of DHCS enrollment (PAVE confirmation or equivalent), if applicable.
- Evidence of exclusion screening clearance (OIG/LEIE, SAM.gov, DHCS S&I).
- A specimen copy of the proposed subcontract agreement, including all applicable exhibits.

- A description of the services to be subcontracted, proposed term, and compensation arrangement.

Incomplete submissions will be returned without review. The review period does not begin until a complete submission is received.

Submission and Contact Information

SUBMIT TO:	VCBH Contracts Department | Email: Contracts.vcbh@venturacounty.gov

VCBH Review Process and Timeline

Upon receipt of a complete submission, VCBH will conduct a review of the proposed Subcontractor and subcontract arrangement. VCBH's review will include, at minimum:

- Verification of licensure and DHCS enrollment status.
- Exclusion database screening.
- Review of the proposed subcontract for inclusion of required flow-down provisions.
- Assessment of the Subcontractor's capacity and qualifications to perform the services described.

VCBH will issue a written decision — Approved, Denied, or Pending (with conditions) — within thirty (30) calendar days of receipt of a complete submission. If DHCS review is required for the proposed subcontract, the timeline will be extended and VCBH will notify the Contractor accordingly.

A decision of Approved is not effective until the Contractor receives a signed written notice from an authorized VCBH representative. Verbal or informal communications do not constitute approval.

Authority to Approve

The VCBH Director or designee is the authorized approving authority for all Subcontractor Approval requests. The VCBH Contracts Department manages the intake, review coordination, and issuance of the written decision on behalf of the authorized approving authority.

Where required by the DHCS Integrated Agreement or applicable regulation, DHCS approval may also be necessary. VCBH will coordinate DHCS review as required and will notify the Contractor of any additional requirements or timelines.

Contractor Obligations Following Approval

Approval of a Subcontractor does not relieve the Contractor of any obligations under the Agreement. Following approval, the Contractor must:

1. Execute a written subcontract that includes, if applicable, all DHCS flow-down requirements set forth in the Agreement and all other applicable Agreement provisions.

2. Provide VCBH contracts.vcbh@venturacounty.gov with a specimen copy of the executed subcontract cover and signature pages within thirty (30) calendar days of execution, unless previously provided.
3. Monitor the Subcontractor's performance and compliance with all Agreement and DHCS requirements on an ongoing basis. This is reviewed annually during the audit period.
4. Require the Subcontractor to implement a corrective action plan if deficiencies are identified.
5. Notify VCBH in writing contracts.vcbh@venturacounty.gov within five (5) business days if the Subcontractor is discovered to be excluded, suspended, or debarred from any federal or state program.
6. Terminate the subcontract if the Subcontractor fails to meet applicable requirements and VCBH so directs.

The Contractor remains fully responsible for the quality, completion, and payment of all services performed by its Subcontractors, as if the Contractor had performed those services directly.

Changes to Approved Subcontracts

Any material change to an approved subcontract — including a change in scope of services, term, Subcontractor personnel, or compensation — must be submitted to VCBH contracts.vcbh@venturacounty.gov for review prior to implementation. VCBH will determine whether the change constitutes a new approval requirement. Minor administrative amendments that do not affect the scope, cost, or compliance obligations of the subcontract do not require re-approval but must be documented and reported to VCBH upon request.

► Form: See Appendix D.9 — VCBH Subcontractor Approval Form

2.9 Assignment

Assignment Approval

Purpose

Contractors are prohibited from assigning the VCBH Agreement, or any portion thereof, to a third party without the prior written consent of the County of Ventura (County). This section of the Provider Guide establishes the procedure for requesting assignment approval, describes the County's review process and decision-making authority, and explains the consequences of an unauthorized assignment.

This requirement applies to all Contractors regardless of contract type, program, or funding source because assignment directly affects the County's contractual relationship and service delivery obligations, all assignment requests require deliberate and formal review before any transfer occurs.

Definitions

Assignment	Any transfer, delegation, or conveyance — in whole or in part — of a Contractor's rights, duties, or obligations under the

	Agreement to a third party, including by operation of law, merger, acquisition, change of control, or otherwise.
Assignee	The third party to whom the Contractor proposes to transfer its Agreement rights, duties, or obligations.
Partial Assignment	An assignment of only a defined portion of the Agreement (e.g., a specific program, service type, or geographic territory), with the Contractor retaining responsibility for the remainder.
County	The County of Ventura, acting through its authorized representative(s) at VCBH.
VCBH Contracts Department	The VCBH administrative unit responsible for receiving, coordinating review of, and issuing decisions on assignment approval requests.

Prohibition on Unauthorized Assignment

No assignment of the Agreement, or any portion thereof, is valid or effective without prior written consent of the County. Any attempted assignment without such prior written consent is null and void and will constitute cause for immediate termination of the Agreement at the County's sole and absolute discretion.

IMPORTANT	Common events that may constitute an assignment and require approval include: sale or transfer of the Contractor's business or assets, merger or acquisition, corporate reorganization, transfer of a controlling interest, or any other change that results in a new legal entity assuming responsibility for Agreement obligations. Contractors are encouraged to contact the VCBH Contracts Department contracts.vcbh@venturacounty.gov as early as possible if any of these events are anticipated.

The prohibition on assignment also applies to any delegation of the Agreement's primary obligations to a related or affiliated entity, unless that entity is itself a party to and signatory of the Agreement. Contractor may not circumvent the assignment requirement by structuring a transfer as a management agreement, operational services agreement, or similar arrangement.

When to Submit a Request

A Contractor must submit an assignment approval request to VCBH contracts.vcbh@venturacounty.gov as soon as they become aware that an assignment may be necessary or anticipated. In no event may any assignment or transfer of obligations occur before written County approval is received. Contractors are

encouraged to initiate the process at least sixty (60) calendar days in advance of any anticipated effective date to allow adequate time for County review, and in cases where DHCS review is also required, to allow additional time for state-level coordination.

How to Submit a Request

To request assignment approval, the Contractor must complete the VCBH Consent to Assignment Agreement (see Appendix D.10) and submit it, along with all required supporting materials, to the VCBH Contracts Department contracts.vcbh@venturacounty.gov.

Required supporting materials include:

- A description of the proposed assignment, including whether it is a full or partial assignment and the specific Agreement provisions to be assigned.
- Legal and organizational information for the proposed Assignee, including entity name, type, Tax ID/EIN, NPI (if applicable), and California licensure or certification.
- Evidence that the Assignee is in good standing with all applicable licensing boards and regulatory agencies.
- Evidence of Assignee's clearance on the OIG/LEIE, SAM.gov, and DHCS S&I exclusion databases.
- A description of the business transaction or event giving rise to the proposed assignment (e.g., asset purchase agreement, merger agreement, corporate reorganization summary).
- A description of the proposed effective date and any transition plan for continuity of services to Members.
- Evidence of the Assignee's capacity to fulfill all Agreement obligations, including financial statements or other documentation as requested by VCBH.

Incomplete submissions will be returned without review. The review period does not begin until a complete submission is received.

Submission and Contact Information

SUBMIT TO:	VCBH Contracts Department | Email: Contracts.vcbh@venturacounty.gov

County Review Process and Timeline

Upon receipt of a complete submission, VCBH will initiate a review of the proposed assignment in coordination with County Counsel and any other County departments deemed appropriate. The review will include, at minimum:

- Verification of the Assignee's legal standing, licensure, and DHCS enrollment status.
- Exclusion database screening for the Assignee and its key personnel.
- Assessment of the Assignee's capacity, qualifications, and financial stability.

- Review of the business transaction giving rise to the assignment to assess program continuity risks.
- Coordination with DHCS where required by the DHCS Integrated Agreement or applicable regulation.

The County will issue a written decision — Approved, Denied, or Pending (with conditions) — within forty-five (45) calendar days of receipt of a complete submission. If DHCS review or County Board of Supervisors action is required, the timeline will be extended, and the Contractor will be notified. The County reserves the right to request additional information during the review period, which may toll the review timeline.

County approval, when granted, may be conditioned upon specific requirements, including execution of a new or amended Provider Services Agreement naming the Assignee as Contractor.

Authority to Approve

Assignment approval requires the written consent of the County of Ventura. The VCBH Director or designee is the authorized approving authority for assignment requests, subject to any requirements for County Counsel review, Board of Supervisors action, or DHCS approval as applicable to the specific transaction.

The VCBH Contracts Department manages the intake, coordination, and issuance of the written decision. A decision is not effective until the Contractor receives a signed written notice from the authorized County representative. Verbal or informal communications do not constitute approval.

Effect of Approved Assignment

An approved assignment does not automatically relieve the original Contractor of its obligations under the Agreement unless and until the County expressly releases the Contractor in writing. If the County approves a full assignment and executes a new or amended Agreement with the Assignee, the original Contractor is released from prospective obligations only; any obligations arising prior to the effective date of assignment remain with the original Contractor.

The Assignee, upon approval and execution of any required documentation, becomes bound by all terms and conditions of the Agreement, including all DHCS flow-down requirements, compliance obligations, and reporting duties, as if it were the original Contractor.

Service Continuity During Transition

Throughout the review and transition period, the Contractor must ensure uninterrupted delivery of services to Members. The Contractor must notify VCBH immediately if any transition event threatens continuity of care or the ability to meet Agreement obligations. VCBH may impose specific transition requirements as a condition of approval, including notification to affected Members, coordination with VCBH clinical staff, and reporting milestones.

► Form: See Appendix D.10 — VCBH Consent to Assignment Agreement

Section 3 – Member Rights and Responsibilities

3.1 Member Rights

Everyone receiving services from VCBH has these rights:

1. The right to privacy as stated in State and Federal regulations.
2. The right to be treated with respect by staff, volunteers, board members, and others.
3. The right to be treated for the life-threatening, chronic disease of substance use disorder with honesty, respect, and dignity, including privacy in treatment and in care of personal needs.
4. The right to be informed of everything about recommended treatment. This includes the choice of no treatment, the risks of the treatment, and the expected results.
5. The right to treatment by qualified staff.
6. The right to receive evidence-based, individualized, outcome-driven treatment for as long as authorized.
7. The right to get treatment for co-occurring behavioral health conditions at the same time, if medically appropriate.
8. The right to receive an individualized, outcome-driven treatment plan.
9. The right to remain in treatment for as long as the treatment provider is authorized to treat the client.
10. The right to receive support, education, and treatment for their families and loved ones, if the treatment provider is authorized to provide these services.
11. The right to ethical care as required by law.
12. The right to be free from verbal, emotional, physical abuse, and inappropriate sexual behavior.
13. The right to know how to file a complaint or appeal a discharge.
14. The right to be free from discrimination based on ethnicity, religion, age, sex, color, sexual preference, or disability.
15. The right to access personal health records, except in a few limited circumstances as permitted by law.
16. The right to ask about financial aid and get help in finding this information.
17. The right to attend religious services or activities inside or outside the facility and to have visits from a spiritual advisor, if these do not interfere with the treatment, program or facility requirements.

Additional Federally Required Member Rights (42 CFR §438.100)

In addition to the rights listed above, Members have the following rights under federal Medi-Cal managed care requirements. Contracted providers must ensure Members can exercise all of these rights and must ensure their staff, subcontractors, and contracted providers take these rights into account when providing services:

- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 CFR §438.100(b)(2)(v))
- The right to be furnished Covered Services in accordance with applicable access, timeliness, and quality standards. (42 CFR §§438.206–438.210; 42 CFR §438.100(b)(3))
- The right to freely exercise any of the rights described in this Section without any adverse effect on how any provider, subcontractor, or contracted staff treats the Member. No retaliation is permitted against a Member for filing a grievance, requesting a State Hearing, exercising appeal rights, or exercising any other right enumerated in this Guide. (42 CFR §438.100(c))

Written Policies Requirement

Contractors must maintain written policies and procedures that: (a) describe the member rights enumerated in this Section; (b) are made available to all staff, subcontractors, and contracted providers; and (c) direct all staff and contractors to consider member rights in the delivery of services. VCBH reviews written member rights policies as part of the annual site audit process. (PSA §5.1; 42 CFR §438.100)

3.2 Member Responsibilities

Everyone receiving services from VCBH has these responsibilities:

1. Treat all providers and staff with courtesy and respect.
2. Be on time for visits or call the provider's office at least 24-48 hours before the visit to cancel or reschedule.
    a. Please reference the "**Missed Appointment Notice**"
3. Give correct and current information to providers and VCBH.
4. Work with the treatment team to develop and agree on goals, do their best to understand their behavioral health problems, and follow the treatment plans and instructions from the treatment team.
5. **Call 988 or the VCBH Crisis Line at 1-866-998-2243** for immediate behavioral health help. Call 911 for medical or safety emergencies.
6. Submit any grievances or appeals to VCBH by calling **1-888-567-2122**

3.3 Grievances

Client Resources - Ventura County Behavioral Health

1. The above link can be used to access Client Resources containing information related to Grievances, Appeals, and State Fair Hearings – all information related to these processes can **also be found in the Ventura County Behavioral Health Plan Member Handbook**
2. Grievances can be filed by a plan member, parent of a plan member or an authorized representative at any time and for any reason.
3. Grievances will be used as learning opportunities to better understand plan members' concerns and identify issues within the VCBH Plan Network.

4. When a grievance is reported, the Grievance Team will collaborate with the VCBH Manager Liaison assigned to the Contracted Provider to facilitate resolution.
5. Grievance forms and self-addressed envelopes must be visibly displayed in the agency lobbies and available to members.
6. To file a Grievance by phone, plan members may call: **VCBH Grievance and Appeals Team at 1-888-567-2122**
7. For the newest BHIN related to Grievances, Appeals and NOABDs please reference: BHIN-25-015-Parity-Requirements-for-Drug-Medi-Cal-DMC-State-Plan-Counties.pdf
8. For more information regarding NOABDs and Appeals please see section 8.

Grievance Forwarding Requirement — All Member Grievances

Contractors must forward all Member grievances to VCBH within twenty-four (24) hours of receipt, or by the end of the next business day, whichever is sooner. This requirement applies to all grievances — written, verbal, or electronically received — regardless of whether the Contractor intends to handle the matter internally.

All grievances must be reported within twenty-four (24) hours through the electronic submission of the VCBH CBO Grievance Reporting form.

Discrimination grievances must also comply with the additional reporting requirements below.

REQUIRED	24-HOUR RULE: ALL Member grievances — not just discrimination grievances — must be forwarded to VCBH within 24 hours of receipt (or end of next business day). (PSA §5.2; 42 CFR §438.100)

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Plan Members can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically: please refer to the website for more detailed information: CRD | Civil Rights Department

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If a Plan Member believes they have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically: please refer to the website for more information: U.S. Department of Health & Human Services - Office for Civil Rights

As stated in your Provider contract, please make sure to report any ***discrimination grievance immediately to VCBH Quality Care Department at vcbhgrievance@ventura.org. Please refer to BHIN 25-

019 Transgender, Gender Diverse, or Intersex Cultural Competency Training Program Requirements for more detailed information and requirements.***

3.4 Cultural Competence and Language Access

Cultural Competence

Contracted providers are required to incorporate both cultural competency and cultural humility into their practice. The U.S. Department of Health and Human Services Office of Minority Health has outlined several concepts on how to do this:

Every Contracted Provider is required to complete an annual Cultural Competency training and to demonstrate compliance with the VCBH state approved Cultural Competency Plan (CCP) and Culturally and Linguistically Appropriate Services (CLAS) established by the federal Health and Human Servies (HHS) Department - https://thinkculturalhealth.hhs.gov/clas/standards

National CLAS Standards – Implementation Requirements

All contracted providers must implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards as required by DHCS and the Office of Minority Health. The CLAS Standards are an evidence-based framework for improving health care quality and equity. Section 12.4 of this Guide addresses cultural competency and humility as clinical practice; this section governs the formal CLAS implementation obligations that flow from the provider's contract with VCBH.

Principal Standard (Standard 1)

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 (Standards 2–4)

Providers must: (a) advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources; (b) recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area; and (c) educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. Annual cultural competency training, as noted in Section 12.4, satisfies the Standard 4 training requirement.

Communication and Language Assistance (Standards 5–8)

Providers must: (a) 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; (b) inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing; (c) ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters is prohibited in clinical settings; and (d) provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. Ventura County threshold languages are identified in the VCBH Provider Portal and are updated annually.

Engagement, Continuous Improvement and Accountability (Standards 9–15)

Providers must: (a) establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations; (b) conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities; (c) collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes; (d) develop and implement a strategy to communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public; and (e) establish culturally and linguistically appropriate conflict and grievance resolution processes to prevent and address cross-cultural conflicts or complaints. VCBH will review CLAS implementation as part of the annual site audit process (Section 12.5).

Language Accessibility Requirements for Contracted Providers

To comply with DHCS language access standards, all contracted providers must:

- **Provide free oral interpretation** in any language for Limited English Proficient (LEP) members at all key contact points, using qualified interpreters who are accurate, impartial, and uphold confidentiality.
- **Translate vital documents** (e.g., consent forms, rights notices, denial letters, treatment plans) into the member's primary DHCS-designated language.
    - These services must be available **at no cost to the member** and provided in a timely manner.

Language Access and Nondiscrimination Summary

- Providers must:
    - Notify members (verbally or in writing) about free language assistance and post DHCS-approved Notices of Availability and Nondiscrimination in offices, clinics, on websites and in any mailing to clients.
        - These Documents can be found at the bottom of the webpage: Client Resources - Ventura County Behavioral Health
    - Follow Section 1557 of the Affordable Care Act and all nondiscrimination laws.
    - Ensure language services are free, accurate, culturally appropriate, and timely to prevent care delays.
    - Make key website content, grievance forms, as well as other necessary forms accessible in DHCS threshold languages or provide translation help.
    - Cooperate with VCBH monitoring and reporting and submit proof of compliance as required; noncompliance may lead to corrective action.

3.5 Plan Member Safety

Safety and risk management involves identifying, assessing, and prioritizing risks followed by coordinated efforts to minimize, monitor, and control the probability or impact of unfortunate events. In the healthcare system this means protecting patients, staff, and organizational resources. Each provider shall maintain a culture of safety and shall have an emergency preparedness plan which will include

identified material and personnel to support these efforts. Contact your manager or direct supervisor to review your program's safety and risk management protocols.

- Within your Contract, Annual Audits as well as Medi-Cal Site Certification (if applicable) and Physical Plant Standards are addressed as well.
- Please also see Home | Occupational Safety and Health Administration for more general information.

Adverse Incident / Unusual Occurrence/ Member Confidentiality Breach Reports
Note: Provider Services Agreements refer to this reporting obligation as "Critical Incident Reporting." This section governs that requirement. VCBH uses DHCS terminology ("Unusual or Sentinel Incidents") and the DHCS Form 5079 or LIC624 process as described below.

Contracted Organizational Providers must use the Department of Health Care Services form "Unusual Incident/Injury/Death Report" or an equivalent approved form for reporting to VCBH Compliance **via email immediately or within 24 hours of discovery.**

- **Oral report:** An oral report must be made to the DHCS within one working day.
- **Written report:** A written report must be submitted within seven calendar days.
- **Forms:** The report is submitted on DHCS Form 5079 - UNUSUAL INCIDENT/INJURY/DEATH REPORT. Licensed residential facilities use LIC624 https://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624.PDF
- Contracted providers are required to self-report or report any actual adverse incident or unusual occurrence to all of the following: immediate supervisor, VCBH Operations Manager Liaison, VCBH Compliance vcbh.compliance@ventura.org, and Provider Network Compliance (PNC) Team PNM.Compliance@venturacounty.gov.

- Any and all unusual, adverse or sentinel events that impact the health, safety, security or well-being of a member shall be reported to VCBH. Matters involving potential breach of members' protected health information (PHI) including violations of the Health Insurance Portability and Accountability Act (HIPAA) may require further remediation on the part of the Provider. Each incident shall be reported within 24 hours to VCBH. VCBH will conduct an investigation and make a determination on a case-by-case basis.
- Reporting obligations to VCBH do not replace or satisfy independent reporting obligations to DHCS, Community Care Licensing, law enforcement, Adult Protective Services, Child Protective Services, OCR, or any other regulatory or oversight agency.
- Contractors remain independently responsible for complying with all mandatory reporting requirements and timelines imposed by federal, state, licensing, accreditation, or professional practice standards.
- Upon request, Contractors shall provide VCBH with copies of reports submitted to regulatory or licensing agencies related to reportable incidents.
- Notification to VCBH shall occur regardless of whether the Contractor has completed its internal investigation or determined whether the event constitutes a reportable breach under HIPAA.

Section 4 – Eligibility and Enrollment

4.1 Eligibility Verification

Providers must verify Medi-Cal eligibility of members prior to delivering services and monthly thereafter using the Medi-Cal eligibility systems. Please see the link to the provider portal DHCS Provider Portal

4.2 Member Identification

Members will present a Medi-Cal Benefits Identification Card (BIC).

Section 5 – Covered Services

5.1 Medi-Cal Specialty Mental Health Services (SMHS)

SMHS Services include but are not limited to:

- Assessment
- Individual, family, and group therapy
- Medication support
    - **Please note that, as a clinical practice, MOST Nurse Practitioners (NPs) and Psychiatrists who work with VCBH will not prescribe Benzodiazepines to Plan Members and will attempt to titrate Plan Members off these medications. This procedure is typically done because research has shown that long term use of these medications has a high potential for addiction and dependence as well as cognitive impairments.**
- Crisis intervention
- Intensive care coordination
- As well as other medically necessary Medi-Cal covered services

Medical Necessity:

Pursuant to Welfare and Institutions Code section 14184.402 for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions.

Criteria for Plan Members to Access the SMHS Delivery System: Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

5.2 Substance Use Disorder Services

Criteria for Plan Members to Access the DMC-ODS Delivery System: BHIN 24-001 DMC ODS Requirements for the Period of 2022-26

The following services are outlined in the link above (BHIN 24-001):

- Outpatient Treatment Services, including those for Co-Occurring Disorders
- Residential and Inpatient Services
- Medications for Addiction Treatment/Medication Assisted Treatment (MAT)
- Recovery Services
- Narcotic Treatment Program (NTP)
- Mobile Crisis Response*

All services listed above are covered by Medi-Cal and if determined to be necessary will be provided through the VCBH Health Plan.

5.3 Crisis Services

Mobile Crisis

- Mobile crisis services provide rapid, community-based response and stabilization for Medi-Cal members experiencing a behavioral health crisis. Teams use de-escalation and support to reduce harm and avoid emergency room (ER) visits, hospitalizations, or law enforcement involvement.
- Services include warm handoffs, referrals, and short-term follow-up to connect individuals with ongoing care. For children and youth, teams collaborate with parents or guardians in line with consent and privacy laws.
- These multidisciplinary teams respond anywhere in the community—such as homes, schools, or public spaces—and are available **24/7**.
    - Mobile Crisis Team: **866-998-2243**

Crisis Residential Treatment Services

Crisis Residential Treatment Services (CRTS) are short-term (up to 3 months) therapeutic programs in a non-institutional residential setting, providing an alternative to hospitalization for beneficiaries in acute psychiatric crisis without medical complications. Services are available 24/7, with structured day and evening programs, and may be offered on-site, via telehealth, or by phone.

Protocol: If a plan member calls your agency in crisis and you do not provide or cannot provide assistance related to the type of crisis the plan member is experiencing the agency receiving the call shall conduct a warm handoff to the Mobile Crisis Team via telephone **866-998-2243**.

Safety Planning:

BEST PRACTICE — Safety plans are personalized, proactive strategies designed to help members cope during times of crisis. VCBH recommends creating a safety plan at the onset of treatment in collaboration with the client, **reviewed frequently and updated as clinically indicated and at least every 6 months**.

SAFETY PLANS ARE AVAILABLE FOR USE IN SMARTCARE

BEST PRACTICE — VCBH recommends utilizing the template entitled "Safety Plan" when multiple Safety Plan options are available in SmartCare. For Safety Plans in languages other than English, please see M-TAC Safety Plan Tool.

5.4 Case Management and Care Coordination

Behavioral health providers shall communicate with members' primary care providers, with appropriate consent (if indicated), to ensure integrated care.

Targeted Case Management

Targeted Case Management provides specialized case management services to gain access to needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services.

- **Strengths-Based Approach**: Focusing on a member's strengths can foster empowerment, independence and sustainability.
- **Comprehensive Resource Coordination**: Link members to various resource options, ensuring they understand how to access and utilize these resources.
- **Education:** Provide education on resources, possible treatment options, and mental health.
- **Interdisciplinary Collaboration**: With plan member's consent, keep regular communication with other professionals (e.g. therapists, psychiatrists, nurses). Encourage member to follow-up with these professionals. Make sure to inform the plan member that regular communication and collaboration are necessary to ensure consistency of care.
- **Regular Follow- Up**: Schedule consistent follow-up to monitor members' wellness, progress, and to ensure they have been thoroughly linked to resources.
- **Utilize Z-codes:** Adding a plan member's z-codes allows providers to be aware of environmental factors that may affect a plan member's care. You can refer to the APL 21-009 for a list of commonly used Z-codes.

Care Coordination

Plan care coordination ensures effective oversight across health systems by supporting:

- Comprehensive physical, mental health, and substance use screening
- Engagement in integrated care programs as needed
- Shared care planning among individuals, caregivers and providers
- Collaboration with managed care and clear case management roles
- Methods for settling disputes without cutting off necessary services
- Access to clinical and medication consultations
- Efficient provider communication and information sharing
- Navigation support and bidirectional referral tracking
- Timely transitions to appropriate levels of care

- Linkage to appropriate Medi-Cal benefits/services (e.g., Enhanced Care Management, Community Supports) through a member's Managed Care Plan

Questions regarding Care Coordination and Transitioning within services can be directed to: VCBHCareManagement@ventura.org

Please refer to DHCS website for: Screening and Transition of Care Tools for Medi-Cal Mental Health Services

For step-up services (e.g., SMHS/DMC-ODS covered services, psychiatric hospitalization, crisis residential treatment)
For step-down services (e.g., transitioning outpatient mental health services from a VCBH Provider to the Managed Care Plan)

- The "**Transition of Care Tool (TOC) Operational Guide August 2025**" provides an overview for the appropriate use and can be found via Provider Resources - Ventura County Behavioral Health

5.5 Excluded and Non-Covered Services

Excluded and non-covered services include any service that does not meet medical necessity or established criteria, as well as any service not specified in your contract or outside your contracted scope of services. For more information please see: Insurance & Eligibility - Ventura County Behavioral Health

5.6 Insurance and Billing Guide

Ventura County Behavioral Health (VCBH) Insurance Guide

This Guide provides a summary of accepted insurance types, descriptions, recommended actions, and applicable UMDAP information for Ventura County Behavioral Health clients.

Insurance Coverage	Description	Recommended Action	Uniform Method of Determining Ability to Pay (UMDAP)
Clients VCBH and Its Contractors Can Serve			
Medi-Cal (Full Scope) *Including Medi-Cal with Gold Coast Health Plan and Kaiser Foundation Health Plan (with County Code 56).*	Standard Active Medi-Cal coverage	• Proceed with Screening for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS).	No UMDAP required.

Medi-Cal (Share of Cost)	Members are responsible for their share-of-cost expenses.	• Proceed with Screening for SMHS and DMC-ODS.	Offer to complete UMDAP for members with a share of cost.
Out-of-County Medi-Cal	VCBH may provide **SMHS only** during a transfer period. **DMC-ODS** services remain the responsibility of the county of origin.	• Proceed with Screening for **SMHS** • Provide SMHS while assisting members with Medi-Cal transfer to the county of Ventura. • **DMC-ODS** services can only be provided *after* Medi-Cal is transferred to Ventura County.	Follow UMDAP guidance according to Medi-Cal coverage (Full-Scope vs Share of Cost).
Medicare Part B + Medi-Cal (Medi-Medi) Medi-Cal serves as the secondary payer and may cover services not paid by Medicare when eligibility and medical necessity criteria are met.	**Medicare** is Primary. **Medi-Cal** is Secondary.	• Proceed with Screening for SMHS and DMC-ODS. • Okay to provide non-Medicare covered services (i.e. case management, nursing support, peer support). • Note: This guidance does NOT apply to beneficiaries who have opted into a Medicare Advantage Plan (Part C). Beneficiaries enrolled with an Advantage Plan need to be redirected to an in-network provider.	Follow UMDAP guidance according to Medi-Cal coverage (Full-Scope vs Share of Cost).
Medi-Cal (Code A) + Commercial Insurance	**Medi-Cal "Code A"** allows Medi-Cal to be billed first.	• Proceed with Screening for SMHS and DMC-ODS. • Plan Member will need to access care through their commercial health plan if "Code A" coverage ends.	Follow UMDAP guidance according to Medi-Cal coverage (Full-Scope vs Share of Cost).
Medicare <u>Part A</u> Only	Part A covers Inpatient Hospitalization, Skilled Nursing, Hospice, and Home Health Care Services.	• Follow the guidance outlined for Uninsured (under Special Population)	N/A
Medicare Only (Part B) (Original/Regular Medicare) *Medi-Cal does not serve as a default backup with Medicare Only*	Medicare limits coverage to certain behavioral health services (e.g., therapy, psychiatry) delivered by LPHAs. Non-covered services (e.g., case management, nursing) require an ABN and are billed to the client only after denial. LPHAs = **Licensed** Practitioners of the Healing Arts (e.g.,	• Inform prospective Medicare-only clients that while therapy and medication services provided by licensed Medicare-enrolled clinicians are typically covered, VCBH also delivers services, such as case management or nursing that are not reimbursed by Medicare. When these non-covered services may be part of treatment, staff must present the Advanced Beneficiary Notice of Noncoverage (ABN) and explain that out-of-pocket costs could apply. This ensures clients understand their	N/A

	psychiatrists, LCSWs, LMFTs, licensed psychologists, NPs). ABN = Advanced Beneficiary Notice of Noncoverage, required to inform clients of possible out-of-pocket cost.	financial responsibility and can make an informed decision about care. • Refer individual to access list of in-network providers through Find Healthcare Providers: Compare Care Near You | Medicare if they elect to go elsewhere for their treatment. • If enrolling with VCBH, proceed with providing services that are covered by Medicare (therapy and medication services provided by licensed Medicare-enrolled clinicians/prescribers). • Complete ABN (most current CMS-R-131 form) for Medicare only clients who access care through VCBH.	
Medicare Advantage (Medicare Part C and/or Medicare Dual Special Needs Plan (DSNP)) Health plan offered by a commercial insurance company that provides all Medicare-covered services through providers contracted in their network Note: Gold Coast Health Plan now offers Advantage Plan known as Total Care Advantage.	Medicare recipients with Part A & B coverage can opt in to an Advantage Plan. Those who elect to receive their Medicare benefits through an Advantage Plan must access care through an in-network provider. Individuals enrolled in a Medicare Advantage Plan (Part C), including Dual Special Needs Plans (D-SNP), must access Medicare-covered services through their plan's contracted network providers. VCBH is not a contracted provider within these networks and cannot bill or receive reimbursement from these plans. Providers should refer clients to their plan for in-network services and should not proceed with services intended to be billed through these plans. If a provider elects to serve a client outside of network requirements, the provider assumes full responsibility for authorization, billing, and reimbursement.	• Follow Guidelines for Commercial Health Plans. • Do not initiate Screening. • Refer individual to their insurer for in-network service providers.	N/A

Insurance Coverage	Description	Recommended Action	Uniform Method of Determining

			Ability to Pay (UMDAP)
Special Population			
Uninsured	No active insurance	• Assist with Medi-Cal application. • If not Medi-Cal eligible, support linkage to alternate community-based provider. • Services may be provided based on medical necessity and availability of county or state funding. Services are prioritized for crisis response, stabilization, and essential behavioral health needs and are not guaranteed across the full continuum of care.	UMDAP required before screening.
Adoption Assistance Program (AAP)	Equivalent to Full-Scope Medi-Cal. If Commercial Insurance is primary, following the recommended actions for Private/Commercial Insurance.	• Must check to confirm Medi-Cal aid codes • Obtain Service Authorization Request (SAR) (SB 785) approval.	No UMDAP required.
Kin-GAP	Insurance coverage for children under the guardianship of a relative.	• Must check to confirm Medi-Cal aid codes • Obtain SAR (SB 785) approval.	No UMDAP required.
AB1051	Out-of-county foster/probation residential placements in Short-Term Residential Therapeutic Programs (STRTPs) (non-presumptive transfers as of 7/1/24)	• County of jurisdiction is responsible for payment • In most cases, requires a direct contract between the County of Jurisdiction and the STRTP • Single case agreement with County of jurisdiction is needed to provide DMC-ODS services	No UMDAP required.
Presumptive Transfer AB1299	Foster/probation youth temporarily placed outside their home county. PT allows access to SMHS only.	• Provide SMHS under presumptive transfer. • Bill county of jurisdiction for authorized SMHS. • DMC-ODS requires single case agreement with county of jurisdiction.	No UMDAP required.
AB109 (Realignment Population)	Individuals involved in the criminal justice system; VCBH has funding flexibility for this group if medical necessity is met.	• Collect insurance information if covered. • Proceed with Screening and Assessment for Substance Use Services (SUS). • For SMHS, refer to Telecare per current protocol.	Follow UMDAP guidance based on insurance coverage.

Insurance Coverage	Description	Recommended Action	Uniform Method of Determining

			Ability to Pay (UMDAP)
VCBH and Its Contractors Cannot Serve (Without Pre-Authorization & Contractual Agreement)			
Private/Commercial Insurance (ONLY)	VCBH is not in-network; clients must contact their insurer for referrals.	• Do NOT initiate Screening. • Refer individuals to their insurer for in-network service providers.	N/A

Private/Commercial (primary) + Medi-Cal (secondary)	Primary insurance is commercial. Follow primary insurance coverage guidance.	• Do NOT initiate Screening.
		• Refer individuals to their insurer for in-network service providers.
		• If the individual insists on being seen at VCBH, advise them to:
		  • Contact their insurance carrier directly.
		  • Request prior authorization and a single case agreement from their insurer.
		Staff must confirm written approval and signed agreement before services can begin.
			N/A

Reminder:

- VCBH will only reimburse services that meet Medi-Cal eligibility or other DHCS-authorized funding criteria. Claims submitted for services outside of these criteria will be denied.
- VCBH reserves the right to conduct routine audits of provider claims and eligibility. Any payments made in error for ineligible services will be subject to recoupment through offset or repayment.

Please Note: Crisis Services are exempt from referral and authorization requirements; however, commercial insurance must still be billed as primary following service delivery.

Section 6 – Access and Availability to Services and Related Data Collection Requirements

6.1 Access to Services

Access and Crisis Line

VCBH operates a 24/7 Access and Crisis Line for all individuals seeking mental health and substance use disorder services. The Access and Crisis Line serves as the primary entry point for county behavioral health services, supports referral and linkage to appropriate levels of care, and coordinates mobile crisis response services for individuals experiencing a behavioral health crisis.

Providers may share Access and Crisis Line information with members as a resource for behavioral health support, crisis intervention, and service navigation. Providers may also contact the Access and Crisis Line directly for care coordination, referral support, and assistance connecting members to

appropriate behavioral health services. Additional information can be found here: 988 Suicide & Crisis Lifeline - Ventura County Behavioral Health

Screening and Referral Processes
VCBH utilizes standardized screening and placement tools to support determinations of medical necessity, level of care, and referral needs for individuals seeking behavioral health services. The DHCS Screening Tool is used as an initial screening tool for mental health services, and the BQuIP (Brief Questionnaire for Initial Placement) is used for individuals requesting substance use disorder services. In addition, the Transition of Care Tool is used to support coordination and referral management between Specialty Mental Health Services and Non-Specialty Mental Health Services through Managed Care Plans.
MH Screening and Transition of Care Tools: Screening and Transition of Care Tools for Medi-Cal Mental Health Services | DHCS
BQuIP: Resources for Counties | DHCS

Providers may be required to utilize these tools in accordance with program requirements, referral workflows, and care coordination processes. Providers may also be required to submit documentation or data necessary to support Screening Tool, BQuIP, and Transition of Care reporting. When applicable, VCBH will provide appropriate training and resources to meet data collection and reporting requirements.

6.2 Appointment Timeliness Requirements

DHCS Timely Access Requirements establish standards and benchmarks for the timeliness of offered and rendered appointments for individuals requesting behavioral health services. These requirements are intended to ensure timely access to behavioral health care and services. Additional information regarding Timely Access Standards can be found in BHIN 26-015 - 2026 Behavioral Health Network Adequacy Certification Requirements.

VCBH monitors timely access performance through data collected in the SmartCare EHR system. VCBH also utilizes specialized monitoring tools and validation processes to identify data entry errors, monitor compliance, and support quality improvement efforts related to timely access performance.

If Timely Access requirements apply to a Provider's program or services, VCBH will provide training and technical assistance related to data collection, SmartCare data entry, error resolution processes, and performance monitoring. Providers are responsible for ensuring timely and accurate data collection and error correction.

Section 7 – Practice Guidelines

7.1 Guides, Manuals, and Information Notices

Manuals_And_Information_Notices - this link outlines guidance for delivering coordinated, trauma-informed, and medically necessary services for children, youth, and families within California's Children and Youth System of Care. They summarize requirements and best practices for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC), cross-system collaboration, workforce training and implementation of statewide policies that support effective, family-centered mental health services.

The **CalMHSA Clinical Documentation Guide for SMHS** (SMHS-Clinical-Documentation-Guide-4.25.2025.pdf) and **DMC-ODS** (SUD-Clinical-Documentation-Guide-4.25.2025.pdf) serve to streamline, standardize, and clarify documentation requirements, ensuring compliance with CalAIM and other state regulations.

7.2 SMHS Assessments and Diagnosis

> **BEST PRACTICE —** Comprehensive assessments including medical, behavioral, social and cultural history should be completed and ***reviewed*** **at least every 6 months** and ***updated*** **annually and as clinically** indicated.

- **CalAIM Assessment 7 Domains**
    1. Presenting Problem & Functioning: Reason for visit, current symptoms, impairment
    2. MH History: Past diagnoses, hospitalizations, treatment response
    3. Medical: Health conditions and meds impacting MH
    4. Substance Use: Current/past use and functional impact
    5. Psychosocial: Housing, supports, trauma, culture, environment
    6. Risk: SI/HI, safety concerns, abuse/neglect
    7. Strengths/Goals: Strengths, needs, preferences, treatment goals
- Use standardized screening tools when appropriate (e.g., PHQ-9 for depression, CANS for children, ASAM for substance use).
- Document medical necessity in accordance with Medi-Cal standards.

Please reference the **CalMHSA Clinical Documentation Guides for more detailed information**: SMHS-Clinical-Documentation-Guide-09.2025.pdf

7.3 Substance Use Disorder (SUD) Treatment Authorization Request (TAR) and American Society of Addiction Medicine (ASAM) Assessments

An ASAM assessment and a TAR are both required for residential substance-use treatment.

ASAM Assessment

- Uses the **American Society of Addiction Medicine (ASAM)** criteria to determine the appropriate level of care based on a person's medical, psychological, and social needs.
- Ensures that inpatient (residential or withdrawal-management) care is medically necessary, not more or less intensive than needed.
- Helps treatment providers and insurers document clinical justification for placement.

Treatment Authorization Request (TAR)

- It is submitted to VCBH Health Plan to request approval for the recommended inpatient services.
- Verifies that the ASAM-based treatment plan meets Medi-Cal requirements and that the services are authorized and reimbursable.
- Prevents delays or denials by confirming coverage and medical necessity before admission or continued stay.

ASAM assessment determines the right level of care and the TAR secures payer approval (VCBH Health Plan) for that care. [Please see UM section: 8.2 Authorization and Reauthorization for TAR Submission and Review Process]

Please reference CalMHSA Documentation Guide for more detailed information: SUD-Clinical-Documentation-Guide-4.25.2025.pdf

7.4 Treatment Planning

- Develop an individualized treatment plan with member and family input (as applicable) and be consistent with the diagnosis and assessment.
- Incorporate the member's strengths, goals and cultural background.
- Coordinate and collaborate with VCBH to ensure as a provider you understand and add to client treatment plans and goals for those clients served within your agency.

Care Plan Requirements

DHCS no longer requires providers to create separate care/treatment plans ahead of time for Medi-Cal SMHS or DMC and DMC-ODS 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.

However, there are some programs, services and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities. For SMHS, DMC, and DMC-ODS services, programs, or facilities for which care plan requirements remain in effect please see: BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf

With CalAIM, there are 3 different Care Plans that a plan member may have. Some members may have none of these care plans, while others may have all three. The 3 possible Care Plans are:

1. **Full Care Plan** (previously referred to as an ISSP)
    a. Required for Mental Health plan members who have the following services: FSP (Full-Service Partnership), TBS (Therapeutic Behavioral Services), ICC (Intensive Care Coordination), IHBS (Intensive Home-Based Services), or TFC (Therapeutic Foster Care), ECM (Enhanced Care Management), MHRCs (Mental Health Rehabilitation Centers), STRTP (Short Term Residential Treatment Program), Long Term Residential Treatment
2. **TCM** (Targeted Case Management) **Care Plan**
    a. Required for clients receiving services under the TCM procedure code

3. **PSS** (Peer Support Specialist) **Care Plan**
    a. Required for any client receiving any peer services

If using SmartCare: All 3 types of Care Plans will go into the "Care Plan" section at the bottom of the Progress Note. As this section may get crowded and confusing, it is imperative that staff writing the Care Plans LABEL them with:

- Type of Care Plan (Full, TCM, or PSS)
- The Name of the staff who is writing or revising the plan
- The Date that the Plan is written or revised

BEST PRACTICE — While the TCM Care Plan is only required to be updated at least annually (and when clinically appropriate), it does need to be REVIEWED at least every 6 months. The date of this review, when needed, can be placed in the labeling of the Care Plan.

Problem List

A problem list is an up-to-date record of a member's current and past conditions, symptoms, diagnoses, risk factors, Social Determinants of Health (SDOH), and service encounters. The Problem Listgives providers, care teams, and clients a clear overview of relevant health issues and must be accurate, current, and concise.

Key points:

- Every plan member must have a problem list in their EHR.
- Providers must add, update, or resolve items whenever a condition changes.
- Review and update the list at every session when appropriate.
- Mark inactive issues as "resolved" or "history of" as needed.
- Each progress note must link to a relevant problem from the list.

A well-maintained problem list supports clear documentation and quality care.

How to Update a Problem List in SmartCare

- By utilizing the "Client Problem List" function in SmartCare
- By utilizing the Problem List section in any Progress Note while you are writing it
- When writing your initial Assessment, you can utilize the Problem List section embedded within the document
- Resolve problems by adding an "End Date" to the problem
- Click the following link to learn about how to create/update a Problem List in SmartCare: How to Add a Problem to the Problem List - 2023 CalMHSA

Progress Notes

The contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among practitioners and providers. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

A complete progress note provides all the information below:

1. **What happened?** The type of service rendered, any problem list updates, and the associated billing service code
2. **When did it happen?** Date of service, duration of service
3. **Where did it happen?** Location of the [plan member] (not the provider!) during the service
4. **How did it happen and how will it proceed next?** Narrative explaining what behavioral health need/problem was addressed (e.g., symptom, condition, diagnosis, and/or risk factors), intervention(s) used, and what the next steps are
5. **Who provided the service?** Service Practitioner name (typed or legibly printed), signature and date of signature
    - Practitioners shall complete progress notes **within three (3) business days** of providing a service, apart from notes for crisis services, which shall be completed within one (1) calendar day.
    - Practitioners shall complete at minimum a daily progress note for > services that are billed daily (i.e., bundled services), such as > Crisis Residential Treatment, Adult Residential Treatment, > DMC/DMC-ODS Residential Treatment, and day treatment services > (including Therapeutic Foster Care, Day Treatment 18 Intensive, and Day Rehabilitation). If a bundled service is delivered on the > same day as a second service that is not included in the bundled > rate, there must also be a progress note to support the second, > unbundled service.
    - Weekly summaries are no longer required for Day Rehabilitation and > Day Treatment Intensive, nor for residential levels of care or > other bundled services.

Group Session Progress Notes

When facilitated by multiple practitioners of different disciplines, every practitioner must document their own progress notes, as applicable to their scope and the service they provided at the group session. Should more than one practitioner render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one practitioner.

Practitioners must document the following in their individual progress notes:

- the practitioner's specific involvement (service provided) during the group session
- amount of time spent providing the service during the session
- brief description of the members' response to the service

*The list of group participants must be maintained outside of any individual health record.

For SmartCare Users: When Facilitating a Group, Please Write Notes through the "Group Service Detail Screen"

- If facilitating a Group Service, you are REQUIRED to set up a group in SmartCare to document all group notes. Please DO NOT write progress notes with a Group Procedure Code (Ex: Group

Therapy, Psychosocial Rehabilitation Group, Behavioral Health Prevention Education Service-Group) for each member of the Group outside of the Group Service Detail Screen in SmartCare. **If you are unsure how to set up a group or document group services, please reference these instructions:**

How to Set Up a Group - 2023 CalMHSA

How to Write a Group Progress Note - 2023 CalMHSA

How to Add or Change a Staff Member in a Group - 2023 CalMHSA

Functional Assessment/Screening Tools

Child Providers:

[Child and Adolescent Needs and Strengths (CANS)]

If using SmartCare this information shall be entered under: "California CANS (Client)"

[Pediatric Symptom Checklist (PSC-35)]

If using SmartCare this information shall be entered under: "PSC-35 (California Pediatric Symptom Checklist) (Client)"

For more information on the tools above please refer to the following link:

https://www.dhcs.ca.gov/provgovpart/pos/Pages/Functional_Assessment_Tools.aspx

Please reference this link for more information on Screening and Transition of Care Tools BHIN 25-020 Adult and Youth STTs for Medi-Cal Mental Health Services

Full Service Partnership (FSP) Programs also have certain Outcome Measures that are required within their programs and must be documented in the EHR, the measures include but are not limited to, PAF, KET, and 3M. If you use SmartCare and these measures are available, please complete them there. Please note: As of June 30, 2026 DHCS is no longer requiring collection and submission of the PAF, KET, and 3M. Any data up to that point must still be reported.

7.5 Evidence-Based Interventions and Practices

Providers are expected to deliver care that aligns with nationally recognized and evidenced based practice. Some of the suggested EBPs for SMHS and DMC-ODS can include but are not limited to:

- Assertive Community Treatment (ACT) - SMHS
- Motivational Interviewing – SMHS & DMC-ODS
- Dialectical Behavior Therapy (DBT) - SMHS
- Cognitive Behavioral Therapy (CBT)– SMHS & DMC-ODS
- Psychoeducation - SMHS & DMC-ODS
- Relapse Prevention – DMC-ODS
- Trauma-Informed Treatment – SMHS & DMC-ODS
-

DHCS is expanding coverage to certain Evidence Based Practices through **BH-CONNECT**. Please utilize the following link for more information and to find your specific population as well as the EBPs that are recommended and incentivized through BH Connect, Evidence Based Practices.

Please reference BH-CONNECT EBP Practice Policy Guide: EBP Policy Guide_5.1.25

American Psychiatric Association (APA) Clinical Practice Guidelines provide evidence-based recommendations for the assessment and treatment of psychiatric disorders and are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format. Please reference these Guidelines via Psychiatry.org - Clinical Practice Guidelines

The DHCS Community Services Division's **SUD Perinatal Practice Guidelines** provide standards for delivering safe, evidence-based, and family-centered substance use disorder treatment to pregnant and parenting individuals. They outline best practices for integrated care, emphasizing maternal health, infant well-being, and coordinated support across medical, behavioral health, and social service systems. Perinatal-Practice-Guidelines-2024

For **Adolescent SUD Best Practices** click on the following link: Adolescent Best Practices Guide OCTOBER 2020

SAMHSA's Peer Recovery Support Services are non-clinical services provided by individuals with lived experience to help others achieve and maintain recovery from substance use and mental health disorders. These services use a person-centered approach to build hope and provide social support, which can include goal setting, developing recovery plans, and reducing relapse through mentorship and coaching. Peer Support Workers for those in Recovery | SAMHSA

Section 8 – Utilization Management

Ventura County Behavioral Health (VCBH) Quality Assurance monitors and educates staff on clinical documentation quality to ensure compliance with State and Federal standards. This function implements a standard method for utilization review, ensuring providers meet medical necessity and documentation requirements for Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) Services. The process is critical for identifying documentation deficiencies, compliance issues, significant gaps and potential fraud, waste, or abuse.

8.1 Medical Necessity

Medical Necessity

Medi-Cal Behavioral Health services must be medically necessary and clinically appropriate to address the member's presenting condition and individualized treatment needs. For Specialty Mental Health Services (SMHS), access criteria and medical necessity shall be determined in accordance with applicable state and federal law and DHCS guidance, including age-specific standards for adults and

members under age 21. For Drug Medi-Cal Organized Delivery System (DMC-ODS) services, services must be based on medical necessity for substance use disorder treatment, recommended by a physician or other licensed practitioner of the healing arts acting within scope, and provided at the level of care appropriate to the member's assessed needs, including applicable ASAM criteria and DHCS requirements.

Service Time

While only some of the activities and interventions that we do with and for Plan Members are billable (meaning we will get reimbursed), it is vital to document ALL activities done with and for Plan Members, whether they will be coded as a billable intervention or nonbillable intervention.

What's billable?

Service time with the plan member for the purpose of providing healthcare. Billable service time can be time spent with member support plan members if it is for the benefit of the member.

- If a clinician consolidates and synthesizes clinical information to make recommendations for treatment or to make a diagnosis, the activity counts as service time and is claimable even when the member is not present. For example, CPT code 99202 (office or other outpatient visit) includes "medically appropriate history and/or examination" as part of the service.
- If the service code billed specifies a case management service or a consulting service on behalf of the member, those activities also count as service time and are claimable even when the member is not present. Here, claimable service time is the time spent consulting on behalf of the member with specialist(s) and/or with the member's support plan member(s).

What's not billable?

The following are not claimable as service time:

- Travel time
- Administrative activities
- Chart Review
- Documentation time
- Utilization review
- Quality assurance activities
- Any other activities a provider engages in that are either already included in the rate for the service code or are claimed separately by the county

8.2 Authorization and Re-Authorization Process

Requirements Applicable to Authorization of all SMHS

VCBH Health Plan evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through concurrent authorization procedures, or retrospectively, such as through retrospective authorization procedures.

- Providers may call the VCBH 24/7 toll-free access line to request expedited authorization of an outpatient service requiring prior authorization.
- VCBH shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

Prior Authorization or Referral for Outpatient SMHS

1. VCBH **does not** require prior authorization for the following services:
    a. Crisis Intervention
    b. Crisis Stabilization
    c. Mental Health Services (including initial assessment)
    d. Targeted Case Management (TCM)
    e. Intensive Care Coordination (ICC)
    f. Peer Support Services (PSS)
    g. Medication Support Services
2. **Prior authorization or VCBH referral** is required for the following services:
    a. Intensive Home-Based Services
    b. Day Treatment Intensive
    c. Day Rehabilitation
    d. Therapeutic Behavioral Services
    e. Therapeutic Foster Care
3. ICC must be included in an established Client Plan.
4. Targeted Case Management (TCM) and Peer Support Services (PSS) require the development (and periodic revision) of a client plan provided in a narrative format in the progress note.
5. For purposes of prior authorization, referral by VCBH is considered to serve the same function as approving a request for authorization submitted by a provider or plan member.
6. VCBH may require providers to request payment authorization for the continuation of services at specified intervals (e.g., every 6 months).

Referral and Concurrent Review for Crisis Residential Treatment and Adult Residential Treatment Services

a. VCBH uses referral and/or concurrent review to authorize all Crisis Residential Treatment (CRT) and Adult Residential Treatment (ART) services.
b. Prior authorization is not required for CRT or ART. A VCBH referral may serve as the initial authorization when the approved service details are included.
c. VCBH reviews and reauthorizes CRT and ART services during the stay based on continued medical necessity.
d. If there is no VCBH referral, concurrent review begins after the first day of admission and continues through discharge.

For more detailed information regarding how to submit a Service Authorization Request (SAR) please see VCBH Policy Library: **CA-50: Service Authorization Requests for Out-of-County AAP and KinGAP Medi-Cal Beneficiaries as well as the SAR Form (CA-50 Service Authorization Request Form).**

Outpatient Authorization Timeframe and Documentation Requirements

1. VCBH must review and make a decision regarding a provider's request for prior authorization as expeditiously as the plan member's mental health condition requires, and **not to exceed five (5) business days** from the receipt of the information reasonably necessary and requested by VCBH.
2. For cases in which a provider indicates, or VCBH determines, that the standard timeframe could seriously jeopardize the plan member's life or health or ability to attain, maintain, or regain maximum function, VCBH shall make an expedited authorization decision and provide notice as expeditiously as the plan member's health condition requires, **but no later than 72 hours after receipt of the request** for service.
3. VCBH may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:
    a. The plan member, or the provider, requests an extension; or,
    b. VCBH justifies (to the State upon request), and documents, a need for additional information and how the extension is in the plan member's interest.
4. The VCBH referral or prior authorization shall specify the amount, scope, and duration of treatment that VCBH has authorized.
5. If the request for authorization of services is denied or modified, or if it is determined that services should be terminated, VCBH will send a NOABD.
6. VCBH will notify the plan member, in writing, prior to discontinuing services when a previously authorized service is terminated, reduced or suspended.

Retrospective Authorization Requirements

1. VCBH conducts retrospective authorization of SMHS under the following limited circumstances:
    a. Retroactive Medi-Cal eligibility determinations
    b. Inaccuracies in the Medi-Cal Eligibility Data System
    c. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries, **and/or,**
    d. Plan member's failure to identify payer (e.g., for inpatient psychiatric hospital services)
2. In cases where the review is retrospective, the authorization decision is communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and is communicated to the provider in a manner that is consistent with state requirements.

Denials

1. VCBH ensures that any decision to deny a service authorization request or to modify a service in an amount, duration, or scope that is less than requested is made by a licensed mental health professional who has appropriate clinical expertise in addressing the plan member's behavioral health needs.

2. VCBH shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the plan member.
3. VCBH shall notify the requesting provider in writing and give the plan member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the plan member shall meet the requirements pertaining to VCBH's QM-18: Person in Care Problem Resolution Processes.

Policy and Procedure Requests

1. The utilization review policies and procedures that VCBH, or any entity VCBH contracts with, uses to authorize, modify, or deny SMHS and DMC-ODS services are available for disclosure to DHCS, VCBH's providers, beneficiaries, and members of the public, upon request.

Inpatient SMHS Authorization Process – Step by Step

1. Emergency Admission:
   - No prior authorization required for psychiatric emergencies (voluntary or involuntary) if the plan member is a danger to self/others or unable to meet basic needs.
   - Hospitals notify VCBH; Reimbursement remains subject to applicable medical necessity and documentation.
   - Continued stay requires authorization and VCBH concurrent review.
2. Initial Authorization:
   - VCBH is available 24/7 to receive admission notifications.
   - Hospitals must submit admission orders, plan of care, treatment request, and face sheet within 24 hours (or once stabilized for emergency conditions).
   - VCBH decides on authorization within **72 hours** based on medical necessity.
3. Continued Stay Authorization:
   - Hospitals submit requests for continued stay before the end of the current authorization.
   - VCBH conducts concurrent review to ensure medical necessity and appropriate level of care.
   - Administrative day criteria may be authorized if criteria and required documentation are met.
   - Decisions to approve, modify, or deny are made by a licensed mental health professional and communicated within **24 hours**.
   - Care continues until a plan is agreed upon or the hospital discharges/downgrades level of care.
4. Administrative Days:
   - Payment approved if acute criteria were previously met and no suitable non-acute placement is available.
   - Hospitals must contact at least five potential placements per week (or fewer if fewer exist).
5. Retrospective Authorization:
   - Allowed in limited cases (retroactive Medi-Cal eligibility, billing issues, dual coverage).
   - Authorization decisions communicated within **30 days**.
6. Denials and Appeals:
   - Denials reviewed by a licensed mental health professional.

- Written notice provided to hospital and plan member
- Appeals: submitted within **90 days**, reviewed by a physician not involved in the initial decision, with a response within **60 days**.

7. Oversight and Compliance:
   - VCBH ensures all claims meet state and federal requirements.
   - Retains right to audit, disallow, or recoup funds for services not provided or in cases of fraud, waste, or abuse.

How to submit a SUD Treatment Authorization Request (TAR) for Residential Services for Substance Use Treatment Services

1. Please email the following information to: SUDTAR@venturacounty.gov
2. **A complete submission will include all required documents:**
   a. Residential TAR Cover Sheet [**"DMC-ODS Residential Treatment Authorization Request (TAR)**" can be found via Provider Resources - Ventura County Behavioral Health]
   b. Medi Cal eligibility (or attestation)
   c. LOC Determination Tool ASAM LEVEL OF CARE GRID.pdf
   d. Full ASAM Assessment or ASAM Assessment Update

Note: All required documents listed above must be submitted within **24 hours** of the initial request. Documents do not need to be submitted if the provider is requesting Provisional Approval. If requesting a Provisional Approval, the provider will submit the SUD TAR Cover Sheet with the necessary information and has **3 days** to submit the remaining required documents for their requested start date to be honored. **Notice of Adverse Benefit Determination (NOABD)**: If a plan member request for treatment services is denied or authorized in an amount that was less than requested, Ventura County Behavioral Health will ensure that plan members are given timely and adequate notice of an adverse benefit determination in writing.

Review Process for SUD TARs

1. **Reviewing documentation** – all documents listed above will be reviewed for completeness and if there are missing elements (i.e. not signed or dated, fields not marked). The TAR will be sent back for Further Review Required (FRR) and sent back to provider.

2. **Characteristics of Levels of Care (3.1, 3.2, 3.3, 3.5)**
   a. **3.1:** Clinically Managed Low-Intensity Residential Services. At this level, services focus on teaching recovery skills, preventing relapse, improving emotional functions and helping clients relearn essential life skills.
   b. **3.2:** Clinically Managed Withdrawal Management – provides detoxification services in a non-medical environment for clients at risk of severe withdrawal requiring 24-hour support. No TAR needed (no prior authorization required).

c. **3.3:** This treatment program provides a structured environment and medium-intensity clinical services. It is designed for patients who have been deeply affected by substance abuse, including those showing temporary or permanent cognitive deficits, TBI or intellectual disability.
d. **3.5:** This level is designed for individuals who have severe substance use issues and have possibly had a series of unsuccessful interventions and require 24-hour oversight. The issues may include substance use disorders, criminal activity, mental disorders, impaired functioning and difficulty adapting to societal norms.
e. ***If provider is requesting higher LOC than indicated***, they must provide a discrepancy statement to justify request.

3. **SUD specifiers (mild, moderate, severe):**
   The DSM-5-TR allows clinicians to specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified.
   a. **Mild**: Two or three symptoms indicate a mild substance use disorder.
   b. **Moderate**: Four or five symptoms indicate a moderate substance use disorder.
   c. **Severe**: Six or more symptoms indicate a severe substance use disorder.

8.3 Denial Notices and Member Appeals

NOABD's - Notice of Adverse Benefit Determination & Appeals

A Notice of Adverse Benefit Determination or NOABD is required to be sent out whenever any adverse action is taken against a plan member. It is an important part of a member's rights and providers have a legal and ethical responsibility to inform members of this. Practitioners must give the member at *least 10 days from the date of the letter* to appeal the decision. To find more information regarding NOABDs please reference: BHIN 25-014

- Plan members have a right to request continuation of benefits that the Contractor seeks to reduce or terminate during an Appeal or State Hearing filing, if filed within the allowable timeframes (within 60 days of the date of the letter).
- To find NOABD letter templates from DHCS go to 2025-BH-Information-Notices and find BHIN Enclosures for 25-015.
- Fillable NOABD's can also be found in **SmartCare**
- All NOABDs must be completed in SmartCare or uploaded into SmartCare for tracking and reporting purposes.

Plan members may request a review of an NOABD decision through the submission of an Appeal. Appeal forms are located in all clinic lobbies and can be accessed from the Client Resources section of the VCBH website: Client Resources - Ventura County Behavioral Health

Appeals must be resolved by the Behavioral Health Plan within 30 days. Plan members can request an Expedited Appeal (must be resolved within 72 hours) if they believe the adverse benefit determination

could jeopardize their life/ health or ability to maintain/regain maximum function. Questions about the Appeal process can be directed to the **VCBH Grievance and Appeals Team at 1-888-567-2122**.

If the Appeal is denied, the plan member has a right to request a State Fair Hearing within 120 days from the date of the notice of appeal resolution. Information about filing a State Fair Hearing is sent directly to the plan member within the Notice of Appeal Resolution and attachment "NAR Your Rights". It can also be found at the bottom of the Client Resources page on the VCBH website.

8.4 Retrospective Chart Reviews for Non–Inpatient SMHS and DMC-ODS Services

Record Review and Utilization Review (UR) Process:

Sample Selection

- UR staff review a 5% random sample of client records twice yearly for anyone with at least one billable service in the previous month.
- Newly contracted providers or those with compliance issues may undergo targeted or more frequent reviews.
- NTP providers receive additional unannounced reviews at least once a year.

Scheduling and Notification

- Programs are notified at least two weeks in advance with the list of records to be reviewed.
- Reviews use standardized UR/SUTS Compliance Review tools to ensure medical necessity and regulatory compliance.
- Reviewers are independent and not involved in service delivery.

Contracted Provider Requirements

- Participate in UR reviews twice yearly.
- Maintain a Quality Assurance Plan, including utilization review, peer review, and medication monitoring.
- Conduct monthly internal peer reviews; submit results for VCBH oversight.
- UR frequency may increase if documentation deficiencies, compliance issues, or potential fraud/waste are found.

Remediation and Corrective Action

- Compliance deficiencies are communicated via EHR Compliance Review Reports.
- UR staff hold feedback meetings to Guide remediation and training.
- Providers have two weeks to address deficiencies; unresolved charges are reconciled through Billing.
- Corrective Action Plans (CAPs) may be issued for serious issues; providers have 30 days to respond.

Appeals and Termination

- Providers may appeal disallowances within 30 days, submitting supporting documentation.
- Failure to remediate may result in financial sanctions, contract termination, or other legal remedies.

Section 9 – Quality Improvement

9.1 Provider Participation in QI Activities

Contracted Providers are expected to participate in VCBH quality improvement activities in support of County, State, and Federal requirements. Provider participation may include involvement in performance improvement activities, audits and reviews, data collection and reporting, corrective action processes, and other quality initiatives requested by VCBH.

QI Program Description and Participation

VCBH maintains a Quality Improvement (QI) Program designed to monitor compliance, quality of care, access to services, and member outcomes across the behavioral health system. Listed below are initiatives in which providers are expected to participate, as applicable.

Quality Improvement Committee (QIC)

VCBH operates an overarching Quality Improvement Committee structure supported by multiple subcommittees with representation from across the department. This structure supports ongoing monitoring, collaboration, and continuous quality improvement activities throughout the behavioral health system.

Providers may be asked to participate in QI meetings, initiatives, or related activities, as applicable to their contracted services.

Performance Monitoring

Providers must meet all performance standards specified in their Scope of Work. Additionally, VCBH monitors performance measures related to access, timeliness, quality of care, and member outcomes. Examples include DHCS Timeliness Standards and the Behavioral Health Accountability Set HEDIS measures.

Providers are expected to support performance improvement efforts by implementing best practices, participating in improvement activities, and complying with documentation and data collection requirements related to applicable measures.

Audits and Reviews

VCBH undergoes regular audits, monitoring activities, and external reviews, including DHCS audits and External Quality Review Organization (EQRO) reviews.

Providers are expected to participate in audits and reviews as requested, including submission of records, policies, procedures, or other documentation necessary to demonstrate compliance.

Member Satisfaction Surveys

VCBH coordinates annual member satisfaction surveys mandated by DHCS, including the Consumer Perception Survey (CPS) for outpatient mental health services and the Treatment Perception Survey (TPS) for substance use services. In the case of both surveys, DHCS issues annual guidance related to survey administration, timelines, formatting, and submission procedures. Additional information about the CPS and TPS can be found in applicable annual BHIN guidance, namely BHIN 25-004 and BHIN 25-025.

If applicable, Providers are expected to support survey administration activities and follow all VCBH instructions regarding survey collection and submission. Survey findings are used to identify opportunities for improvement and monitor member experience and outcomes.

9.2 Required Data Reporting

Substance Use Services (SUS) Providers: California Outcomes Measurement System Treatment (CalOMS Tx)

The California Outcomes Measurement System Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. A CalOMS Tx record is completed for each new admission to treatment, each discharge from treatment, and annual updates for open treatment episodes.

Providers must submit CalOMS Tx data monthly in accordance with DHCS reporting requirements. If no reportable activity occurred during the reporting period, Providers must submit a "no activity" report as defined in the CalOMS Tx reporting instructions and data dictionary. Providers are expected to comply with all applicable reporting timelines and requirements.

Newly contracted Providers must establish CalOMS Tx portal access as soon as possible following contract execution. Upon onboarding, the Provider Network Management team will coordinate with the VCBH EHR team to facilitate setup and access.

Substance Use Services (SUS) Providers: Drug and Alcohol Treatment Access Report (DATAR)

The Drug and Alcohol Treatment Access Report (DATAR) is a DHCS reporting system used to monitor treatment capacity, utilization, access to services, and wait times for substance use disorder treatment providers.

Providers are required to submit monthly DATAR reports for each applicable service site by the 10th day of the following month. Newly contracted Providers must establish DATAR portal access promptly to ensure timely reporting compliance. Additional information can be found in BHIN 23-068.

Substance Use Services (SUS) Providers: ASAM Level of Care Reporting

All substance use disorder treatment clients within the VCBH system are assessed using the American Society of Addiction Medicine (ASAM) criteria. Assessments are completed at intake and updated periodically throughout treatment.

ASAM assessment and follow-up data must be reported to DHCS monthly. These submissions allow DHCS to monitor whether the ASAM-recommended level of care aligns with the level of care provided. Contracted Providers must either:

- Enter ASAM assessment data directly into the SmartCare Electronic Health Record (EHR), or
- Submit data to VCBH using an approved standardized reporting template.

Providers are expected to comply with all applicable DHCS reporting requirements and timelines.

All Providers: Monthly 274 and Annual Network Certification Reporting

Providers are required to submit information necessary to support VCBH's annual Network Certification and monthly 274 reporting requirements. Requested information may include provider demographics, credentialing information, service locations, specialties, languages spoken, and other network adequacy-related data.

Providers are responsible for ensuring submitted information is accurate, complete, and provided within requested timelines. See section 6 for additional information.

9.3 Corrective Action Processes

When deficiencies or areas of non-compliance are identified through audits, monitoring activities, clinical reviews, or performance data analysis, Providers may be required to submit a Corrective Action Plan (CAP) within fifteen (15) calendar days, unless otherwise specified by VCBH.
Each CAP must include:

- Description of the identified deficiency or non-compliance
- Root cause analysis
- Corrective actions and responsible parties
- Timeline for completion
- Method for monitoring and evaluating effectiveness

Providers shall use the CAP template included in Appendix D of this Provider Guide, unless otherwise directed by VCBH.

Section 10 – Community-Based Resources and Linkages

In Ventura County, there are several resources available for accessing community services related to Specialty Mental Health Services (SMHS) and DMC-ODS services.
Here are some key resources:

- ***2-1-1*** is a free information and referral service that connects people to health and human services in their community, 24/7. Websites like the Ventura County 211 service offer comprehensive listings of community resources, including mental health services. 211ca.org
- ***Transportation Services for Seniors and People with Disabilities***
    - Dial-A-Ride
    - GO ACCESS
- ***Department of Rehabilitation***: Provides services and advocacy resulting in employment, independent living, and equality for individuals with disabilities. Plan members will likely require a letter from VCBH to work with the Department of Rehabilitation.
    - DOR Oxnard/Ventura
- ***IHSS (In Home Supportive Services)*** - Through In-Home Supportive Services (IHSS), help is available for qualified applicants to pay for support services, including light domestic help, non-medical personal care, and assistance to and from medical appointments. https://venturacounty.gov/human-services-agency/ihss-recipients_
- ***Social Security/Social Security Disability Insurance/Supplemental Security Income***
    - ***Social Security*** = Retirement benefits based on your work history. To qualify, individuals must have worked for a certain number of years (typically at least 10 years or 40 quarters), paying into the Social Security system through payroll taxes. You can start receiving benefits as early as 62 years of age, however the amount is higher the longer you wait.

- ***Social Security Disability Insurance (SSD or SSDI)*** = Disability benefits for people who have worked and paid into Social Security but are no longer able to work due to a disability. Typically, you need to have worked for at least 5 out of the last 10 years, though the exact requirements depend on your age.
- ***Supplemental Security Income (SSI)*** = Financial assistance for low-income individuals who are elderly, blind, or disabled, regardless of work history. There is no requirement to have worked or paid Social Security taxes to qualify for SSI.
  - Appointing a representative for Social Security - Form SSA 1696: Link: Appointment of Representative (ssa.gov)

- ***CalFresh*** - You can visit https://www.ventura.org/human-services-agency/main-homepage/how-to-apply-for-calfresh/ for more information.
- ***Food Pantries*** - This website will take you to the FoodShare website where you can download the Pantry List (found on bottom left of page) with addresses, days and times to pick up food - Find Help - Food Share of Ventura County
  - Most food pantries want confirmation that the plan member lives in the area, i.e. bill or ID with local address
- ***DMV information*** - plan members may be eligible for a Reduced Fee Identification Card (DL 937) form or a No Fee Identification Card Eligibility Verification (DL 933) to provide to a plan member.
  - Most VCBH Clinics will have these forms available, but if you do not have them or are out of them, they can be requested via: https://www.dmv.ca.gov/portal/driver-licenses-identification-cards/reduced-no-fee-id-card-program-information-for-organizations/
- ***Crisis Services***

  Ventura County provides 24/7 crisis services, including a crisis hotline and mobile crisis teams to help individuals in immediate need. All the following numbers can also be found and printed for plan members from SmartCare on the "Safety Plan".
  - VCBH Crisis Hotline :1-866-998-2243
  - 988 Suicide and Crisis Lifeline
    a. Available 24/7
    b. Call or text 988
    c. Chat: https://988.lifeline.org/chat
  - California Peer Run Warmline: Call or Text 855-845-7415
  - The Trevor Project: Available 24/7 for LGBTQ+ Youth
    a. Call 866-488-7386
    b. Text START to 678-678
    c. Crisis Text Line
    d. Text Home to 741-741
  - Trans Lifeline: Available 24/7 - Call 877-565-8860
- ***Community Mental Health Centers*** - Various centers in the area offer outpatient services, including PT/OT therapy and support groups.
  - Adult Day Health Care Centers - Oxnard Family Circle ADHC and Among Friends ADHC

- Turning Point Foundation
- PathPoint

- ***NAMI Ventura County:*** The National Alliance on Mental Illness offers support groups, educational programs, and resources for individuals and families affected by mental illness.
  - Website: NAMI Ventura County

Section 11 – Claims and Billing

11.1 Claim Submission Requirements

Claims must include the following information:

- **Member DOB**
- **Gender at Birth**
- **Client Identification Number (CIN)**
- **Client First and Last name**
- **Clinician Name, NPI and Taxonomy**
- **Date of Service**
- **Procedure Code**
- **Diagnosis**
- **Service Facility Name, NPI, TAX# and address**

Approving and Denying Claims

Claims or service lines that meet all the business requirements are approved. Claims or service lines that do not meet a business requirement are denied.

- **Zero Dollar Claims:** A service line submitted must be for an amount greater than $0. SD/MC will deny all claims in which all services lines are submitted for $0.
- **Beneficiaries with a Share of Cost**: Plan Members with a share of cost must certify by fulfilling the share of cost amount before Medi-Cal reimburses providers for services rendered to the plan member.
- Claims are denied if the CIN doesn't match with the Medi-Cal Eligibility Data Systems data (MEDS) or if the member wasn't enrolled during that month.

Member Eligibility

Plan Member must be Medi-Cal eligible during the month the service is provided. SD/MC verifies eligibility by matching the CIN and service month on the claim with (MEDS).

Dates of Service – For psychiatric inpatient claims, service dates must be in the same calendar month.

Duplicate Services

- **Inpatient, 24-Hour, and Day Services** - Inpatient, 24-hour, and day services are considered duplicate services if provided on the same day. These services will be denied, except for Crisis Stabilization. Crisis Stabilization may be duplicated more than once when an appropriate over-riding modifier (i.e. 59,76 or 77).

- **Outpatient Services -** Duplicate services are not allowed except for Sign Language or Oral Interpretive Services, Peer Support Services, group services, and mobile crisis. If a provider renders two or more separate encounters of the same procedure code to a member on the same day, all encounters must be claimed as one service line to ensure the additional encounters are not denied as duplicate services.

Co-Practitioners/Groups - If more than one practitioner treats the same plan member at the same time, each practitioner must submit a separate claim for the service they solely provided.

For SmartCare Users: When Facilitating a Group, Please Write Notes through the "Group Service Detail Screen"

- If facilitating a Group Service, you are REQUIRED to set up a group in SmartCare to document all group notes. Please **DO NOT** write progress notes with a Group Procedure Code (Ex: Group Therapy, Psychosocial Rehabilitation Group, Behavioral Health Prevention Education Service-Group) for each member of the Group outside of the Group Service Detail Screen in SmartCare.

If you are unsure how to set up a group or document group services, please reference these instructions:

How to Set Up a Group - 2023 CalMHSA
How to Write a Group Progress Note - 2023 CalMHSA
How to Add or Change a Staff Member in a Group - 2023 CalMHSA

Claiming for Interpretation and Interactive Complexity

- Billing guidelines for sign language or oral interpretation services (coded as T1013) and interactive complexity specify that these services must be submitted on the same claim as the primary service, such as therapy.
- Interpretation services are billable when a practitioner uses an oral interpreter to translate for clients with a different language. For inpatient stays, digital services, interactive complexity, or mobile crisis services the interpreter can be on site but cannot be billed.
- Claims for interpretation are limited to the duration of the primary service, with one unit equaling 15 minutes and must include the taxonomy code and NPI of the primary service provider.

Service Facility Location Address - Must be a physical address. If a service facility address is submitted as a P.O. Box, Lock Box or Lock Bin, the associated service will be denied.

Professional Claims/Fee-for-Service Medi-Cal (FFS/MC) - MHP(BHP) may contract with individual and group providers who are licensed and enrolled to provide mental health services under the Fee-for-Service Medi-Cal program. Counties may also submit claims for professional services provided in a hospital (Professional Claims in an Inpatient Setting: CCR Title 9, §1810.237.1).

Service Facility Validation (ie. Medi-Cal Certification)- Except for claims submitted by: 1) FFS/MC individual and group providers, 2) BHCONNECT providers, and 3) Mobile Crisis providers, SD/MC verifies that the service facility (i.e., organizational provider) was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided.

Rendering Provider Taxonomy Code - SD/MC verifies that the provider's taxonomy matches the first four characters of an allowed code for the service; mismatches result in denial. Outpatient claims without a taxonomy code are denied unless special circumstances apply (see DHCS Billing Manuals)
Psychiatric Inpatient Hospital Services – Revenue Codes - All claims for psychiatric inpatient hospital services (acute psychiatric inpatient hospital and administrative day services) must include a valid revenue code.
Date of Admission and Date of Discharge – Date of admission must be included in all claims for hospital admissions and 24-hour services. Date of discharge is not required for 24-hour services.
Administrative Day Services – Cannot be claimed on the Date of Admission
Clinical Trainees and Community Health Workers (CHW) - When claiming for Clinical Trainees and CHWs, in addition to using the appropriate taxonomy and procedure modifier found in the table below, the Supervisor's NPI will be required on all claims for services rendered.

No.	Profession(s) Type	Taxonomy	Modifier
1.	Medical Student in Clerkship	1744	None
2.	LCSW, MFT or LPCC Clinical Trainee	3902	AJ
3.	Psychologist Clinical Trainee	3902	AH
4.	Registered Nurse Clinical Trainee	3902	TD
5.	Vocational Nurse Clinical Trainee	3902	TE
6.	Psychiatric Technician Clinical Trainee	3902	HM
7.	Occupational Therapist Clinical Trainee	3902	CO
8.	Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee	3902	HP
9.	Pharmacist Clinical Trainee	3902	HO
10.	Physician Assistant Clinical Trainee	3902	None

Telehealth Modifiers and Place of Service Codes - If a telehealth modifier is used, the place of service code must be 02 or 10 unless the service is mobile crisis.
Day Treatment Intensive and Day Rehabilitation Services – Minimum Hours - must be provided for at least three hours before it is eligible for reimbursement. One unit of service is equal to 1 hour of service.
Place of Service Codes - SD/MC will deny all claims for outpatient services that do not include a place of service code.

- The Service Table lists all the outpatient procedure codes and the place of service codes that may be billed with each procedure code. Place of Service Codes

Dependent Codes - procedure codes that must be billed before the primary procedure can be billed and must be on the same claim as the primary procedure. See the Service Tables lists all outpatient procedure codes. Speciality Mental Health Service Table DMC-ODS Service Table
Units of Service – Outpatient Services - refer to Service Table for maximum units billed per Member per day. Only the time it takes to provide direct services associated with that code can be counted toward a unit of service. All units of service must be whole numbers, or the service line will be denied.
How To Select Codes Based on Time - On the Service Table, "Minimum Time Needed to Claim 1 Unit" states the minimum time of direct patient care associated with one unit of the code.
Codes with Defined Time Ranges

Most codes follow the **midpoint rule**, meaning a unit is earned once half the time for that code is reached (e.g., 31 minutes of a 60-minute service). Service interruptions don't reset time. Some codes are exceptions to this rule.

- [Group Services] - Group services are indicated by appending modifier HQ or by the definition of the service. SD/MC will adjust the rate for group services by 4.5.
- Please reference the Service Table for more detailed information: https://www.dhcs.ca.gov/services/MH/Documents/Specialty-Mental-Health-Service-Table-25-26.xlsx
- https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Service-Table-25-26.xlsx

Lockout Codes/Rules (reference Service tables above for more information as well) procedure codes that create a lockout citation with other similar codes are not separately reimbursable.
What are Medi-Cal lockout codes? – Lockout codes are rules that apply to covered Outpatient SMHS and DMC-ODS services

1. Some services are prohibited from being billed by outpatient providers on the same day. For example: Individual Therapy cannot be billed when someone is in a Psychiatric Hospital unless it was done on the first day of admission to the facility.
2. Certain services cannot be billed by outpatient providers while the client is in certain treatment settings. These can include inpatient psychiatric treatment facilities, crisis residential, psychiatric health facilities and OTP/NTP (Opiate Treatment Program/Narcotic Treatment Program) settings. Services provided/claimed in locked out places of service will be denied.
3. **All Medi-Cal Outpatient codes are locked out if a client is in jail. When selecting "Prison/Correctional Facility" as a location within SmartCare it will automatically restrict the billing from being submitted. (This is subject to change when the CalAIM Justice Involved Initiative is implemented).** Please use the following link to view the service tables that indicate which services are locked out. MedCCC - Library

11.2 Claim Forms and Codes

Billing in SmartCare:
All claims are submitted electronically. Upon contract approval and rate settings, a CBO who uses SmartCare will require the following:

- The provider must be Medi-Cal certified.
- VCBH Credentialing team will need to review the clinical staff credentials to enter notes in the system.
- VCBH's EHR team will create user accounts for staff to configure the system.
- A SmartCare program and Fiscal program code will be created.
- VCBH QA, EHR and Billing department coordinates the training.

For CBOs who are service entry only in SmartCare the process is the same as above except for a key difference, clinicians will not have access to documents in SmartCare unless they are within their Master

CDAG, as CBOs will be documenting in their own EHR system. However, CBOs will be required to enter all state reporting elements and manually input the services for billing.

Procedure Codes

Please refer to the most recent Service Tables provided by DHCS: MedCCC - Library

CalMHSA maintains a CPT code reference guide that crosswalks to SmartCare: Procedure Code Definitions - 2023 CalMHSA

11.3 Timely Filing Standards

Claim Timeliness – Original Claims

The timeline for initial submission of Specialty Mental Health Medi-Cal and DMC-ODS claims is critical. Original claims must be submitted and received by the plan within 12 months from the month of service. An original claim submitted after 12 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied.

11.4 No Balance Billing Prohibition

PSA §6.6: Contractors may never bill Members for Covered Services under any circumstances

Contractors must not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against a Member — or any person acting on behalf of a Member — for Covered Services provided under the Provider Services Agreement. This prohibition applies regardless of whether VCBH becomes insolvent, fails to pay Contractor, or makes delayed payment for any reason.

Contractors accept the amounts paid by Medi-Cal as payment in full for all Covered Services. The prohibition on balance billing applies to:

- All Covered Services provided to eligible Medi-Cal Members, whether or not VCBH has reimbursed Contractor for those services.
- All services authorized or referred by VCBH or another contracted provider.
- Services for which Contractor has received partial reimbursement from a third-party payer, where the remaining balance is a Medi-Cal-covered service.

A Member's applicable share of cost, if any, is not a form of balance billing and is not prohibited by this section. Members with a share of cost must certify the applicable share before Medi-Cal reimburses providers, as described in Section 11.1. No charges beyond the certified share of cost may be collected from Members.

REQUIRED	PROHIBITED: Billing Members for Covered Services is a contract violation and may constitute fraud under the Medi-Cal program. (PSA §6.6; W&I Code §14019.3; 42 CFR §438.100(b)(3))

11.5 Claim Denials, Adjustments, and Resubmissions

All providers must submit clean and timely claims to VCBH. This helps to make sure that VCBH can process and pay the claims accordingly and in a timely manner. If the provider does not submit clean and timely claims, VCBH will deny those claims. Providers have the right to appeal claim denials and ask that VCBH re-reviews the claims. VCBH monitors all claims for discrepancies and overpayments, as well as potential fraud, waste, and abuse.

FFS Claim Denials

Claims that do not meet all appropriate requirements are returned as not approved for payment, along with the reason for denial.

1. **Denial Reasons**
    a. A different provider other than the provider claiming the service provided the service.
    b. The days were denied by the UR staff and Psychiatrist.
    c. A 5850 episode was not opened because the records were not sent.
    d. The provider did not write a progress note / discharge summary on the day requested.
    e. Provider's signature is illegible.
    f. The provider is not contracted/credentialed with VCBH.
    g. Claim is not submitted in a timely manner.
    h. Claim is incomplete or illegible.
    i. Claim is a duplicate claim.
    j. Other Health Insurance is primary.

2. **If a claim fails to satisfy requirements**, Utilization Review confirms the denial and informs Billing.
    a. Billing team sends a denial letter to provider summarizing denial reason along with a denial explanation of benefits (EOB).

3. **To prevent a denial**, the Provider can take the following steps:
    a. Ensure that the provider is credentialed/contracted with VCBH for the Fiscal Year related to dates of service on claim.
    b. Ensure medical necessity is met and documented.
    c. Submit a clean claim.
    d. Submit the claim within the approved timeframe (**within 12 months of service date**).

Claim Appeals

A provider can appeal claim denial for reconsideration of approval and payment if the provider submits a replacement claim along with appeal letter to Billing. Depending on initial reason of denial, Utilization Review or Billing reviews appeal. If the denial is overturned, Billing proceeds with standard claim processing. If the denial is upheld, Billing sends a letter to the provider confirming that the denial is upheld.

Overpayments

Documentation related to recoveries of all overpayments, including overpayments due to fraud, waste, or abuse, is retained for 10 years.

Network providers are required to report any overpayments they identify immediately to their assigned VCBH Contract Manager and the VCBH Fiscal Manager. The notification must include the amount and the reason for the overpayment.
In cases when VCBH discovers an overpayment in contractor professional fees, VCBH notifies the provider and their assigned VCBH Contract Manager immediately of the overpayment. The notification includes the amount and reason for overpayment.
The overpayment must be repaid to VCBH within thirty (30) days of written notice of the overpayment from VCBH.

- When a provider does not repay the overpayment as required, the overpayment is applied as a credit to the provider's account.
- In cases where the application of an overpayment as a credit does not satisfy the repayment requirement, VCBH Fiscal and Billing teams assess and determine next steps, as appropriate, on a case-by-case basis, which may include collections or charge adjustments.

Note: If a duplicate payment is received from the State, duplicate service is voided and charge is adjusted. If there is a credible allegation of fraud, all payments to a network provider are suspended. VCBH reports annually to the Department of Health Care Services (DHCS) on the recoveries of overpayments.

11.6 Billing Errors and Corrections within SmartCare

IMPORTANT REMINDERS

- Check for billing errors regularly (e.g., monthly) and correct them as needed
- No reimbursement shall be given for notes with billing errors ***after 365 days***
- If a staff member is leaving, check for billing errors and make corrections prior to their termination date.
    - Please refer to the "**CBO Error Correction Guide"** for various common service note errors found via Provider Resources - Ventura County Behavioral Health
- If a note needs to be deleted, please submit a ServiceNow ticket to resolve the issue
    - Reference "**SmartCare ServiceNow Request Cheat Sheet**" Provider Resources - Ventura County Behavioral Health
    - Please use: https://vchca.service-now.com/sc

Please utilize this link for instructions and information related to the use of SmartCare: Home - 2023 CalMHSA

11.7 Record Retention Requirements

Contractors must maintain and make available, upon request, all records pertinent to services rendered under the Provider Services Agreement for the longest of the following periods:

Condition	Retention Period
Standard — contract-based	10 years from the final date of the contract period
Standard — service-based	10 years from the date the service was rendered or until a minor child is 25, whichever is later
Unemancipated minors	Until the Member reaches twenty-five (25) years of age
Litigation / audit hold	Until final resolution of any audit, investigation, claim, or litigation — including exhaustion of all legal remedies — if notice is received before the applicable retention period expires

The 'longest of' standard applies: identify which condition produces the longest retention period for each record and apply that period.

Records Subject to This Requirement

Retention requirements apply to all of the following records, without limitation:

- Clinical and medical records for all Members served under the Agreement.
- Financial records, supporting documents, statistical records, and billing documentation.
- Payroll and personnel records for staff providing Covered Services.
- Subcontractor agreements, monitoring documentation, and exclusion screening records.
- Incident, unusual event, and critical incident reports.
- Audit responses, corrective action plans, and related correspondence.
- Overpayment documentation and repayment records.

Litigation Holds and Access Rights

If any litigation, claim, financial management review, or audit is initiated before the expiration of the applicable retention period, Contractor must retain all related records until all issues are fully resolved and all legal remedies have been exhausted. Contractors must make retained records available to VCBH, DHCS, CMS, the Office of Inspector General, and other authorized federal and state agencies upon request and at reasonable times. These requirements apply to Contractor's subcontractors and must be incorporated into all subcontract agreements. (PSA §9.5; 42 CFR §§438.3(h) and 438.3(u); 22 CCR §72543; Exhibit C)

11.8 Invoice Procedures

Invoice Submission

Deadline: Invoices must be submitted by the 10th of the month following service delivery, or as otherwise specified in your contract.
Format: Use the VCBH invoice template (see Appendix D).

Required Invoice Documentation

Each invoice must include the following:

- On provider's letter head or containing provider's name and address
- Purchase Order number and remit to address
- Unique invoice number, invoice date, and billing period
- Electronic Health Record System report from the County EHR system that demonstrates and ties to the specific units of service that are included in the invoice
- Unit rates, quantity, and extended amounts
- Summary totals by service type
- Certification statement (see below)

Certification of Claims for Payment
Each invoice must include the following certification statement, signed by an authorized representative: *"I certify that the services billed were provided to eligible members, meet medical necessity criteria, are documented in accordance with DHCS and VCBH requirements, and were provided by qualified staff. I understand that payment is subject to audit and any overpayments must be refunded."*

False Claims Warning
Submitting false or fraudulent claims is a violation of state and federal law and may result in civil and criminal penalties, contract termination, and debarment from future contracts. Additionally, once VCBH is aware that there is a billing or invoice discrepancy, those claims cannot processed until the matter is resolved.

Payment Processing
VCBH will process approved invoices within forty-five (45) working days of receipt of a complete and correct invoice. Payment is contingent upon:

- Complete and accurate invoice submission
- Current submission of all required reports
- Compliance with contract requirements
- Availability of appropriated funds

11.9 Individual Service Level (ISL) Data Reporting

Effective January 1, 2027, contracted providers whose contracts include ISL-applicable services are required to collect and report Individual Service Level (ISL) data. ISL reporting captures County-funded services and expenditures that are not billable or not billed to Medi-Cal, in support of the County's obligations under the Behavioral Health Services Act (BHSA) and DHCS Integrated Agreement Contract 24-40149. The ISL codes applicable to your contract are identified in Exhibit H. Providers should

refer to Exhibit H for the full framework of ISL obligations, including data collection, submission requirements, and compliance timelines. This section provides supplementary guidance on what types of services and expenditures are subject to ISL reporting.

Services and Expenditures Subject to ISL Reporting
Contractors shall collect and report ISL data for County-funded services and expenditures subject to this requirement. Such services and expenditures may include, but are not limited to:

- Services provided to individuals without Medi-Cal coverage;
- Services not claimable or not billed under Medi-Cal rules;
- Outreach, engagement, and supportive services not reflected in Medi-Cal claims data;
- Direct client expenditures and flexible or "whatever-it-takes" supports;
- Subacute, housing, or other residential supports funded by County; and
- Any other County-funded activity identified by DHCS or County as subject to ISL reporting.

(Use the Bullets style from the Home tab — do not manually type bullet characters.)

Direct Client Expenditures and Flexible Supports
Contractors shall document and report all County-funded direct client expenditures and flexible supports provided on behalf of individuals that are not billed to Medi-Cal.
Such expenditures include, but are not limited to:

- Housing supports, hotel or motel vouchers, or rental assistance;
- Transportation assistance (bus passes, ride-share, mileage reimbursement);
- Food, clothing, hygiene items, or other essential needs;
- Employment and education supports;
- Child care assistance;
- Medication costs not covered by Medi-Cal; and
- Translation or interpreter services not billed to Medi-Cal.

All such expenditures must be tracked at the individual client level in accordance with County-issued ISL reporting specifications.

Invoicing Alignment
Where ISL data can be captured through the invoice process (e.g., per-client, per-day billing for housing or subacute/IMD services), Contractors shall use County-issued invoice templates that incorporate required ISL fields. Updated invoice templates will be provided by County.

For services paid through cost-based or program-budget arrangements that do not include client-level line items, Contractors shall submit a separate service reporting file alongside the invoice, capturing the minimum ISL data elements as specified by County.

Section 12 – Compliance and Program

VCBH monitors compliance to all laws throughout the year and conducts an annual contract audit.

12.1 Fraud, Waste and Abuse Prevention

All providers shall comply with applicable Federal, State, and County, statutes, laws, regulations, policies and procedures with the highest standards of ethics, integrity, honesty and responsibility. This includes, but is not limited to, the Federal False Claims Act and the State False Claims Act in adherence to the Deficit Reduction Act. Providers must prevent, detect, and report fraud, waste, and abuse.

- Compliance with Federal, State, and County, statutes, laws, regulations, policies and procedures.
    a. All contracted providers must regularly monitor and review their work to ensure compliance with all Federal, State, and County laws, regulations, policies, and procedures, including the Federal and State False Claims Acts.
    b. The VCBH Quality Management Program will also conduct planned compliance monitoring based on periodic risk assessments.
    c. Additionally, audits may be performed by Federal, State, or County Auditor-Controller staff, or by the VCBH Quality Assurance Unit, to verify adherence to all applicable requirements.
- Reporting any actual or perceived compliance violations
    a. Contracted providers are required to self-report or report any actual or perceived compliance violations to all of the following: immediate supervisor, VCBH Operations Manager Liaison, VCBH Compliance and possibly Provider Network Compliance (PNC) Team PNM.Compliance@venturacounty.gov. This will typically include provider complaints that do not meet the criteria for grievance but may still need an investigation. VCBH Compliance may notify the Ventura County Health Care Agency's (VCHCA) Compliance Program Officer (CPO). Substantiated violations may be routed to the CPO.
    b. VCBH Compliance can be reached by email at vcbh.compliance@ventura.org, Brown mail:
        Ventura County Behavioral Health, Compliance
        1911 Williams Drive, Suite 210, Oxnard, CA 93036
        Phone (805) 981-4295
    c. The VCHCA CPO can be reached by phone at (805) 677-5241. Should you choose to contact VCHCA CPO directly.
    d. CPO or designated individuals will refer the potential fraud, waste, or abuse to the Department's Medicaid Fraud Control Unit at 800-822-6222 or_ fraud@dhcs.ca.gov.
    e. Training
        i. VCBH will provide annual training to providers. This training will include integrity, ethics, and other areas of concern.

**For more information, please see Civil Division | The False Claims Act and 42 CFR 438.608 Program Integrity Requirements Under the Contract

12.2 HIPAA and Confidentiality Requirements

Federal and State Laws Regarding Confidentiality

The California Confidentiality of Medical Information Act (CMIA) and the Health Insurance Portability and Accountability Act (HIPAA) are both laws designed to protect medical information, but they operate at different levels and have different scopes and requirements. Here's a comparison of the two:

Scope and Jurisdiction

- **HIPAA**: HIPAA Home | HHS.gov
  - **Federal Law**: HIPAA is a federal law that applies nationwide in the United States.
  - **Scope**: HIPAA sets standards for the protection of health information held by covered entities such as healthcare providers, health plans, and healthcare clearinghouses. It also applies to business associates who handle protected health information (PHI) on behalf of covered entities.
- **CMIA**: California Code, CIV 56.10.
  - **State Law**: CMIA is specific to California and provides additional protections beyond those required by federal law.
  - **Scope**: CMIA applies to healthcare providers, health care service plans, and contractors in California. It covers the confidentiality of medical information and patient records in the state.

42 CFR Part 2: CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

Background information: The Part 2 statute (42 U.S.C. 290dd-2) protects "records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States." Confidentiality protections help address concerns that discrimination and fear of prosecution deter people from entering treatment for SUD.

Major Changes in the Part 2 Rule

The final rule includes the following modifications to Part 2 that were proposed in the NPRM (Notice of Proposed Rulemaking):

- **Patient Consent**
  - Allows a ***single consent (found in the Plan Member Information Packet below)*** for all future uses and disclosures for treatment, payment, and health care operations.
  - Allows HIPAA covered entities and business associates that receive records under this ***consent to redisclose*** the records in accordance with the HIPAA regulations.[1]
  - All information above regarding 42 CFR Part 2 can be found at: Fact Sheet 42 CFR Part 2 Final Rule | HHS.gov
  - Find answers to Commonly Asked Questions About the 2024 Part 2 Final Rule | Focus:PHI

Plan Member Information Packet

Consent for Treatment, Payment, Operations (TPO) and Informed Consent - CONTAINS NOTICE OF PRIVACY PRACTICES INCLUDING CONSENT FOR USES AND DISCLOSURES OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)
The packet can be found via: Client Resources - Ventura County Behavioral Health

****Please check in SmartCare to ensure this packet has been completed. If the packet has not been completed, complete it and upload to SmartCare.****

- If a plan member has declined to fill out and sign this packet, a SmartCare Flag: "Plan Member Declined to sign TPO Authorization" will be on their SmartCare account.

PLEASE REFERENCE THE FOLLOWING LINK FOR FAQS SPECIFICALLY RELATED TO THIS PACKET: "Frequently Asked Questions - Plan Member Information Packet" via Provider Resources - Ventura County Behavioral Health
Releasing information to a plan member or regarding a plan member shall comply with applicable privacy laws and regulations and shall follow established best practices to ensure privacy, clarity, and compliance with regulations. [***Covered Entities do not require* a ROI]** and releasing information is **necessary for Care Coordination**. Here are some key steps:

- ***Covered Entities - NO release of information needed***
    - Include, but are not limited to: VCBH, all VCBH Contracted Providers (CBOs), medical offices, hospitals, health insurance companies are classified as covered entities, allowing them to share protected health information (PHI) without needing authorization (such as a Release of Information) if the sharing is essential for the plan member's treatment.
    - SUS providers must always ensure the TPO consent is signed within the PMIP even when disclosing to covered entities.
- ***Non-covered Entities - release of information needed***
    - Non-covered entities are organizations whose primary purpose is not to provide treatment to the plan member, such as schools, the judicial system, or concerned community members.
    - Authorizations (Release of Information) are necessary to share PHI with third parties, which are considered non-covered entities.
- **Confidentiality:** Maintaining plan member confidentiality and privacy is paramount. All providers must adhere to legal and ethical guidelines regarding the storage, handling, and sharing of plan member information. (HIPAA & 42 CFR)
- Fillable Forms can be found in SmartCare and if SmartCare is ever down or not working, you can use the forms via CalMHSA
    - SmartCare Downtime Forms - 2023 CalMHSA

* Always make sure to adhere to the most current laws, including HIPAA and 42 CFR Part 2, as they are now more aligned than in the past. See page: Federal and State Laws Regarding Confidentiality *

Protecting electronic Protected Health Information (ePHI) and other sensitive data is a critical responsibility for all HCA staff. When email messages containing sensitive information must be sent outside of HCA (for example, to external providers, patients, vendors, or partners), encryption is required to ensure confidentiality and compliance with HIPAA and County security policies.

The County of Ventura provides a secure email encryption capability for all employees. Please follow the steps below whenever you send sensitive information externally.

Sending Emails with PHI or Sensitive Information

When to Use Email Encryption

You must encrypt email when sending:

- ePHI or patient-identifiable information
- Confidential clinical, financial, or personnel data
- Any information that should not be accessible to unauthorized individuals. When in doubt, encrypt the message.

How to Send an Encrypted Email

1. Compose your email **-** Draft your message as you normally would, including any necessary attachments.
2. Add the encryption keyword to the subject line, type: **#secure#**
    a. This can be placed at the **beginning or the end** of the subject line.
    b. **Only use #secure#**. Other texts, such as PHI or ePHI, will not trigger encryption.
    c. Example: Patient Referral Information #secure#
3. Send the email - Once sent, the message will automatically be encrypted.

What the Recipient Will Experience

- The recipient will receive a notification email indicating that they have a secure message from the sender.
- They will be prompted to create a free Microsoft Purview Message Encryption (one-time setup).
- This same account will be used to access **all future encrypted emails.**

Important Reminders

- PHI (not just ePHI) may only be sent externally for permitted purposes.
- Encryption is required for any PHI sent outside your agency.
- Encryption does **not** replace the need to follow minimum necessary and privacy best practices.

Failure to properly protect ePHI may result in regulatory violations and patient privacy risks.
Stay informed and stay safe!

[Minor Consent]

In California, the law that allows minors aged 12 and older to consent to mental health treatment, without parental permission or notification is outlined in the Family Code section 6924 and the Health and Safety Code section 124260. These laws acknowledge that minors may need timely access to these services for their well-being.

Here are the key points from the relevant California laws:

1. **Family Code section 6924:**
    a. This section states that minors who are 12 years of age or older can consent to confidential medical services if, in the opinion of the ***attending professional person, the minor is mature enough to participate intelligently in the outpatient services.***
    b. Mental health treatment, including outpatient treatment and counseling, is included under the umbrella of confidential medical services.
2. **Health and Safety Code section 124260:**
    a. "Notwithstanding any law to the contrary, a minor who is 12 years of age or older may consent to mental health treatment or counseling services if, in the opinion of the attending professional person, ***the minor is mature enough to participate intelligently in the mental health treatment or counseling services."***
    b. The minor's parent or guardian is not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.

Here are the key points in simple terms:

1. **Age Requirement:** Minors who are at least 12 years old can seek mental health treatment on their own.
2. **Types of Treatment:** This includes counseling and therapy sessions.
3. **Confidentiality:** The treatment is confidential, meaning parents or guardians do not have to be informed or give permission.
4. **Mental Health Treatment**: Minors aged 12 and older can consent to mental health services if they are seeking treatment for issues such as emotional or behavioral problems. This includes the ability to receive counseling and psychiatric services.
5. **Medication for Mental Health Issues**: While the law does allow minors to seek mental health services without parental consent, the specifics of prescribing medication might involve additional considerations. In practice, many healthcare providers will still involve parents in discussions about medication, especially for younger minors, due to the complexities and potential side effects of psychotropic drugs.
6. **Exceptions/Emergency Situations**: In cases of emergency or when a minor's safety is at risk, providers might act in the best interests of the patient. There are some exceptions where a parent or guardian might need to be involved, such as situations involving serious harm to the minor or others.

***This section does not authorize a minor to receive inpatient psychiatric care, convulsive therapy, psychosurgery or psychotropic drugs on their own consent. ***

PLEASE NOTE: The "Agreement to Pay"(previously known as PFI Part B) section of the Intake Packet MUST be signed by the person financially responsible for the Plan Member. [However, If signing this document could put the Minor/Plan Member at risk for harm, please consult with your supervisor prior to reaching out to the LAR for a signature. These are circumstances in which alternative arrangements will be made.]

When a minor Client is receiving treatment through minor consent, **[please make sure to utilize a "Minor Consent" flag in SmartCare.] If you are unfamiliar with adding a flag in SmartCare, please follow these directions: How to Create a Flag to Alert Treatment Team Members to Important Client Information - 2023 CalMHSA

There are 2 different Flag options for a Minor Consent Client to help differentiate between the different types of minor consent. If you have a minor receiving treatment under minor consent, you must assign one of the following flags:

- Minor Consent with Parent Involvement
- Minor Consent NO Parent Involvement (This flag is set as an "Always Pop Up")

IF YOU ARE TREATING A MINOR UNDER MINOR CONSENT WITHOUT ANY PARENT/GUARDIAN INVOLVEMENT, IT IS IMPERATIVE YOU CHOOSE THE CORRECT FLAG AS TO PREVENT BILLING AND OTHER VCBH PROGRAMS FROM SENDING ANY CORRESPONDANCE (INCLUDING BILLING STATEMENTS) TO THE MINOR CLIENT'S HOME.

***** If adding a flag, make sure to also add a reminder to remove the "minor consent" flag when clients turn 18*****

What to do if you have a minor who is requesting services without parental permission?

- Assess the minor for the following abilities:
    - **Cognitive Ability**: The therapist will assess the minor's cognitive functioning, including their ability to understand the nature of the treatment, the purpose of therapy, and any potential risks or benefits. This includes determining whether the minor can articulate the reasons for seeking therapy and demonstrate an understanding of the process.
    - **Maturity**: The therapist must evaluate the minor's emotional and psychological maturity. This involves considering the minor's ability to make reasoned, responsible decisions, including recognizing consequences of their actions. The therapist will document observations of the minor's behavior, decision-making skills, and overall emotional maturity.
    - **Decision-Making Skills**: The therapist may document whether the minor is able to independently make informed choices. This includes considering the minor's ability to weigh the benefits and risks of therapy, and their ability to express concerns, preferences, and desires related to their mental health.
    - **Capacity to Participate in Treatment**: The therapist shall document whether the minor is capable of understanding treatment goals, how the treatment works, and any necessary

follow-up care or actions. This might include the minor's ability to engage in therapy, express emotions, and communicate effectively.

This assessment might include direct observations, clinical interviews, and any standardized tools or assessments used to gauge the minor's maturity and provide specific examples of such. The documentation shall also note the applicable law and therapists' knowledge of the law.

PHI Breach Reporting

All PHI breaches must be reported to VCBH compliance **immediately or within 24 hours of discovery to *vcbh.compliance@ventura.org*.** This includes suspected or confirmed security incident, breach, ransomware event, or unauthorized disclosure involving member information.

- CBOs must implement internal policies and investigation processes for breaches.
- Breach outcomes and remediation steps must be submitted to VCBH Compliance ***vcbh.compliance@ventura.org*.** within 30 days of the initial incident discovery.

12.3 Mandatory Reporting Obligations

Mandated Reporting Basics

You are a mandated reporter **only while working in your official role**. Off duty, you are not.

Mandated reporters (teachers, health workers, social workers, etc.) must report suspected **child abuse, elder abuse, or dependent-adult abuse** when they:

- See abuse or neglect
- Hear about it
- Reasonably suspect it

Ventura County 24-hr Hotline: 805-654-3200

Child Abuse Reporting (CANRA: Penal Code §§ 11164–11174.3)

Abuse includes physical, sexual, emotional abuse, and severe neglect.

Neglect means failing to provide needed care.

How to report:

- Immediate phone report
- Written report within 36 hours (Form: Suspected Child Abuse Report – BCIA 8572) BCIA 8572, Suspected Child Abuse Report (ca.gov)

Elder & Dependent Adult Abuse Reporting (W&I Code §§ 15600–15675 and Penal Code § 368)

Who is protected:

- Elders: 65+
- Dependent adults: 18–64 with physical/mental limitations or in 24-hour care
- Types of abuse: physical, sexual, neglect, financial abuse, emotional abuse, abandonment, isolation.

How to report:

- Immediate phone report

- Written report within 2 working days (Form: SOC 341) SOC 341 (2/24) - Report of Suspected Dependant Adult-Elder Abuse
- Link to online report: Adult Protective Services – Human Services Agency

Documentation & Handling Reports

- Do not place Suspected Abuse Reports in the medical record
- Check with your Administrator to determine how to manage storage of this report
- Document in a progress note that a report was filed (e.g., worker name or report number)
- Remember: clients may see this note

Protection for Reporters

Immunity: No liability when reporting in good faith
Confidentiality: Your identity and the report are protected
Failure to report can lead to criminal charges and professional discipline

Tarasoff: Duty to Protect California Code, CIV 43.92 - to view California Legislature
If a patient poses a serious, imminent threat, clinicians must take steps to protect potential victims—this may include:

- Warning the potential victim
- Contacting law enforcement
- Psychiatric evaluation or hospitalization
- Notify your Administrator/supervisor immediately if a Tarasoff situation may arise
  Document every step and consult with supervisors or legal resources

12.4 Conflict of Interest and Ethical Considerations

Dual Relationships and Boundaries

Dual Relationships: Dual relationships occur when a Care Provider/Clinician has a relationship with a plan member that extends beyond the therapeutic/treatment one.

1. **Social or Personal Relationships:** Developing friendships or romantic relationships with a current or former plan member. Providers shall not provide therapy to someone with whom they have a personal relationship.
2. **Professional Relationships**: Such as becoming business partners or hiring a plan member for a job outside of therapy.

These relationships can be problematic because they can blur the lines of professional conduct and ethics, potentially harming the therapeutic relationship or exploiting the plan member's trust.

Therapy Never Includes Sexual Behavior - “Sexual contact of any kind between a therapist and a client is *unethical and illegal* in the State of California.” www.bbs.ca.gov

Appropriate Boundaries: Boundaries in therapy and case management refer to the limits and guidelines that define the professional plan member relationship.

1. **Physical Boundaries**: Maintaining appropriate physical distance and touch during sessions/meetings.
2. **Emotional Boundaries**: Ensuring that the therapist/case manager does not rely on the plan member for emotional support or disclose personal issues unrelated to therapy/treatment.
3. **Social Boundaries**: Avoiding socializing with plan members outside of therapy/treatment, including on social media, unless it is for therapeutic purposes and with clear boundaries set.

Setting and maintaining these boundaries is crucial for creating a safe and therapeutic environment where plan members can trust that their Care Provider/Clinician's actions are solely focused on their well-being.

Decision Making Frameworks

SMHS - In specialty mental health services, decision-making frameworks are crucial for guiding clinical practice, ensuring effective and ethical care, and meeting the complex needs of plan members. Here are several key frameworks and approaches used in this field:

1. Bio-Psycho-Social Model
2. Ecological Systems Theory
3. Strengths-Based Approach
4. Trauma-Informed Care
5. Cultural Competence and Humility
6. Evidence-Based Practice (EBP)
7. Ethical Decision-Making Models
8. Client-Centered Therapy
9. Motivational Interviewing (MI)
10. Systems Theory

These frameworks help guide Clinicians in making informed, ethical, and person-centered decisions in specialty mental health services. They support a comprehensive understanding of plan members' needs and ensure that interventions are tailored to their unique situations.

DMC-ODS - In substance use services, decision-making frameworks are crucial for guiding clinical practice, ensuring effective and ethical care, and meeting the complex needs of plan members. Here are several key frameworks and approaches used in this field:

1. ASAM Criteria
2. RIPTEAR Framework
3. Low-Barrier Models
4. Strategic Prevention Framework
5. Targeted Interventions
6. 3Cs Framework
7. Case Management

Ethical Consultation

Ethical consultation is an important process that helps mental health professionals resolve complex or uncertain ethical situations while ensuring compliance with professional codes, laws, and client welfare standards. In California, this process is guided by the expectations of licensing boards and professional associations. Please refer to your regulatory board or certifying body for more detailed information and to receive further consultation after having discussed the issue with your supervisor.

Liability Insurance

If you provide treatment services directly, it's advisable to secure your own liability insurance.

- **Personal Coverage**: *Agency policies may not cover you for all situations*, especially if a claim arises outside the scope of your employment or if you're working independently. Your own policy ensures you're fully protected.
- Overall, personal liability insurance is a proactive measure that can safeguard your career and reputation. If you have more questions about liability insurance, please consult your clinical supervisor. It's generally affordable and usually billed annually.

Conservatorships - Conservatorships | California Courts | Self Help Guide

A conservatorship in California is a court-ordered arrangement in which a judge appoints a conservator to manage the personal care or finances of an adult who cannot do so themselves. Courts usually prefer to appoint a family member or close friend as conservator, though professionals or organizations may also serve. There are two main types: a **Conservatorship of the Person**, which covers decisions about daily care, living arrangements, and medical needs, and a **Conservatorship of the Estate**, which involves managing the conservatee's finances. California also recognizes specific forms such as general probate conservatorships, limited conservatorships for adults with developmental disabilities, and LPS conservatorships for certain mental health situations.

- **Murphy Conservatorship - is a specific type of LPS conservatorship that targets individuals with chronic, severe mental illness who require involuntary psychiatric care due to repeated hospitalizations or long-term mental health needs.**

Duration and Termination

Conservatorships in California are generally considered temporary and can be terminated or modified. A conservatee, or the conservator, can petition the court to end the conservatorship if the conservatee's condition improves or if the conservatorship is no longer necessary**. In the case of LPS conservatorships, they can be renewed annually if the need for care continues.**

Behavioral Health Equity

Behavioral health equity is the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable healthcare services and support. To promote behavioral health equity, systems must *improve access to care, promote quality programs, and reduce persistent disparities in mental health and substance use services for underserved and historically marginalized communities*.

In conjunction with access to quality services, health equity involves addressing social determinants of health.

Social Determinants of Health (SDOH) are nonmedical factors that influence health and wellness outcomes. These include:

1. employment and housing stability
2. insurance status
3. proximity to services
4. culturally responsive care
5. access to healthy food
6. air and water quality (think contamination & pollution)
7. safe housing
8. language and literacy skills
9. poverty

By improving these conditions, we can help members obtain their highest level of health and wellness within their own set of circumstances. We do this by tailoring our member's care plan to respond to their unique needs and situation. One way to document a member's SDOH is by identifying Z-codes in client's chart.

Cultural Competency, Humility and Sensitivity

A provider can improve their quality of care by incorporating both cultural competency and cultural humility into their practice. The U.S. Department of Health and Human Services Office of Minority Health has outlined several concepts on how to do this:

- ***Cultural competency*** is a developmental process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations. Strategies for practicing cultural competency include:
  - ☐ Learning about your own and others' cultural identities
  - ☐ Combating bias and stereotypes
  - ☐ Respecting others' beliefs, values, and communication preferences
  - ☐ Adapting your services to each client's unique needs
  - ☐ Gaining new cultural experiences

Every Contracted Provider is required to complete Cultural Competency training once a year.

12.5 Annual Site Audits

Overview:

DHSC mandates annual contract audits for Ventura County Behavioral Health (VCBH) Providers including Medi-Cal Specialty Mental Health (SMH), DMC-ODS Substance Use Disorder (SUD), Substance Use Block Grant (SUBG), Behavioral Health Services Act (BHSA) and DUI Providers. Audits ensure compliance with contracts and applicable regulations while providing feedback to improve program operations.

Audit Frequency and Coordination

- SMH, DMC-ODS, BHSA and SUBG Providers: at least one audit per fiscal year
- DUI Providers: two audits per fiscal year
- On-site audits occur at least once every three years
    - Desk/Remote audits occur when onsite visit is not required
- Audits are coordinated by the PNM Compliance Department with the VCBH Audit Team (Fiscal, Operations, QA/Utilization Review).

Audit Preparation

- **Audit Tools**: Updated annually and tailored to contract scope and funding.
- **Pre-Audit**: VCBH Audit Team reviews contracts, budgets, staffing, policies and previous contract and audit documentation.
- **Roles**:
    - **PNM Compliance**: Contract requirements, Audit Tool preparation, documentation collection, Collaboration with Providers, General Contract and Staffing standards, issuing and monitoring Corrective Action Plans (CAPs)
    - **Operations Manager**: Program performance, facilities standards review, incident reports
    - **Fiscal**: Budget, expenditures, billing/invoicing and fiscal compliance
    - **Quality Assurance/Utilization Management**: Utilization review, chart audits

Audit Process

Notification: Provider receives notice at least one month prior, including audit purpose, tool, schedule, list of audit team members and documentation requirements with deadlines.

Entrance Conference: Review audit format, expectations, timelines and documentation with Provider

Information to be reviewed by VCBH Auditors

a. General Contract Standards
b. Staffing Standards
c. Fiscal Standards
d. Quality and Utilization Management
e. Physical Plant/Facility Standards
f. Operations/Scope of Work

Audit Execution:

- Audit team review Program Operations, Fiscal, QA/UM, Facilities, Staffing and Contract compliance
- Pre-reviewed forms and policies are filled into audit tool to reduce duplicative documentation
- Provider is offered technical assistance to meet the standards and deadlines

- Tracker used to document audit due dates and milestones
  Exit Conference (optional): Provider will receive an invite to discuss audit findings; Provider has 30 days to provide clarifications when a CAP is issued.

Required Audit Reporting and Follow-Up

- Audit report and Corrective Action Plan (CAP) are sent to Provider, VCBH leadership and DHCS.
- Provider CAP responses reviewed for timeliness, adequacy and any unresolved issues may result in corrective actions, withheld payments, contract modifications, or termination.
- PNM Compliance coordinates resolution and ensures timely closure and reporting of audit findings.

12.6 Code of Conduct

All contractors and their staff must adhere to the following code of conduct.

Professional Standards

- Treat all members, families, and colleagues with respect and dignity.
- Maintain professional boundaries at all times.
- Provide services without discrimination based on race, ethnicity, national origin, religion, sex, age, disability, sexual orientation, or gender identity.
- Comply with all applicable professional licensing board standards.
- Report suspected fraud, waste, abuse, or violations of law.

Prohibited Activities

Staff shall not:

- Accept gifts, gratuities, or personal benefits from members or families.
- Engage in romantic or sexual relationships with current members.
- Use member information for personal gain.
- Provide services while under the influence of alcohol or controlled substances.
- Engage in any form of harassment, abuse, or exploitation.

12.7 Prohibited Associations

Contractors may not employ or contract with individuals who:

- Are excluded from participation in federal healthcare programs (check SAM.gov and OIG LEIE).
- Have been convicted of healthcare-related fraud or patient abuse.
- Have had professional licenses revoked or suspended.

Verification Requirement: Screen all employees and contractors monthly against exclusion databases. Maintain documentation of screening results.

Exclusion Notification: 2-Business-Day Written Notice to VCBH

Notification Upon Discovery of Excluded or Debarred Person or Entity

If at any time a Contractor discovers — through monthly screening, a report, or any other means — that any employee, contractor, subcontractor, officer, director, owner, or managing employee has been

excluded, debarred, suspended, or listed on the OIG LEIE, SAM.gov, or the DHCS Suspended and Ineligible (S&I) Provider List, the Contractor must take all of the following actions:

1. Immediately cease allowing the excluded individual or entity to provide, direct, supervise, or receive payment for Covered Services.
2. Notify VCBH in writing within two (2) business days of discovery. Send written notice to PNMcontracts.vcbh@venturacounty.gov. The notice must include: (a) full name of the individual or entity; (b) the nature and basis of the exclusion, debarment, or suspension; (c) the date of discovery; and (d) a description of the immediate remedial actions taken.
3. Retain complete documentation of the discovery, the written notification to VCBH, and all remedial actions for the period required under the record retention requirements of this Guide.

Failure to notify VCBH within the required two (2) business days is an independent basis for corrective action, payment withholding, or contract termination — separate from the underlying exclusion event itself. (PSA §2.4; 42 CFR §§455.436 and 438.602(d))

12.8 Good Neighbor Policy

Contractors operating facilities in residential areas must maintain positive community relations by:

- Maintaining facilities in good repair and attractive appearance.
- Addressing noise complaints promptly.
- Ensuring adequate parking and traffic management.
- Responding to community concerns within 48 hours.
- Reporting community complaints to VCBH within 5 business days.

12.9 Federal Funding Requirements

Byrd Amendment - Lobbying Restrictions

If your contract uses federal funds and exceeds $100,000, you must comply with the Byrd Amendment (31 U.S.C. § 1352), which prohibits use of federal appropriated funds for lobbying.

Certification Required: Complete and submit the Byrd Amendment Certification Form (see Appendix D) with your contract.

Prohibited: You may not use federal contract funds to pay anyone to influence federal or state officials regarding the award, continuation, or modification of the contract.

Penalties: Violations may result in civil penalties of $10,000 to $100,000 per violation.

Notification of Federal Funding

Contracts funded in whole or in part by federal funds are subject to all applicable federal requirements including but not limited to:

- Federal procurement standards (2 CFR Part 200)
- Anti-lobbying restrictions (31 U.S.C. § 1352)
- Non-discrimination requirements
- Labor standards (where applicable)

- Environmental standards (where applicable)

12.10 Non-Discrimination Program Requirements

All contracted providers must comply with applicable federal and state non-discrimination laws and regulations, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA), Title II of the ADA, Section 1557 of the Affordable Care Act, California Government Code § 12990, and the Unruh Civil Rights Act. Discrimination on the basis of race, color, religion, national origin, sex, age, disability, sexual orientation, gender identity, marital status, or any other protected class is prohibited in the provision of services, employment practices, and all activities under the contract.

Required Written Policy

Each contracted provider must maintain a written non-discrimination policy that: (a) is distributed to all staff and posted in a visible location at each service site; (b) identifies a designated person responsible for receiving and responding to non-discrimination complaints; (c) describes the internal complaint process; and (d) includes notice that members may file discrimination grievances directly with VCBH, the DHCS Office of Civil Rights, and the U.S. Department of Health and Human Services Office for Civil Rights.

Member Complaint Process

A member who believes they have experienced discrimination in the delivery of services may file a grievance with the provider's designated complaint contact, with VCBH's Member Services, or directly with the Office for Civil Rights (HHS) at (800) 368-1019 or www.hhs.gov/ocr. Providers must forward any discrimination grievance received from a member to VCBH within twenty-four (24) hours of receipt.

Equal Employment Opportunity

Contractors with fifty (50) or more employees who receive contracts of $50,000 or more are required to develop and maintain a written Affirmative Action Plan consistent with California Government Code § 12990. VCBH may request a copy of the plan during annual audits.

12.11 Drug-Free Workplace

All contracted providers must comply with the California Drug-Free Workplace Act of 1990 (Government Code §§ 8350–8357) and, where applicable, the federal Drug-Free Workplace Act of 1988 (41 U.S.C. § 8101 et seq.). Providers receiving contracts of $25,000 or more from a federal agency must maintain a drug-free workplace certification as a condition of the contract.

Required Actions

Each contracted provider must: (a) publish and distribute to all employees a written drug-free workplace policy statement prohibiting the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in the workplace; (b) establish an ongoing drug-free awareness program informing employees about the dangers of drug abuse, the provider's drug-free workplace policy, available counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed on employees for drug violations; (c) notify employees that compliance with the drug-free workplace policy is a condition of employment; and (d) notify VCBH within ten (10) days of receiving notice that an employee has been convicted of a criminal drug violation occurring in the workplace.

Note Regarding Clinical Staff

The drug-free workplace policy applies to all staff, including clinical and administrative employees. Separately, Section 12.6 of this Guide prohibits any staff from providing services while under the influence of alcohol or controlled substances. These are independent obligations and both apply.

12.12 Physician Incentive Plans

This section applies to contracted providers who employ or contract with physicians, psychiatrists, or other licensed clinical practitioners to deliver covered services. It does not apply to non-clinical service vendors.

Disclosure Requirement

If a contracted provider uses a physician incentive plan (PIP) or any compensation arrangement — whether for individual practitioners or at an organizational level — that may affect the referral of services or the provision of covered services under the contract, the provider must disclose the existence and material terms of that arrangement to VCBH. Disclosure must be made: (a) prior to execution of the contract; and (b) within thirty (30) days of any material change to the arrangement.

What to Submit

The PIP disclosure must describe: (a) the type of incentive arrangement (e.g., capitation, withholds, bonuses, shared savings); (b) the services or referrals affected; (c) whether the arrangement places any individual practitioner at substantial financial risk for services they do not directly provide; and (d) any stop-loss or other risk mitigation protections in place. Submit disclosures to VCBH Provider Network Management Contracts at PNMcontracts.vcbh@venturacounty.gov.

Prohibited Arrangements

No incentive arrangement may be used that: (a) specifically rewards reductions or limitations in covered services that are medically necessary; (b) places a practitioner at substantial financial risk without adequate stop-loss protections as defined under 42 CFR §§ 422.208 and 422.210; or (c) uses withholds, bonuses, or capitation in a way that may negatively affect the quality of care provided to members. VCBH reserves the right to audit any PIP arrangement at any time and may require modifications to bring a plan into compliance.

12.13 Artificial Intelligence – Use Restrictions and Disclosure Requirements

Contracted providers are subject to restrictions on the use of artificial intelligence (AI) tools in connection with client information and County data. These requirements are set out in the Provider Services Agreement and summarized here for reference.

Prohibition on Use of Client Information with AI Systems

Contractors shall not submit, upload, input, or otherwise transmit client records, Protected Health Information (PHI), DHCS encounter data, or any other personally identifiable information of individuals receiving services under the contract to any generative artificial intelligence system, large language model (LLM), machine learning platform, automated decision-support tool, or similar technology — whether commercially available, open-source, or proprietary — without prior written approval from

VCBH's Privacy Officer. This prohibition applies regardless of whether the tool is marketed as HIPAA-compliant or subject to a separate vendor Business Associate Agreement.

This prohibition applies to all uses of AI tools in connection with work performed under the contract where client information is involved, including clinical documentation, summarization or analysis of client records, automated billing or claims preparation, service coordination workflows, and any other function in which client information could be transmitted as input to, or used as training data by, the AI system.

Basis for This Requirement
This requirement flows from VCBH's obligations under the DHCS Integrated Agreement Contract 24-40149, Exhibit A, Section 11 (GenAI Technology Use & Reporting), which obligates VCBH to notify DHCS of any generative AI (GenAI) technology in use — including technology used by VCBH's contracted providers — and to complete the DHCS GenAI Reporting and Factsheet (STD 1000) as required. A contractor's failure to provide timely disclosure to VCBH may impair VCBH's ability to meet its reporting obligations to DHCS and may constitute a breach of the contract.

Disclosure Obligation
Contractors shall notify VCBH in writing prior to executing the contract if any services, workflows, documentation practices, or systems the Contractor intends to use in performance of the contract include, or are made available through, any generative artificial intelligence (GenAI) technology, including large language models (LLMs), automated documentation tools, decision-support platforms, or similar AI-driven technology, whether provided by a third-party vendor or developed or deployed internally. After executing the contract, Contractors shall provide similar notice before deploying any such technology, and within ten (10) business days of identifying any previously unreported GenAI technology in use.

Written AI Policy and Subcontractors
Contractors shall maintain a written policy governing the use of AI tools by personnel who have access to client information under the contract, and shall provide a copy to VCBH upon request. Contractors shall include equivalent AI use restrictions in all subcontractor agreements through which a subcontractor may access, receive, or process client information, and are responsible for ensuring subcontractor compliance.

County AI Policy
If the County of Ventura adopts or has adopted a policy governing the use of artificial intelligence by county contractors, Contractors shall comply with that policy to the extent it applies to their contract, as notified in writing by VCBH. VCBH will provide a copy of the applicable provisions and a reasonable implementation period of not less than sixty (60) days following written notice.

Section 13 – Training and Education

13.1 Training and Education Requirements

Providers must participate in:

- Initial Orientation and Onboarding
- Mandatory trainings (e.g., cultural competence, privacy, compliance)
- Ongoing updates provided by VCBH Plan

Training

Training and orientation are essential components of onboarding new contractors. VCBH offers trainings via Cornerstone Learning Management System.

- VCBH Plan Providers are expected to complete the trainings listed as mandatory in the VCBH Mandatory and Professional Development Training Policy.
- VCBH Plan Providers will be audited by the Provider Network Compliance Team to ensure these requirements are being met.
- The Provider/Contractor (CBO Liaison) will be identified and given access to the Cornerstone system.
- The Provider (CBO Liaison) will be assigned mandatory trainings via their Cornerstone account.
- The Provider (CBO Liaison) will complete the assigned trainings themselves.
    - The Provider then determines whether they would like to utilize the County trainings to meet their contract requirements to train their staff.

      OR
    - Alternatively, the Provider may identify and implement comparable staff training that meets these requirements.
- If there are questions regarding trainings themselves Providers can email VCBH.Training@venturacounty.gov.
- Please remember to contact your VCBH Manager Liaison with questions as well, as they are your primary point person.

13.2 Professional Development

Practitioners must comply with continuing education requirements per their licensure board and or certifying board.

Clinical Supervision

Clinical supervision is a structured process where a more experienced clinician provides guidance, support, and oversight to a less experienced practitioner. It is the responsibility of the practitioner, with the help of their supervisor, to locate appropriate clinical supervision support. **All supervisors and supervisees MUST maintain active license/certification and/or registration with their CA Governing Board and follow all legal and ethical requirements.**

13.3 Required Trainings

As indicated above, Contracted Providers must comply with maintaining training records and with reporting requirements, as outlined in the fully executed provider contract with VCBH. Compliance evidence may include evidence of compliance including attendance records, training reports, handouts, and other training documentation. Contracted Providers are required to provide and ensure participation in all mandatory trainings either by registering staff in VCBH provided trainings, or establishing their own trainings, ensuring regulatory compliance. Please see **Mandatory and Professional Development Training**" policy.

Section 14 – Appendices

Appendix A – Glossary (defines key Medi-Cal and Plan terms)

Abuse: Provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medi-Cal program

Appeal: A review by the Contractor of an adverse benefit determination or a denial to expedite an authorization decision.

Assessment: Service activity which may include a clinical analysis of the history and current status of a person in care's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Behavioral Health Services Act (BHSA): The Behavioral Health Services Act replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders (SUD), expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels.

CFR 42 Part 2: Code of Federal Regulations sets forth the amended statutory authority for the confidentiality of alcohol and drug abuse patient records.

Claim: A request for payment that a care provider submits to a health care plan, like Ventura County Behavioral Health (VCBH), or a plan administrator, like the Department of Health Care Services (DHCS), when a person in care receives services.

Clean Claim: A claim with no errors or omissions sent from a provider, requesting payment for a service provided to a person in care.

Client Plan (Clinical): Also known as "care plan" or "treatment plan," a plan for the provision of behavioral health services and supports for persons who meet eligibility criteria for SMHS and DMC-ODS services requiring an authorized Plan.

Clinical Trainee: A clinical trainee is 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; 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, including, but not limited to, all coursework and supervised practice requirements.

Cognitive Behavioral Therapy (CBT): A form of talk therapy that helps individuals identify and change unhelpful or unhealthy thought patterns and behaviors. It is based on the core principle that a person's thoughts, feelings, and behaviors are all interconnected and that by changing one, a person can affect the others and improve their well-being. CBT is a problem-focused, goal-oriented, and typically short-term approach that concentrates on current challenges rather than past events.

Community Health Worker (CHW): CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served. Historically, CHWs have been employed across public health, medical, and behavioral health settings CHWs must demonstrate minimum qualifications. Please follow links for more information: CHW-Qualifications-and-Supervising-Provider-Requirements-FAQ & Community Health Workers

Community Based Organization (CBO): Entities contracted with Ventura County Behavioral Health (VCBH), to provide services to clients.

Contingency Management: An evidence-based, cost-effective behavioral treatment for SUD that provides motivational incentives to treat individuals and reinforces positive behavior change for an individual to reduce the use of substances such as stimulants and opioids.

Continuing Education (CE): Designated units of participation in one-hour increments in an approved or accredited program designed for professionals with certificates or licenses related to professional practice.

Contract: Any authorized County agreement (purchase order, contract, Memorandum of Agreement, etc.) for the procurement of supplies, equipment, services, or construction. Contracts are subject to the procurement standards and sole source requirements in accordance with 2 CFR 200.317-200.326.

Contract Monitoring: Review of a variety of administrative, programmatic, clinical, and fiscal activities of the Community Based Organizations (CBO) contract providers (Contractors). These activities include but are not limited to; review of reporting documents, fiscal documentation, site visits, desk audits, and other analyses of services provided.

Contracted Provider: All network providers (including providers owned or operated by VCBH), and any out-of-network providers with whom VCBH contracts for the delivery of covered services to members.

Corrective Action Plan (CAP): A step-by-step plan of action that is developed to achieve targeted outcomes for resolution

Credentialing: The process of checking and confirming that a provider's qualifications, licenses, and experience meet the standards to provide care and bill Medi-Cal and Medicare.

Crisis Intervention: Service, lasting less than 24 hours, to or on behalf of a youth for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per instance.

Crisis Stabilization: Means a service lasting less than 24 hours, to or on behalf of a plan member for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24-hour health facility or hospital–based outpatient program or at other provider sites which have been certified by the department or a Mental Health Plan to provide crisis stabilization services.

Current Procedural Terminology (CPT): A uniform language for coding health care services and procedures to streamline reporting, increase accuracy and efficiency. CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category. CPT code descriptors are clinically focused and use common standards to make sure different people have a common understanding across care delivery.

Day Rehabilitation: Is a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty–four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Dependent Procedure: These are procedures that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes). Dependent procedures cannot be billed unless the provider first bills primary procedure to the same member by the same rendering provider on the same date on the same claim.

Dialectical Behavior Therapy (DBT): A type of talk therapy for people who experience emotions very intensely. It's a common therapy for people with borderline personality disorder, but therapists provide it for other mental health conditions as well.

Direct Patient Care: If the service code billed is a patient care code, direct patient care means time spent with the patient for the purpose of providing healthcare. Counties should only consider direct patient care time, as defined in the billing manual, when choosing the most appropriate code to bill. However, this does not mean that counties would not be reimbursed for activities such as chart review, documentation, and other activities associated with preparing to see a patient or post service time. The rates DHCS pays to counties are adjusted to incorporate the cost for staff time not spent on direct patient care, which includes activities the provider engages in before and after seeing a patient, and "no shows".

Discrimination Grievance: A complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including 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.

Department of Health Care Services (DHCS): The State Agency that oversees California's Medi-Cal program and the implementation of MHSA.

Drug Medi-Cal Organized Delivery System (DMC-ODS): A continuum of care system for providing substance use disorder treatment services. A Medi-Cal SUD delivery system to provide SUD treatment services to members in counties that choose to opt into and implement the program

Expedited Appeal: An Expedited Appeal can be requested when the plan member or the provider determines that the 30-day timeframe of the standard appeal resolution process would seriously jeopardize the plan member's life, health or ability to attain maintain or regain maximum function. This appeal may be submitted orally, without a written appeal. The expedited appeal must be resolved within 72 hours from the time Ventura County Behavioral Health receives the appeal.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law.

Fee-for-service (FFS): A method of payment, in which care providers are paid for each service performed.

Full-Service Partnership (FSP): A special program funded under Mental Health Services Act (MHSA) that provides a full spectrum of mental health services to children/youth and transition age youth who are seriously emotionally disturbed and adults and older adults who have a serious mental health disorder and are unserved or underserved and at risk of homelessness, incarceration, hospitalization, or institutionalization. The term "partnership" is used to emphasize the collaborate work between service providers, the client, significant others, peers, and other community supports – partners all working together towards the achievement of client goals. Individuals enrolled in an FSP may qualify for basic needs supports.

Grievance: Verbal or written expression/complaint of dissatisfaction about anything other than an Adverse Benefit Determination. Grievance may include but not limited to:

- The quality of care or services provided.
- Aspects of interpersonal relationships such as rudeness of a provider or employee.
- Failure to respect the person's rights regardless of whether remedial action is requested.
- A person's right to dispute an extension of time proposed by the Ventura County Mental Health/Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan to make an authorization decision.

Group Practice: The entity that owns and is responsible for the member's medical record describing the services provided by a licensed or pre-licensed professional. If professional services are provided to the member by county-operated and/or county-employed health care professionals, the BHP is considered to be the "group practice" because the BHP owns and is responsible for the member's medical record. If the member receives their specialty mental health services from a county-contracted provider (a community-based organization or other provider), then the clinic or the clinic's owner in that location owns and is responsible for the member's medical record. If a psychiatrist, advanced practice nurse and physician assistant all work for a practice at a discrete location, then that practice owns the medical record and is considered the group practice. If the psychiatrist owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the psychiatrist, then the psychiatrist-owner is considered to be the group practice as he/she owns and is responsible for the member's medical record.

International Classification of Diseases - Clinical Modification (ICD-10-CM) Codes: Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).

Intensive Care Coordination (ICC): Service that is responsible for facilitating assessment, care planning, and coordination of services, including urgent services, to foster and/or probation involved youth. Includes work within the Child & Family Team (CFT) to ensure that plans from any of the system partners (mental health, child welfare, education services, probation, etc.) are integrated to comprehensively address goals and objectives. Also includes facilitation and participation in CFTs and team coordination to ensure participation by the child or youth, family or caregiver and other natural or paid supports so that the assessment and plan addresses the child or youth's needs and strengths in the context of the values and philosophy of the Pathways to Mental Health Core Practice Model.

Intensive Home-Based Services (IHBS): Services are individualized, strength-based interventions designed to address behaviors and/or symptoms that interfere with a youth's functioning. Interventions are aimed at helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community. Must be determined necessary by the CFT and documented in the CFT action plan.

Legally Authorized Representative (LAR): Parent, caregiver, guardian, conservator, or any other court ordered entity authorized to make treatment decisions.

Lockouts: Lockouts are codes that cannot be billed together.

Medication Support Services: Services provided by medical staff which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for

medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the youth.

Overpayment: Any payment made to a contracted provider by VCBH to which the contracted provider is not entitled under Title XIX of the Social Security Act.

Peer Support Specialist: A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing educational requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

Plan Development: Service activity which consists of development of plans, approval of plans, and/or monitoring of a person in care's progress.

Plan Member: Any persons certified as eligible under the Medi-Cal Program according to Title 22, Section 5100.2.

Revenue codes: Codes that explain in what capacity the reported charges and HCPCS code apply in the related line.

Service Line: A line on the claim describing one service and containing one procedure code. A service line can contain multiple units of one procedure code but cannot contain more than one procedure code.

Specialty Mental Health Services (SMHS): A variety of services covered by Medi-Cal and provided by VCBH and contracted providers. Generally, SMHS are more intensive and provide more support than the mental health services that are covered by a Managed Care Plan.

Substance Use Block Grant (SUBG): The Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG for short) program provides funds to all 50 states to help plan, implement, and evaluate activities that prevent and treat substance use.

Targeted Case Management (Case Management/ Brokerage/Linkage): Services that assist a person in care to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of individual progress.

Telehealth: The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care

management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. (Telehealth includes telemedicine.) (Business and Professions Code section 2290.5(a)(6))

Therapy: Service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the person in care is present. Therapy may only be provided by LPHA staff or Psychiatrists/ Psychiatric Nurse Practitioners.

Waste: Generally understood to mean the overutilization or inappropriate utilization of services and misuse of resources and typically is not a criminal or intentional act. Extravagant, careless, or needless expenditure of funds or consumption of resources that results from deficient practices, poor systems controls, or bad decisions. Waste may or may not provide any personal gain. Waste is not necessarily illegal; however, it hurts the organization by depleting its resources.

Appendix B – Acronyms Index

ADA: Americans With Disabilities ACT
ACT: Assertive Community Treatment
ADHC: Adult Day Health Care Centers
APCC: Associate Professional Clinical Counselor
AMFT: Associate Marriage and Family Therapist
ACSW: Associate Clinical Social Work
AOD: Alcohol or Other Drug Counselor
AOT: Assisted Outpatient Treatment
ASAM: American Society of Addiction Medicine
BHAS: Behavioral Health Accountability Sets
BHBH: Behavioral Health Bridge Housing
BHIN: Behavioral Health Information Notice
BHP: Behavioral Health Plan
CBO: Community-Based Organization (contracted providers)
CBT: Cognitive Behavioral Therapy
CalAIM: California Advancing and Innovating Medi-Cal
CANS: Child and Adolescent Needs and Strengths
CALMHSA: California Mental Health Services Authority
CAP: Corrective Action Plan
CARE ACT: Community Assistance Recovery, and Empowerment Act
CEU: Continuing Education Unit
CIN: Client Identification Number
CHW: Community Health Workers
CMS: Centers for Medicare & Medicaid Services
CPS: Consumer Perceptions Survey
CPT: Current Procedural Terminology
CSC: Coordinated Specialty Care
DBT: Dialectical Behavior Therapy
DHCS: Department of Healthcare Services
DMC: Drug Medi-Cal
DMC-ODS: Drug Medi-Cal Organized Delivery System
DSM: Diagnostic and Statistical Manual of Mental Disorders
EHR: Electronic Health Record
EBP: Evidenced Based Practices
EPSDT: Early Periodic Screening, Diagnosis and Treatment
ERSES: Educationally Relayed Social Emotional Services
FACT: Forensic Assertive Community Treatment
FDA: U.S. Food and Drug Administration
FFS: Fee-for-Service

FSP: Full-Service Partnership
FWA: Fraud, Waste, and Abuse
HCPCS: Healthcare Common Procedure Code System
HEDIS: Healthcare Effectiveness Data and Information Sets
HIPAA: Health Insurance Portability and Accountability Act
IHBS: Intensive Home-Based Services
LAR: Legal Authorized Representative
ICC: Intensive Care Coordination
ICD-10: International Classification of Diseases, Tenth Revision
ISP SEP: IPS Supported Employment
LAR: Legally Authorized Representative
LAI: Long-acting injectable
LCSW: Licensed Clinical Social Work
LOA: Leave of absence
LPCC: Licensed Professional Clinical Counselor
LMFT: Licensed Marriage and Family Therapist
LPHA: Licensed Practitioner of the Healing Arts
MAT: Medication for Addiction Treatment
MTA: Medication Treatment Agreement
MCO: Managed Care Organization
MCP: Managed Care Plan
MHC: Mental Health Counselor
BHP: Mental Health Plan
MIST: Misdemeanor Incompetent to Stand Trial
MST: Multisystemic Therapy
NPI: National Provider Identifier
NOABD: Notice of Adverse Benefit Determination
NPPES: National Plan and Provider Enumeration System
NTP: Narcotic Treatment Program
OTP: Opioid Treatment Program
PIMS: Provider Information Management System
PIP: Performance Improvement Project
PSC-35: Pediatric Symptoms Checklist
PSS: Peer Support Specialist
OHC: Other Health Coverage
QA: Quality Assurance
QI: Quality Improvement
QIC: Quality Improvement Committee
RISE: Rapid Integrated Support and Engagement
ROI: Release of Information
SDOH: Social Determinants of Health

SMHS: Specialty Mental Health Services
SSDI: Social Security Disability Income
SSI: Supplemental Security Income
SUD: Substance Use Disorder
SUS: Substance Use Services
SUTS: Substance Use Treatment Services
TAY: Transitional Age Youth
TBS: Therapeutic Behavioral Services
TAR: Treatment Authorization Request
TCM: Targeted Case Management
TFC: Therapeutic Care
TPO: Treatment, Payment, and Operations
TPS: Treatment Perception Survey
UR: Utilization Review
UM: Utilization Management
VCBH: Ventura County Behavioral Health
VCPOP: Ventura County Power over Prodromal Psychosis
WM: Withdrawal Management

Appendix C – Key Contacts

- **Contracts Department:** Contracts.VCBH@venturacounty.gov
- **Provider Relations:** PNMRelations@venturacounty.gov
- **PNM Compliance (contract non-compliance, annual site audits, etc.):** PNM.Compliance@venturacounty.gov
- **Quality Improvement:** VCBH.Quality@venturacounty.gov
- **Quality Assurance:** VCBH.QA@ventura.org
- **Training:** VCBH.Training@venturacounty.gov
- **Utilization Management:** QM.UR@venturacounty.gov
- **Billing:** BH_Billing@ventura.org
- **Compliance (violations, incident reports, etc.):** VCBH.Compliance@ventura.org

Appendix D – Forms and Templates

The following forms and templates are available on the VCBH website or by request from the Contracts Team. Fillable versions are provided as separate documents.

D.1 Monthly Invoice Template

The invoice template includes:

- Header fields: Contractor Name, Contract Number, Billing Period, Invoice Number, Date
- Service Detail Table: Member ID, Date of Service, Service Type, Units, Rate, Amount
- Summary Section: Total Units, Total Amount, Credits, Net Amount Due
- Certification Statement
- Signature block: Authorized Signature, Name, Title, Date

D.2 Corrective Action Plan (CAP) Template

The CAP template includes:

- Contractor information
- Deficiency/Non-Compliance description
- Root Cause Analysis
- Specific Corrective Actions (numbered list)
- Responsible Party for each action
- Timeline for completion
- Method to measure effectiveness
- Prevention of recurrence

D.4 Quarterly Report Template

The Quarterly Report template covers:

- Service volume by type
- Performance metrics against standards
- Quality improvement activities
- Staffing changes
- Member satisfaction results
- Incidents/grievances summary

D.5 Incident Report Form

The Incident Report form captures:

- Date/time of incident
- Member information (ID only)
- Type of incident
- Description of what occurred
- Staff involved
- Immediate actions taken
- Follow-up required
- Supervisor notification

D.7 Clinical Record Review Checklist

The checklist covers:

- Assessment completed within timeframe
- Treatment plan present and current
- Medical necessity documented
- Progress notes timely and complete
- Required signatures present
- Informed consent obtained
- Privacy practices acknowledgment

D.8 Byrd Amendment Certification Form

Includes the standard federal certification with:

- Three-part certification statement per 31 U.S.C. § 1352
- Signature block
- Warning about penalties ($10,000 to $100,000 per violation)

D.9 VCBH Subcontractor Approval Form

Required per Provider Services Agreement §2.5. This form must be completed and submitted to the VCBH Contracts Department before any subcontracting arrangement is entered into. The form captures Contractor information, proposed Subcontractor details, subcontract scope, and Contractor representations and warranties. The VCBH Contracts Department uses this form to initiate the approval review process.

The VCBH Subcontractor Approval Form is available as a fillable document that can be found Provider Resources - Ventura County Behavioral Health and can also be requested from the VCBH Contracts Department (Contracts.vcbh@venturacounty.gov). See Section 2.5 of this Guide for complete submission requirements and instructions.

D.10 VCBH Consent to Assignment Agreement

Required per Provider Services Agreement §2.6. This agreement is used to formalize County consent to any assignment of the Provider Services Agreement. It is executed by the County of Ventura, the Assignor (current Contractor), and the Assignee (receiving party), and documents the assignment, assumption of obligations, insurance confirmation, and County's consent.

The VCBH Consent to Assignment Agreement can be found via Provider Resources - Ventura County Behavioral Health and can also be requested from the VCBH Contracts Department (Contracts.vcbh@venturacounty.gov). See Section 2.6 of this Guide for complete submission requirements and instructions.

Appendix E – County Administrative Requirements

E.1 Assurance Regarding Use of Small, Minority, and Women-Owned Businesses

Contractor assures that it will make good faith efforts to utilize small business, minority-owned business enterprises, and women-owned business enterprises as subcontractors when possible. A small business is an independently owned and operated business which is not dominant in its field and employs fewer than 100 persons.

Good faith efforts include:

- Placing qualified small and minority businesses on solicitation lists
- Ensuring small and minority businesses are solicited whenever they are potential sources
- Dividing total requirements into smaller tasks or quantities to permit maximum participation
- Establishing delivery schedules which encourage participation
- Using services of Small Business Administration and minority business assistance offices

E.2 Cross-Reference Table for County Requirements

County Requirement	**Where Covered in This Guide**
Code of Conduct	Section 12.6 - Professional Standards and Prohibited Activities
Prohibited Associations	Section 12.7 - Exclusion Screening Requirements
Good Neighbor Policy	Section 12.8 - Community Relations
Quality Management Program	Section 9 - QA/QI Requirements
Utilization Review	Section 8 - Utilization Management
Certification of Claims	Section 11.7 - Invoice Certification
Lobbying Restrictions (Byrd Amendment)	Section 12.9 and Appendix D.8
Small Business Assurance	Appendix E.1
ISL Data Reporting (New)	Section 11.10 - Individual Service Level (ISL) Data Reporting
AI Use Restrictions	Section 12.14 - Artificial Intelligence – Use Restrictions and Disclosure Requirements

Appendix F– Regulatory References

Key regulations applicable to DCHS contractors:

- *California Code of Regulations* Title 9, Division 1, Chapter 3 (SMHS)
- Health and Safety Code § 11834 et seq. (DMC-ODS)
- Welfare and Institutions Code §§ 5600-5778 (Mental Health Services)
- 42 U.S.C. § 1396d(r) (EPSDT)
- 45 CFR Parts 160 and 164 (HIPAA)
- 42 CFR Part 2 (Substance Use Disorder Confidentiality)
- 31 U.S.C. § 1352 (Byrd Amendment)
- 2 CFR Part 200 (Uniform Administrative Requirements for Federal Awards)
- 42 CFR § 438.608 (Program Integrity Requirements)
- Title 22 CA Code of Regs as applicable to DMC-ODS
- Medi-Cal Contractual Requirements
- DHCS Behavioral Health Information Notices (BHINs)
- Applicable Medi-Cal State Plan and Federal Requirements