Annual DMC-ODS Training
FY 2024-25

County of San Diego Health and Human Services Agency

Behavioral Health Services
Health Plan Operations Unit
Drug Medi-Cal Organized Delivery System

1

FY 24-25 DMC-ODS Annual Training

- Everyone is muted on entry
- Questions will not be answered during the training, please put questions in the chat
- QA will send out a Q&A following the training
- The training is being recorded and will be available on Optum
- All information is accurate as of August 22, 2024
  - For future updates, please reference any communications from BHS, including the monthly Up To the Minute (UTTM)
- Attendance today is being tracked.

2

2

FY 24-25 DMC-ODS Annual Training

- "Big Picture" updates – State and County level
- Review DMC-ODS Requirements
- BHINs to know from the last year
- Other Intergovernmental Agreement Requirements

3

3

BHS HPO LEADERSHIP TEAM DMC-ODS

- Tabatha Lang, Operations Administrator
- Noelle Vitor, Behavioral Health Program Coordinator, SUD QA Team
  - Diana Daitch Weltsch and Glenda Baez, SUD QA Supervisors
- Erin Shapira, Program Coordinator, BHS Quality Assurance
  - Malisa Touisithiphonexay, AA3
- Alfie Gonzaga, Program Coordinator, Health Plan Administration
- Becky Ferry-Rutkoff, IT Principal
  - Cynthia Emerson, SUD MIS Manager, Principal Administrative Analyst

4

4

BHS QA SUD TEAM

- Charissa Allen
- Blanca Arias
- Tara Benintende
- Natalie Capra
- Melissa Geiger
- David Kim
- Helen Kobold
- Kevin Kolodziej
- Tammy Pham
- Jennifer Zapata

5

5

Annual Training State and County Updates

6

CalAIM Behavioral Health Initiatives-2023

Policy:	Launch Date:	Major Milestones:
Standardized Screening and Transition Tools	January 2023	BHIN 22-065, APL 22-028, Adult Screening Tool, Youth Screening Tool, Transition of Care Tool, Translations (12 languages), Informational Webinars (6 total)
Behavioral Health Payment Reform	July 2023	BHIN 23-036, BHIN 23-026, BHIN 23-023, BHIN 23-017, BHIN 23-013, BHIN 22-046, Fact Sheet.
Medi-Cal Mobile Crisis Services	January 2023 Rolling implementation	SPA 22-0043
Justice Involved Initiative	SPA Approved January 2023 Multi-phase implementation	Webpage BHIN 23-059
Behavioral Health Administrative Integration	January 2025/January 2027	Concept Paper (January 2023), Informational Webinars, Early Implementers Workgroup.

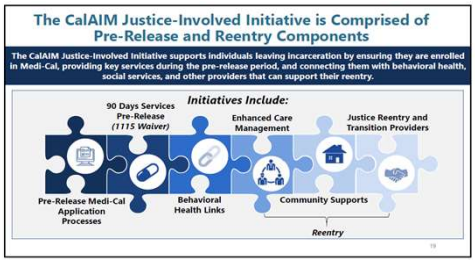
7

State's Audit Process for Counties

- Updated beginning FY 23-24
  - Systemic Focus
  - Continued focus on FWA for recoupment rather than isolated errors
  - One onsite process when Specialty Mental Health Services and DMC-ODS audits occur in the same year
  - Counties are provided the opportunity to officially respond to audit findings before release of the report

8

Justice Involved Initiative



9

Justice Involved Initiative – cont'd

- Targeted pre-release services within the 90-day period prior to release to support transition from correctional facility
- Pre-release service providers will determine need for Behavioral Health Links

10

Justice Involved Initiative – cont'd

- BH Links promote continuity of treatment and correctional facilities are required to facilitate referrals/links to post-release behavioral health provider and share information with the individual's Health Plan
- Locally, BHS is working to identify referral pathway to ensure coordination of care and compliance with BH linkages
- BHS must be ready for referrals by October 1, 2024 (may come from other counties)
- Local correctional facilities looking to implement pre-release services in 2025

11

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration

- As part of CalAIM, California pursued a Section 1115 Demonstration to increase access to and improve mental health services for Medi-Cal members living with significant behavioral health needs.

The objectives include:

- Amplify the state's ongoing investments in behavioral health and further strengthen the continuum of community-based care.

12

BH-CONNECT Objectives, cont

- Meet the specific mental health needs of children, individuals who are justice involved, and individuals experiencing or at risk of homelessness.
- Ensure care provided in facility-based settings is high-quality and time-limited
- Central Goal: Expand a robust continuum of community-based behavioral health care services for Medi-Cal members living with significant behavioral health needs.

13

BH-CONNECT Section 1115 Demonstration

Find the BH-CONNECT Section 1115 demonstration application and public hearing materials posted on https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

14

Demonstration Authority Being Requested

"*" Indicates Statewide v. Opt In.

- Workforce initiative to invest in a robust, diverse behavioral health workforce to support Medi-Cal members living with SMI/SED and/or a SUD*
- Activity Stipends to ensure children and youth involved in child welfare have access to extracurricular activities that support health and wellbeing*
- Cross-sector incentive program to support children and youth involved in child welfare who are also receiving specialty mental health services*
- Statewide incentive program to support behavioral health delivery systems in strengthening quality infrastructure, improving performance on quality measures, and reducing disparities in behavioral health access and outcomes*
- Incentive program for opt-in counties to support and reward counties in implementing community-based services and EBPs for Medi-Cal members living with SMI/SED and/or a SUD
- Transitional rent services for up to six months for eligible high-need members who are experiencing or at risk of homelessness
- FFP for care provided during short-term stays in IMDs

15

BH-CONNECT- Forthcoming State Plan Amendment

- **Assertive Community Treatment (ACT)** *(SMHS)*
- **Forensic ACT (FACT)** *(SMHS)*
- **Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)** *(SMHS)*
- **Individual Placement and Support (IPS) model of Supported Employment** *(SMHS & DMC-ODS)*
- **Community health worker services** *(SMHS & DMC-ODS)*
- **Clubhouse services** *(SMHS)*
- **Transitional rent services** *(SMHS & DMC-ODS)*

16

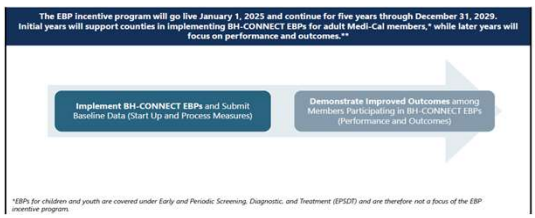
BH-CONNECT Section 1115 Demonstration

Overview: Statewide Features

- **Workforce initiative** to invest in a robust, diverse behavioral health workforce to support Medi-Cal members living with significant behavioral health needs.
- **Statewide incentive program** to support behavioral health delivery systems in strengthening quality infrastructure, improving performance on quality measures, and reducing disparities in behavioral health access and outcomes.
- **Centers of Excellence** to offer training and technical assistance to delivery systems and providers to support fidelity implementation of EBPs
- Implementation of **other CMS milestones** (to be described in implementation plan)
- **Cross-sector incentive program** to support children and youth involved in child welfare who are also receiving specialty mental health services.
- **Activity Stipends** to ensure children and youth involved in child welfare have access to community and school-based activities that support health and well-being.
- Clarification of **coverage requirements for EBPs** for children and youth, including for Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and potentially additional therapeutic modalities
- Establishment of an **initial child welfare/specialty mental health assessment** at the entry point into child welfare
- Inclusion of a **County Child Welfare Liaison** within MCPs

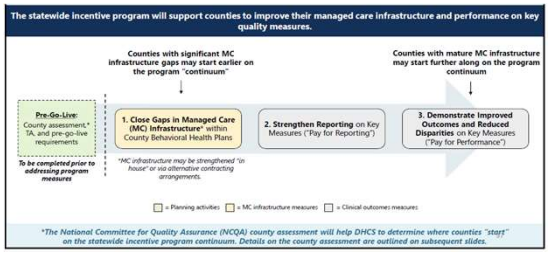
17

BH-CONNECT Section 1115 Demonstration EBP INCENTIVE PROGRAM



18

STATEWIDE INCENTIVE PROGRAM



19

The National Committee for Quality Assurance

The assessment will focus on areas most relevant to counties in fulfilling BH-CONNECT expectations and avoid duplication with other reporting initiatives.

- Prior to beginning the assessment, counties will be granted access to training materials, including the full list of MBHO standards included in the assessment, to inform their decision on whether to participate.
- The assessment will focus only on the **two categories of MBHO standards (of five total*)** that are most relevant to counties' participation in BH-CONNECT and quality improvement activities (highlighted at right):
  1) Quality Management and Improvement
  2) Care Coordination
- DMC-ODS counties will complete a single assessment inclusive of SMHS and DMC-ODS managed care functions.

MBHO Standards Focus Areas

Included in assessment:
- Quality Management and Improvement
- Care Coordination

Not included in assessment:
- Utilization Management
- Credentialing and Recredentialing
- Members' Rights and Responsibilities

20

Senate Bill 43

- Senate Bill (SB) 43 makes changes to the Lanterman-Petris-Short (LPS) Act –a California law governing involuntary detention, treatment, and conservatorship of people with behavioral health conditions. The criteria by which people may be civilly detained under the LPS Act includes danger to self; danger to others, or; grave disability.
- SB 43 expands the definition "gravely disabled" to include (new elements in bold text):
- People with a mental health disorder, **a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder,**
- And, who are unable to provide for their basic needs for food OR clothing OR shelter **OR access to necessary medical care OR personal safety.**
- SB 43 also makes the following changes:
- Expands the array of testimony that can be submitted into conservatorship proceedings without requiring in-person cross examination.
- Requires counties consider less restrictive alternatives in conducting conservatorship investigation.
- Expands State reporting requirements.
- **The County Board of Supervisors adopted a Resolution to delay implementation of SB 43 to January 1, 2025.**

21

SB 43- BHS Key Strategic Areas

- Starting in January 2024, the County began convening a multi-sector planning group to support rapid implementation of SB 43. Planning efforts are supporting four key strategies needed to support readiness for the changes brought forth by this major update to State law:
- Education and Training,
- Expanding treatment, services and supports for those with substance use disorder,
- Establishing alternatives to emergency departments for 5150 detentions, and
- Updating procedures and adding capacity to support the Office of the Public Conservator.
- Various sectors are involved in planning such as County (BHS, Law Enforcement, EMS, HSEC, and MCS), and Non-County (EDs, Hospitals, Substance Use Treatment Providers, Organizations Serving People Experiencing Homelessness, Harm Reduction Services.

22

Prop 1- Behavioral Health Service Act *aka* Behavioral Health Transformation (BHT)

- BHT complements and builds on California's other major behavioral health initiatives including, but not limited to, California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration proposal the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis, 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

23

Behavioral Health Transformation (BHT)

- Californians voted to pass Proposition 1 to modernize the behavioral health delivery system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities. DHCS is enacting changes resulting from Proposition 1 through the Behavioral Health Transformation (BHT) project.

  The two legislative bills that created the language in Proposition 1 are:

- Behavioral Health Services Act SB 326
- Behavioral Health Infrastructure Bond Act AB 531

24

Behavioral Health Transformation (BHT)

- Expands eligible services to include treatment for substance use disorders (SUDs) alone and allows counties to use funds in combination with other state and federal funds to expand SUD services. Because of the expansion to cover SUD, the bill updates the name of the MHSA to the Behavioral Health Services Act (BHSA).

25

Behavioral Health Transformation (BHT), cont.

- Modernizes county allocations (90% of total BHSA funds) to require the following priorities and encourages innovation in each area
- 30% for Housing Interventions
  - To include rental subsidies, operating subsidies, shared housing, family housing for children and youth who meet criteria, and the non-federal share for certain transitional rent.
    - Half of this amount (50%) is prioritized for housing interventions for the chronically homeless.
    - Up to 25% may be used for capital development

26

Behavioral Health Transformation (BHT), cont.

- 35% for Full Service Partnership (FSP) programs (also known as the "whatever it takes" model)
- 35% for Behavioral Health Services and Supports
  - A majority (51%) of this amount must be used for Early Intervention in the early signs of mental illness or substance misuse. ▪ A majority (51%) of these Early Intervention services and supports must be for people 25 years and younger
- Allows some movement from one category into another within limits

27

Behavioral Health Transformation (BHT), cont.

- Creates new state-wide, state-led investments (10% of total BHSA funds):
  - Prevention (4% of total funding)
  - Workforce (3% of total funding)
  - Statewide oversight and monitoring (3% of total funding)

28

Behavioral Health Transformation (BHT), cont.

- Expanding BH workforce to reflect and connect with CA diverse population
- Focus on outcomes, accountability and equity
- Infrastructure
  - Construction of BH treatment & residential care setting and permanent supportive housing
  - Housing for Veterans with BH needs
  - DHCS and BHS Planning underway and more to come

29

Overall, there are **continued** changes before us so

30

Key Information Notices from 23-24

31

31

23-054

- All existing programs were required to submit their MAT P&P to DHCS no later than January 2024
- Once approved, any change to a facility's MAT policy requires written notice to DHCS
- Initial applicant for licensed/certified SUD facilities shall support a MAT policy with the Initial Treatment Provider Application

32

32

23-066

- Provided notification of licensing and certification fee increases aligning with HSC 11833.02 (SB137)
  - Fees had been unchanged since FY 14-15
  - Directs DHCS to increase fees by up to 20% each FY through 26-27 to reach a cumulative increase of 75%
  - Once the 75% increase is met, DHCS can increase up to 5% annually

33

33

24-001

- DMC-ODS Requirements for 2022-2026
  - Updates and supersedes 23-001 and 21-024. Specifically, updates 23-001 to bring it into alignment with BHINs released throughout calendar year 2023
  - Topics covered in 24-001:
    - EPSDT
    - DMC-ODS Program Criteria for Services
    - Covered DMC-ODS Services
    - DMC-ODS MAT Policy
    - Justice-Involved Populations and CalAIM Justice-Involved Initiatives
    - Indian Health Care Providers
    - Responsibilities of DMC-ODS Plans for DMC-ODS Benefits
    - Evidence-Based Practice Requirements
    - DMC-ODS Quality Improvement
    - DMC-ODS Financing

34

34

24-005

- Mobile Narcotic Treatment Programs
  - Provides guidance on establishing and regulating mobile NTPs, including the application process
    - Further communication will be provided if and when the service is available.

35

35

Anticipated future Information Notices

- Residential Authorizations
  - No draft has been provided and no timeline has been mentioned; however state solicited conceptual feedback in early 2023
- AOD certification standards are being updated to align with Medi-Cal Transformation
- Anticipated DHCS implementation of ASAM 4th edition by 1/1/25

36

36

Documentation Redesign Changes (BHIN 23-068)

37

37

Assessments

- Outpatient providers are no longer required to complete assessments within 30 days (60 days for those under 18 or experiencing homelessness
- Residential providers are no longer required to complete assessments within 10 days but still follow the authorization process detailed in the SUDPOH
- Based on unanimous provider feedback, and quality of care standard in alignment with the prior compliance requirements was established in the January 2024 Quality Improvement Partners (QIP) meeting
- Residential Withdrawal Management providers are exempt from the "multidimensional LOC assessment" requirement if a pre-assessment occurs within 72 hours of admission and there are contingency plans to transfer the resident to a level of care where a full assessment would be conducted

38

38

Assessments

- Effective January 1, 2025, all providers must use the ASAM Interview Guide or ASAM Continuum software, **or** a validated tool can be used if approved by DHCS
  - For providers using Smartcare, the ASAM Interview Guide is already available for adults. We are still seeking clarification on the assessment tool used for adolescents
- An evidence-based assessment of a client's needs for Medications for Addiction Treatment (MAT) is required in alignment with BHIN 23-054.

39

39

Progress notes

- Clarified that the day of service is considered day zero
- Some minor language changes that were updated in the current progress note template and instructions and will be reflected in Smartcare forms

40

40

Care Planning requirements

- There is no longer a requirement for a standalone client/care plan (i.e. Peer Support Specialist Services, Perinatal Plan of Care)
- All relevant federal and state care planning requirements can be documented throughout the client record or by using a dedicated care plan template
- It was updated that if a client has not had a physical examination within the last 12 months or the physician has not reviewed the physical exam results, a goal to obtain a physical examination is still required but can be documented anywhere in the client's record in alignment with other care planning requirements

41

41

Final reminders

- Unless identified in the previous slides, all other requirements remain in effect
- Remember that disallowances are focused on themes related to fraud, waste, and abuse

42

42

Billing/Payment Reform

- A reminder that the current billing manual and service table is currently posted to the Billing tab on the Optum website, and there is a crosswalk available under the Toolbox tab
- Providers should continue to use their best judgement on which service is most appropriate based on the service provided, the discipline of who provided the service, and how it is documented.
- Due to the difficulty in updating the billing manual regularly, DHCS is planning on providing an FAQ

43

43

Other Service Reminders

44

44

Care Coordination

- Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.
- Care coordination shall be provided to a beneficiary in conjunction with all levels of treatment. Care coordination may also be delivered and claimed as a standalone service. Through executed memoranda of understanding, the Contractor shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a beneficiary-centered and whole-person approach to wellness.
- Care coordination services shall be provided by an LPHA or a registered/certified counselor.

45

45

Care Coordination

- Care coordination services shall include one or more of the following components:
  - Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
  - Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
  - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

46

46

Peer Support Specialist Services

- As of 7/1/23, must be provided by a certified Peer Support Specialist
- Can provide services in all levels of care other than Recovery Services
  - Reminder: Per BHIN 22-005, "Effective January 1, 2022, counties can no longer submit DMC-ODS claims for services delivered by peers as a component of Recovery Services."
- Peer Support Services include the following components: Educational Skill Building Groups, Engagement, and Therapeutic Activity (further defined in BHIN 22-026)
  - Per the billing manual, the Engagement service component is designed to support outreach and engagement efforts prior to initiation and treatment
- Must be supervised by a Peer Support Specialist Supervisor
- For more information, please refer to the CalAIM for BHS Providers section of the Optum website

47

47

Clinician Consultation

- These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.
  - Please refer to the SUDPOH for currently available resources for Clinician Consultation
  - Remember this is not for internal consultation
- The Contractor shall only allow DMC providers to bill for clinician consultation services.

48

48

Recovery Services

- Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.
- Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care of a covered DMC-ODS service, or as a service delivered as part of these levels of care.

49

49

Recovery Services

- Recovery services include: assessment, care coordination, counseling (individual and group), family therapy, recovery monitoring (which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD) and relapse prevention (which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD).Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care of a covered DMC-ODS service, or as a service delivered as part of these levels of care.
- Recovery Services may be provided in person, by telehealth, or by telephone.

50

50

Medications for Addiction Treatment (MAT)

- Medications for addiction treatment includes all FDA-approved drugs and biological products to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care
- When MAT is being provided as a standalone service, MAT includes the following components: assessment; care coordination; counseling (individual and group counseling); family therapy; medication services; patient education; prescribing and monitoring for MAT for OUD and AUD and non-opioid SUDs which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD, AUD and non-opioid SUDs; recovery services; SUD crisis intervention services; and withdrawal management services.

51

51

Medications for Addiction Treatment (MAT)

- Reminder that all programs are required to have an effective referral process to MAT providers in alignment with BHIN 23-054, including an established relationship with a MAT provider and transportation to appointments, if MAT is not available at the facility
- Continue to follow all requirements in BHIN 23-054 and your DHCS approved MAT policy and give written notice to DHCS for any changes

52

52

Residential Authorization Requirements

53

53

Residential Authorizations

- Initial Authorizations (within 72 hours of admission)
  - Notify Optum via telephone
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- Continuing Authorizations (within 10 days of admission)
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- Extension Authorizations (no later than day 80 from admission)
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- All forms available under the SUDURM tab on the Optum website

54

54

Other Important Program Requirements

55

55

DMC Certification and Enrollment

- DHCS shall certify eligible providers to participate in the DMC program.
- The DHCS shall certify any Contractor-operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
- Providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements
- All providers of services must be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with all applicable regulations and guidelines.

56

56

DMC Certification and Enrollment

- The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a provider's pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.
- The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
- A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. A conviction shall include a plea of guilty or nolo contendere.

57

57

Professional Staff Requirements

- Professional staff shall:
  - Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
  - Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.
  - Defined as any of the following: LPHAs, AOD Counselor, Medical Director of a Narcotic Treatment Program who is a licensed physician in the state of California, or a Peer Support Specialist with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meet all other applicable California state requirements, including ongoing education requirements.

58

58

Professional Staff Requirements

- Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.
- Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.
- Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
- Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.

59

59

Medical Director Responsibilities

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement written medical policies and standards for the provider.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

60

60

Medical Director Responsibilities

- Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine services are medically necessary.
- Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section
- The SUD Medical Director may delegate their responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.
- Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed, and dated by a provider representative and the physician

61

61

Perinatal Services

- Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum beneficiaries, such as relationships, sexual and physical abuse, and development of parenting skills.
- Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
- Shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. Shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted.

62

62

Perinatal Services

- Shall include:
  - Parent/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to H&S Code Section 1596.792).
  - Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment)
  - Education to reduce harmful effects of alcohol and drugs on the parent and fetus or the parent and infant
  - Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant)

63

63

Client Rights

- Must have written policies guaranteeing the rights specified in 42 CFR 438.10
- Comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensure employees and subcontracted providers observe and protect those rights
- Receive information regarding contractor's PIHP and plan
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
- Participate in decision regarding their health care, including the right to refuse treatment
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in Federal regulations

64

64

Client Rights

- May request and receive a copy of their medical records as specified in 45 CFR 164.524 and 164.526
- Have the right to be furnished with health care services in accordance with 42 CFR 438.206 and 438.210
- Ensure that each beneficiary is free to exercise their rights, and the exercise of those rights does not adversely affect the way providers treat the beneficiary
- Cannot prohibit or restrict a provider acting within lawful scope of practice from advising a beneficiary who is their patient on: health status, medical care, treatment options, information to decide on relevant treatment options, risks/benefits/consequences of treatment or non-treatment, and right to participate in decision of their own health care

65

65

Program Complaints

- Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.
- Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

66

66

Grievance & Appeal Process

Providers are required to have available/posted materials displayed in a prominent public place (such as the program waiting room/lobby) and/or be offered to the client, in **all** threshold languages, including:

- Grievance/Appeal Posters
- Grievance/Appeal Brochures
- Self-addressed envelopes with grievance/appeal forms
- Interpreter services notification
- Toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Access and Crisis Line Posters
- Beneficiary Handbook
- Denial and Termination notices

67

67

NOABD

What is a Notice of Adverse Benefit Determination?

Notices

Notices inform resident/clients about the adverse or unfavorable determination made, the justification with a description of guidelines or criteria used, citation to authority that supports the action, and the resident/client's appeal rights.

Requirements

Notices are required by both Federal and State laws. 42 CFR §438.400-424; APL 17-006. Notices apply for all Medi-Cal covered benefits and services.

Language

The NOABD language must be clear and non-technical. Providers should use forms translated into threshold languages when appropriate.

68

68

NOABD: Choosing the correct notice

There are eight different kinds of notices. A template for each notice is available on Optum the Optum Website under the NOABD tab in all threshold languages.
Click here to view a table explaining the eight notices available on the Optum Website

- **The Termination Notice**
  - Similar to former "10-day Notice" letter. This is the most commonly used notice.
  - When a provider terminates, reduces, or suspends a previously authorized service (i.e. residential)
  - Must be sent to the beneficiary when discharging for non-compliance (all DMC-ODS programs) as well as for unsuccessful discharges (i.e. AWOL)
- **The Denial of Authorization Notice**
  - When client requests services but is assessed as not meeting medical necessity
  - When the provider denies a request for service, including denials based on type/level of service, medical necessity, appropriateness, setting, or effectiveness of the service
- **The Timely Access Notice**
  - When requested services cannot be provided within timelines

69

69

NOABD: Choosing the correct notice

There are eight different kinds of notices. A template for each notice is available on Optum the Optum Website under the NOABD tab in all threshold languages.
Click here to view a table explaining the eight notices available on the Optum Website

- **Modification Notice**
  - When a provider modifies or limits a request services
- **Payment Denial Notice**
  - When the play denies, in whole or part for any reason, a provider's request for payment for service that has already been delivered to a client.
- **Financial Liability Notice**
  - The provider plan denies a client's request to dispute financial liabilities.
- **Delivery System Notice (Not currently applicable for DMC-ODS Programs)**
- **Authorization Delay Notice**
  - When requested services cannot be provided within timelines.

70

70

NOABD

71

71

NOABDs and Appeals

- **Clients who disagree with their discharge or other adverse determination may file an appeal. Standard Appeals take up to 30 days to resolve.**

72

72

Record Retention

- Records are required to be kept and maintained under this section and shall be retained:
  - by the provider for a period of 10 years from the final date of the contract period between the plan and the provider,
  - from the date of completion of any audit,
  - or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations.

73

73

Training Requirements

- All staff received compliance training within 30 days of their first day at work and annually thereafter
- 5 hours of CMEs for physicians and CEs for LPHAs each calendar year in addiction medicine
- At least one staff trained in administration of Naloxone
- All treatment staff receive ASAM training prior to providing services
- All personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements set forth in BHIN 21-001 and its accompanying exhibits.
- Other requirements as documented on the DMC-ODS Required Trainings website

74

74

Cultural Competence

- All services, policies, and procedures must be culturally and linguistically appropriate
- Must participate in the implementation of the most recent Cultural Competence Plan
- Must participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients
  - Including those with limited English proficiency, diverse cultural and ethnic background, disabilities, and regardless of gender, sexual orientation, or gender identity

75

75

Access to Services

- Must provide SUD services to individuals that meet access criteria and medical necessity requirement as specified in BHIN 24-001
  - Clinical record as a whole indicates that the client's presentation and needs are aligned with the criteria applicable to their age
- Must have written admission criteria for determining eligibility and suitability for services. This must be documented in the client's record
- Ensure that policies, procedures, practices, rules and regulations do not discriminate against special populations. When the needs of a client cannot be reasonably accommodated, a referral(s) is made to appropriate programs
- Ensure that Parole and Probation status is not a barrier to SUD services

76

76

Transitions to other Levels of Care

- Must ensure the transition of the beneficiaries to appropriate LOC. This may include step-up or step-down in covered DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary.
- Care coordinators shall ensure transitions to other LOCs occur no later than 10 business days from the time of assessment or reassessment with no interruption of current treatment services.
- The initial treating provider shall be responsible for arranging care coordination services and communicating with the next provider to ensure smooth transitions between LOCs.

77

77

Covered DMC-ODS Services

- Shall provide medically necessary covered SUD services as defined in the Drug Medi-Cal Billing Manual to clients who meet access criteria for receiving SUD services
  - Please also reference your contract and Statement of Work for services to be provided by your program
- Shall also observe and comply with lockout and non-reimbursable service rules

78

78

MOU Requirements Between Medi-Cal Mental Health Plans/Drug Medi-Cal Organized Delivery System and Medi-Cal Managed Care Plans

79

79

DHCS Behavioral Health Information Notice

- The purpose of this new Behavioral Health Information Notice (BHIN) is to clarify the responsibilities of Medi-Cal Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) when entering into a Memorandum of Understanding (MOU) with Medi-Cal Managed Care Plans (MCPs).
- The BHIN also issued the MOU Template that is required to be utilized for MOU's between MHPs/DMC-ODS and MCPs.
- The BHIN documents the oversite and compliance requirements as well as reporting requirements to the Department of Health Care Services (DHCS).
- The MOU is intended to clarify roles and responsibilities between MHPs/DMC-ODS and MCPs and support local engagement, care coordination, information exchange, mutual accountability and transparency.
- MHPs/DMC-ODS must execute MOUs with MCPs by January 1, 2024

80

80

MOU Between MHP or DMC-ODS and MCP Requirements

- MHPs/DMC-ODS are responsible for providing medically necessary covered Specialty Mental Health Services and Drug Medi-Cal services to beneficiaries set forth in the State Plan and the DMC-ODS Intergovernmental Agreement, MCP Boilerplate Contract, including the coordination of a beneficiary's care.
- The MOU between the MHP or DMC-ODS and MCP shall serve as the primary vehicle for ensuring coordination of medically necessary services, including health-related social service needs, when beneficiaries are accessing services from both systems.
- Describes the services that each party must coordinate for beneficiaries.
- Describes each party's provision of services and oversight responsibilities.
- Requires each party to provide educational materials to beneficiaries and network providers about accessing medically necessary services. Train network providers, subcontractors and downstream subcontractors on MOU requirements and services provided by each party.

81

81

MOU Between MHP or DMC-ODS and MCP Requirements

- Describes required policies and procedures covering beneficiary screening and assessment, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services and administering Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) to DMC-ODS beneficiaries ages 11 and older. The MOU requires each party to refer beneficiaries to the other party as appropriate and describes each party's referral process.
- Describes the requirements for coordinating beneficiary access to care and describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination. Includes requirements for parties to coordinate provision of medically necessary services, treatment planning, clinical consultation, Enhanced Care Management (ECM), Community Supports, and prescription drugs.
- Requires parties to have policies and procedures to ensure the continued care coordination for services in the event of a disaster or emergency.
- Describes the parties' quality improvement (QI) activities to ensure oversight and improvement of the MOU requirements.

82

82

MOU Between MHP or DMC-ODS and MCP Requirements

- Requires MHP or DMC-ODS to retain all documents related to the MOU requirements for at least ten years.
- Describes the minimum data and information that the parties must share to ensure the MOU requirements are met and describes the data and information the parties may share to improve care coordination and referral processes, and requirements for parties to share information about beneficiaries as set forth in the MHP-MCP MOU and DMC-ODS-MCP MOU template and in accordance with federal and state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2.
- Describes the policies and procedures for resolving disputes between the parties and the process for brining the disputes to DHCS when the parties are unable to resolve disputes between themselves.
- Describes additional general contract requirements.

83

83

MOU Compliance and Oversight Requirements

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

84

84

MOU Compliance and Oversight Requirements

- MHPs and DMC-ODS Counties must work collaboratively with MCPs to establish dispute resolution processes and timeframes within the MOU.
  - Includes how the MHP or DMC-ODS County will work with the MCP to resolve issues related to coverage or payment of services under conflicts regarding respective roles for case management for specific beneficiaries, or other concerns related to the administered services to beneficiaries.
- MHPs and DMC-ODS Counties and MCPs must complete the plan-level dispute resolution process. If the parties fail to resolve the dispute, either party must submit a written "Request for Resolution" to DHCS. If the MHP or DMC-ODS County submits the Request for Resolution, it must be signed by the county behavioral health director.
- MHPs and DMC-ODS Counties must provide training and orientation of MOU requirements with subcontractors, downstream subcontractors, and network providers, as applicable, on an annual basis, at a minimum. The training must include information on MOU requirements and the services that are provided or arranged for by each party and how those services can be accessed or coordinated for the beneficiary.
- Starting January 1, 2025, MHPs and DMC-ODS Counties must submit an annual report that includes updates from the quarterly meetings with the MCP and the results of their annual MOU review to DHCS.

85

85

Healthy San Diego Managed Care Plans (MCP)

HHSA | LIVE WELL SAN DIEGO

Healthy San Diego

Medi-Cal Managed Care Plan Contact Card

Health Plan	Member Services/Transportation	Behavioral Health	Telephone Medical Advice Line	Vision Services	Medi-Cal RX	Denti-Cal
Blue Shield CA Promise Health Plan	1-855-699-5557	(855) 321-2211	1-800-609-4166	1-855-699-5557	(800) 977-2273	(800) 322-6384
Community Health Group	1-800-224-7766	(800) 404-3332	1-800-647-6966	Vision Service Plan 1-800-877-7195	(800) 977-2273	(800) 322-6384
Kaiser Permanente	1-800-464-4000	(877) 496-0450	1-800-290-5000	1-800-464-4000	(800) 977-2273	(800) 322-6384
Molina Healthcare	1-888-665-4621	(888) 665-4621	1-888-275-8750	March Vision Services 1-888-463-4070	(800) 977-2273	(800) 322-6384

County Mental Health Plan	Jewish Family Service	Consumer Center for Health Education & Advocacy
To access Specialty Mental Health and the Drug Medi-Cal Organized Delivery System 1-888-724-7240	Patient Advocacy Program Complaints & Grievances/Inpatient & Residential 1-800-479-2233	Patient Advocacy Program Complaints & Grievances/Outpatient services 1-877-734-6368

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

blue CONNECTED Promise Health Plan | Community | KAISER PERMANENTE | MOLINA HEALTHCARE

4/2024 Medi-Cal Managed Care Plans cover transportation to all Medi-Cal covered services including Specialty Mental Health, Drug Medi-Cal Organized Delivery System and Denti-Cal

86

86

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

HHSA | LIVE WELL SAN DIEGO

Drug Medi-Cal Quick Guide

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

87

87

Optum San Diego Website Healthy San Diego

- Optum San Diego Website houses resources/educational materials for Medi-Cal Specialty Mental Health Service Providers and Drug Medi-Cal Organized Delivery System Providers.
  - https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/healthysandiego.html
- The MHP-MCP MOU and the DMC-ODS-MCP MOU will be posted on the Optum San Diego Website-Healthy San Diego Page.

88

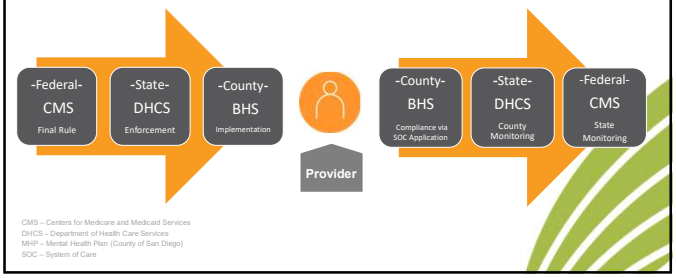
88

Network Adequacy/System of Care Application

89

89

NACT and 274 Expansion Background and Flow of Data



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

90

New NACT Reporting Standard

- 274 Expansion Project
  - Based on X12 274 Health Provider Directory standard selected by DHCS to ensure all provider network data is consistent, uniform, and aligns with national standards. (BHIN 22-032)
  - DMC-ODS Providers
    - 274 reporting requirements for DMC-ODS have been deployed into production since October 2023.

91

91

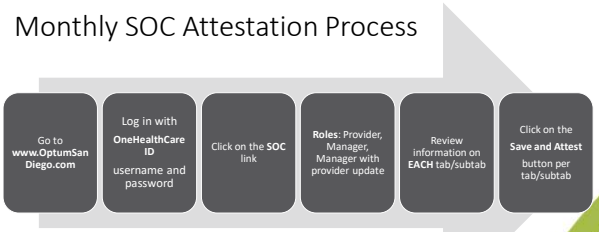
New NACT Reporting Standard

- Registration
  - New hires and program transfers are required to **register promptly and** attest to information once registration is completed.
- Monthly attestations
  - Effective immediately, Staff/Providers and Program Managers are required to attest to all SOC information **monthly**.
  - Program Managers are expected to visit the SOC app to review their programs' information and attest to information **monthly**.
  - Providers are expected to update their current profile in the SOC app **as changes occur** to show accurately on the provider directory.

92

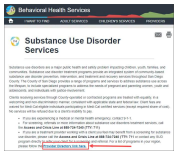
92

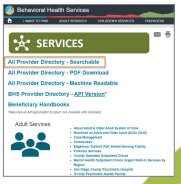
Monthly SOC Attestation Process



93

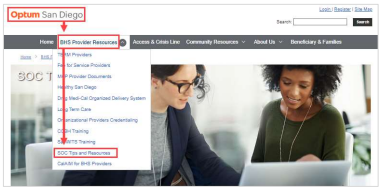
Provider Directory





94

Tips and Resources



OptumSanDiego.com

Optum Support Desk
- 1-800-834-3792
- sdhelpdesk@optum.com

95

95

Program Integrity 101

96

96

INTERNAL COMPLIANCE PROGRAM

- Recommended that programs have an internal program integrity/compliance program commensurate with the size and scope of their agency.
- Contractors with more than $250,000 in annual agreements with the County must have a compliance program that meets the following:
  1. Development of a code of conduct and compliance standards
  2. Assignment of a compliance officer who oversees/monitors compliance program
  3. A communication plan which allows workforce members to express complaints/concerns without fear of retribution

97

97

INTERNAL COMPLIANCE PROGRAM

- Contractors with more than $250,000 in annual agreements with the County must have a compliance program that meets the following:
  4. Create and implement training and education for workforce members regarding compliance requirements, reporting and procedures
  5. Development and monitoring of auditing systems to detect and prevent compliance issues
  6. Creation of discipline processes to enforce at the program
  7. Development of response and prevention mechanisms to respond to, investigate and implement corrective action regarding compliance issues

98

98

INTERNAL COMPLIANCE PROGRAM

Regardless of size/scope, all programs have processes in place to ensure, at a minimum:

1. Staff have proper credentials, experience, and expertise to provide client services
2. Staff shall document client encounters in accordance with funding source requirements and Health and Human Services Agency (HHSA) policies/procedures
3. Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures
4. Staff promptly elevate concerns regarding possible deficiencies or errors in the quality of care, client services, or client billing
5. Staff shall act promptly to correct problems if errors in claims or billings are discovered

99

99

REPORTING FWA

- Any concerns about ethical, legal, and billing issues (or of suspected incidents of FWA) should be reported immediately to: the HHSA Agency Compliance Office (ACO):
  - By phone at 619-338-2807, or
  - By email at Compliance.HHSA@sdcounty.ca.gov
  - or contact the HHSA Compliance Hotline at 866-549-0004
- Additionally, contact your program COR immediately and the SUD QM team at QIMatters.HHSA@sdcounty.ca.gov

100

100

REPORTING FWA

- In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done:
  - By phone: 1-800-822-6222
  - Online form
  - fraud@dhcs.ca.gov
  - Medi-Cal Fraud Complaint – Intake Unit
    Audits and Investigations
    PO Box 997413, MS 2500
    Sacramento, CA 95899-7413

101

101

PAID CLAIMS VERIFICATION

"Paid claims verification" – Each program must develop Policy & Procedure to verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.

- Flexibility in developing your own process
- Can current processes (i.e. sign-in sheets) be leveraged to create your paid claims verification process
- Keep it simple (i.e. random verification)
  - i.e. random verification during specified time periods

102

102

Utilization Management Program

The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, that services are medically necessary, that the ASAM Criteria shall be used to determine placement into the appropriate level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

103

103

DMC-ODS Required Trainings (sandiegocounty.gov)

DHCS Information Notices

DMC-ODS on Optum

CalAIM for BHS Providers

104

104

Email the SUD QA team at:

QIMatters.HHSA@sdcounty.ca.gov

105

105

THANK YOU!

The end.

THANK YOU FOR ATTENDING!

106