Annual DMC-ODS Training
FY 2025-2026

County of San Diego Health and Human Services Agency

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

August 28, 2025

LIVE WELL SAN DIEGO

Annual DMC-ODS Training FY 2025 - 2026

- Everyone is muted upon entry.
- The training is being recorded and will be available on the Optum
- All information is accurate as of August 28, 2025
  - For future updates, please reference any communications from BHS, including the monthly Up To the Minute (UTTM), also on Optum

Annual DMC-ODS Training FY 2025 - 2026

- “Big Picture” updates – State and County level
- Review DMC-ODS Requirements
- BHINs to know
- Other Intergovernmental Requirements

BHS HPO DMC-ODS Leadership Team

- **Tabatha Lang,** Operations Administrator
- **Vacant**, 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, Management Information Systems (MIS)

SUD QA Team

- Charissa Allen
- Blanca Arias
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- Natalie Capra
- Melissa Geiger
- David Kim
- Helen Kobold
- Kevin Kolodziej
- Tammy Pham
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BH-CONNECT

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

LIVE WELL
SAN DIEGO

What is BH-CONNECT?

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

Three Key Authorities:

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

Goals of BH-CONNECT Demonstration

Required by CMS

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

California-specific

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

Goals of BH-CONNECT Demonstration, cont.

San Diego – Specific:

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

Eligibility and Populations of Focus

Individuals with significant mental health and substance use disorders

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

Key Features

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

New Medi-Cal EBP Coverage

Assertive Community Treatment (ACT)

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

Forensic ACT (FACT)

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

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

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

New Medi-Cal EBP Coverage, cont.

Individual Placement and Support (IPS) Model of Supported Employment

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

Clubhouse Services

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

Community Health Worker Services

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

Access, Reform, and Outcome Incentives

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

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

County Participation Requirements

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

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

Demonstration Timeline

Demonstration Year 0
MCP Foster Care Liaison
Effective January 2024

January 2025

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

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

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

Phased-In Approach for Opt-In Counties

Upon IMD Opt-In County Go-Live *(rolling basis)*

- Participate in the incentive program and meet accountability requirements
- Begin providing Peer services with justice involved specialization and CHW services
- Begin TA for ACT/FACT through COEs, completing preliminary fidelity assessment

January 2025

Demonstration goes live

Demonstration Year 2

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

Within 2 Years of Go-Live

Begin providing FACT and CSC for FEP

Within 3 Years of Go-Live

Begin providing IPS Supported Employment

Relevant Behavioral Health Information Notices (BHINs)

Fiscal Year 2024-2025 and beyond

BHIN 24-001

- DMC-ODS Requirements for 2022-2026:
  - Updated and superseded 23-001 and 21-024; brings regulations into alignment with BHINs released throughout 2023.
  - Topics covered in this BHIN:
    - EPSDT
    - DMC-ODS Program Criteria for Services
    - Covered DMC-ODS Services
    - DMC-ODS MAT Policy
    - JI Populations & CalAIM Justice Involved Initatives
    - Indian Health Care Providers
    - Responsibilities of DMC-ODS Plans for DMC-ODS Benefits
    - EBP Requirements
    - DMC-ODS Quality Improvement
    - DMC-ODS Financing

California Outcome Measurement System (CalOMS)

- **BHIN 24-030**
  - Updated demographic data
- **BHIN 25-001**
  - Update to Protocols for Collecting and Reporting Discharge Data in CalOMS
    - New CalOMS Treatment Data Collection Guide – Section 8: Discharge, has specific instructions on discharge statuses and exit reasons.
    - CalOMS is updated to mandate last date of service, primary exit reasons, etc.

BHIN 25-003: AOD Certification

Certification of Alcohol and Other Drug Programs

- Superseded BHIN 23-058Updates mandatory certification requirements & provides guidance for SUD programs already certified.
- Some areas covered in this BHIN:
  - Certification Process
  - Compliance and Enforcement
  - Operational Requirements
  - Clients Rights and Protections
  - Specialized Services
  - Facility Standards
  - Staff and Personnel Requirements
  - Investigations and Complaints

BHIN 25-007: Traditional Health Care Practices Benefit Implementation

- Effective March 21, 2025: DMC-ODS counties shall provide coverage for Traditional Health care practices **received through Indian Health Services (IHS) facilities, operated by Tribes or Tribal Organizations (Tribal Facilities).**

- Two new service types that may be provided are **Traditional Health** and **Natural Helper Services.**

BHIN 25-008: Narcotic Treatment Programs Regulation Changes

- Brings DHCS into alignment with SAMHSA guidelines (February 2024)
  - Updates to treatment standards
  - Expanded access to treatment
  - Criteria for take-home MOUD eligibility
  - Guidelines for initial dosage of methadone
  - Restrictions on patient supply of take-home methadone
  - Focus practitioner autonomy and client-centered care

BHIN 25-010: Peer Support Services

Medi-Cal Peer Support Services, Specialists and Certification Program Standards

- 3 service components (as outlined in the CA Medicaid Plan): Educational Skills Building Groups, Engagement and Therapeutic Activity
  - Ed. Skill Building Groups: promote skill building in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, maintenance of skills (limited to 2-12 Medi-Cal Members)
  - Engagement: Activities/Coaching to support participation in BH treatment.
  - Therapeutic Activity: Non-clinical activities which promote recovery, wellness, independent living.
- Peer Support Specialist Qualifications/Peer Support Supervisor Requirements
- Sets forth a Code of Ethics
- Defines which codes can be used

- **https://www.dhcs.ca.gov/Pages/Medi-Cal-Peer-Support-Services-Specialist-Program-Frequently-Asked-Questions.aspx**

BHIN 25-019: Transgender, Gender Diverse or Intersex Cultural Competency Training Requirements

Based on SB 923: The Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act

- Puts forth that all staff who are in direct contact with members, whether oral, written or otherwise in the delivery of services must complete evidenced-based cultural competency training for the purpose of provider trans-inclusive health care for individuals who identify as TGI.

- Refresher training is required if a complaint about failure to provide trans-inclusive care is filed and upheld.

25-028: BH-CONNECT: Enhanced Community Health Worker Services

- Effective April 11, 2025: New benefit in SMHS and DMC-ODS; more information in State Plan Amendment 24-0052
- Enhanced CHW Services are tailored preventative services for members living with significant behavioral health needs.
- Focus on supporting engagement in chronic disease management, conducting outreach to individuals with complex needs and facilitating improved mental health and SUD outcomes, among many other diverse areas of focus.
- Two areas of service activities: Health education and Health navigation
- Group and individual services for up to 6 hours per year per member

25-029: Alcohol or Other Drug (AOD) Counselor Educational Requirements

- Effective January 1, 2026:
- Updates to Registered Counselor terminology
  - **First-year registered counselor:** Registered less than 1 year and has **not yet renewed**; status remains until first renewal, even if they transfer certifying organizations.
  - **Registered counselor:** Registered **1+ years** and has **renewed at least once**; status continues even if transferring to another certifying organization.

- Updates to requirements for first-year Registered Counselors that register on or after July 1, 2025
  - **Education Requirement:** First-time registrants (on/after July 1, 2025) must complete 80 hours of approved education, including core competencies, within 6 months of registration (hours earned pre-registration may count).
  - **Verification:** Counselors must submit proof of completed education to their certifying organization, which must confirm compliance within 45 days or require completion of missing hours before registration expires.
  - **Renewal:** First-year counselors must apply for renewal at least 120 days before expiration; certifying organizations must notify within 7 days of receipt and issue a decision (approve, deny, or incomplete) within 45 days.

Anticipated Future Information Notices

ASAM Criteria 4th Edition

- In December 2023, the American Society of Addiction Medicine (ASAM) released the ASAM Criteria 4th edition. In alignment with the goals of CalAIM and the evolving standards of care, the California Department of Health Care Services (DHCS) is anticipated to adopt the 4th edition of the ASAM Criteria for use within DMC-ODS soon.

Other Service Reminders

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 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.

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.

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

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 (Section A)
  - Remember this is not for internal consultation
- The Contractor shall only allow DMC providers to bill for clinician consultation services.

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.

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.

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.

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

Contingency Management

- Contingency Management (CM), under the Recovery Incentives Program, is an evidence-based practice to treat individuals with stimulant use disorders by providing them with incentives to **reinforce positive behavioral change measured by negative drug tests for stimulants.**

- California is the first state in the country to receive federal approval for CM as a benefit in the Medicaid program from the Centers for Medicare & Medicaid Services as part of the CalAIM 1115 Demonstration. The Recovery Incentives Program is available in participating DMC-ODS counties, including San Diego County, in outpatient, intensive outpatient, and Narcotic Treatment Program settings.

Contingency Management: Eligibility

- Must be Medi-Cal enrolled and meet criteria for individualized SUD treatment.
- Reside in a participating DMC-ODS county approved for Recovery Incentives Program
- Receive services in non-residential DMC-ODS programs offering CM per DHCS rules.
- Members who are receiving care in residential treatment are not eligible for dual enrollment in CM.
- For more information, contact your program COR or QI Matters.

Contingency Management: Process and Requirements

- Must be Medi-Cal enrolled and meet criteria for individualized SUD treatment.
- Notify the COR for awareness
- Obtain member consent
- Current SUD provider contacts Contingency Management (CM) provider to initiate referral and coordination of care (i.e., member consent, transition planning, ongoing care).
- CM completes intake
- Maintain ongoing care coordination.
- For more information: BHS Info Notice 06-11-2025 on Optum.

Telehealth Consents

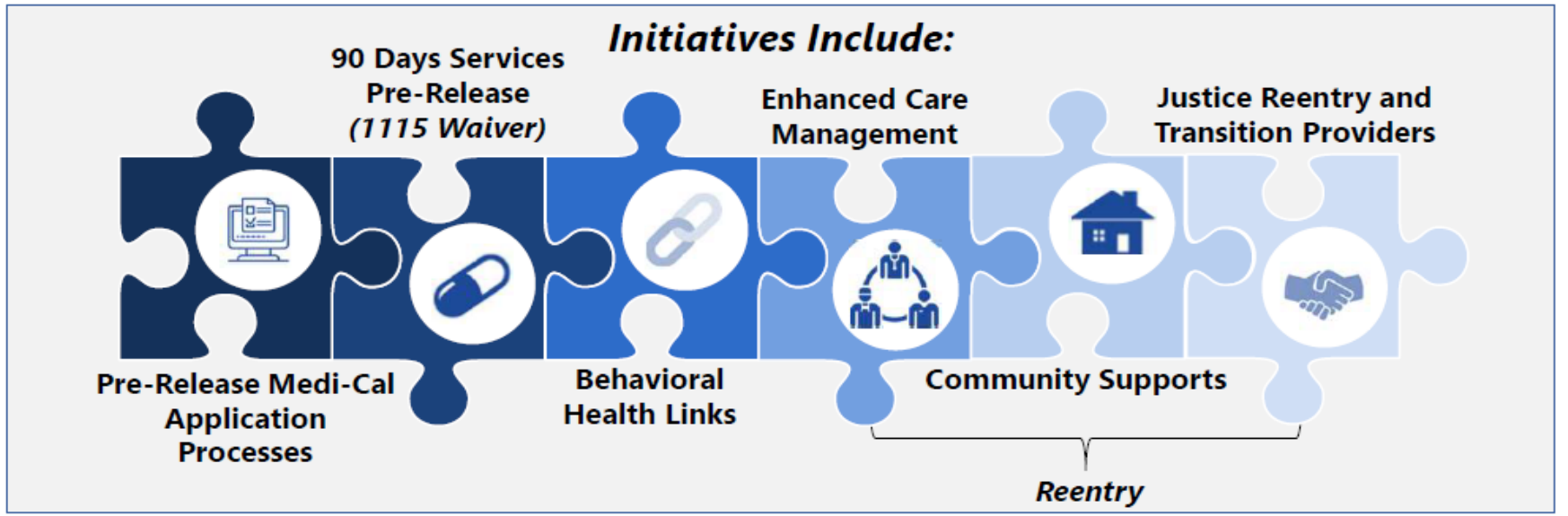
Telehealth is an option for most services as a means of increasing accessibility to SUD services. BHS is responsible for ensuring that SUD providers who are part of the County of San Diego DMC-ODS Network follow standard telehealth protocols for protecting member confidentiality. Contracted organizational providers in the County of San Diego DMC-ODS shall:

- Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries:
- The beneficiary has a right to access covered services in person. Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at anytime without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
- Non-medical transportation benefits are available for in-person visits. Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

Justice Involved Initiative

The CalAIM Justice-Involved Initiative is Comprised of Pre-Release and Reentry Components

The CalAIM Justice-Involved Initiative supports individuals leaving incarceration by ensuring they are enrolled in Medi-Cal, providing key services during the pre-release period, and connecting them with behavioral health, social services, and other providers that can support their reentry.



Justice Involved Initiative

- 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

Justice Involved Initiative

- 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 has established a referral pathway to ensure coordination of care and compliance with BH linkages.
- Three programs are in place to assist with these referrals: two for adults (Neighborhood House's Project In-Reach and Project In-Reach Ministries) and one for youth up to age 21 (CoSD Next Move).
- Although local correctional facilities estimate to go-live with pre-release services and referrals by October 2025, CDCR (state prison) has already begun to send referrals to our local BH Linkage providers.

Residential Authorization Requirements

Residential Authorization Requirements

- **Initial Authorizations (submit within 72 hours of admission)**
  - Enroll client in SmartCare Client Program
  - Notify Optum via telephone
  - Complete fax coversheet
  - Provide proof of insurance or no insurance
  - **If Adult:** complete SUD Residential Authorization Request
  - **If Adolescent**: complete Initial Level of Care Assessment or SUD Residential Authorization Request

Residential Authorization Requirements

- **Continuing Authorizations (submit within 10 days of admission)**
  - If level of care (LOC) change, enroll the client to new LOC in SmartCare
  - Complete Fax coversheet
  - **If Adult:** complete Adult ASAM Criteria Assessment or SUD Residential Authorization Request
  - **If Adolescent:** complete Initial Level of Care Assessment or SUD Residential Authorization Request

Residential Authorization Requirements

- **Extension Authorizations (submit no later than day 80 from admission)**
  - If level of care (LOC) change, enroll the client to new LOC in SmartCare
  - Complete Fax coversheet
  - If Adult: complete SUD Residential Authorization Request
  - If Adolescent: complete Initial Level of Care Assessment or SUD Residential Authorization Request

Important DMC-ODS Program Requirements

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.
- 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.

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.

AOD Certification

- References: BHIN 25-003;HSC Chapter 7.1
- All programs are required to obtain and maintain an AOD Certification from DHCS.
- **Initial Certification:** Required before providing services.
- **Re-Certification:** Providers are eligible to renew certifications every two years provided the programs remains in compliance with the Standards set forth in BHIN 25-003.
- In accordance with the Alcohol and/or other Drug Program Certification Standards, Section 3000(b), the program shall submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation and renewal fees to the department 120 days prior to the expiration date reflected on the certificate. Failure to provide all necessary documentation shall result in the termination of the certification in accordance with Section 3000(d).

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.

Professional Staff Requirements

Professional staff shall (continued):

- 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.

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.
- 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.

Medical Director Responsibilities

- 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.

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.

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 childcare 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).

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.

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.

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
- A record of the annual minimum four hours of training shall be maintained on the Staffing Status Report (SSR) and System of Care (SOC) application.

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. Ensure that Parole and Probation status is not a barrier to SUD services.
- When the needs of a client cannot be reasonably accommodated, a referral(s) is made to appropriate programs.

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.

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

Grievances and Appeals; NOABDs

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 Pre-Paid Inpatient Health Plans (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

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 member is free to exercise their rights, and the exercise of those rights does not adversely affect the way providers treat the member.
- Cannot prohibit or restrict a provider acting within lawful scope of practice from advising a member 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.

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.

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 member, 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
- Integrated MHP and DMC-ODS Member Handbook
- Denial and Termination notices

NOABDs

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.

Tracking

There is currently a manual process for reporting NOABD information. Programs submit NOABD data on a quarterly basis. Quarterly submissions are due to QA by the 15th of month following the end of the quarter.

NOABD: Choosing the Correct Notice

- **There are (9) different types of notices**
- **The Termination Notice- Completed by providers**
  - Like 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 member when discharging for non-compliance (all DMC-ODS programs) as well as for unsuccessful discharges (i.e. AWOL)

- **The Denial of Authorization Notice- Completed by Optum**
  - When member 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

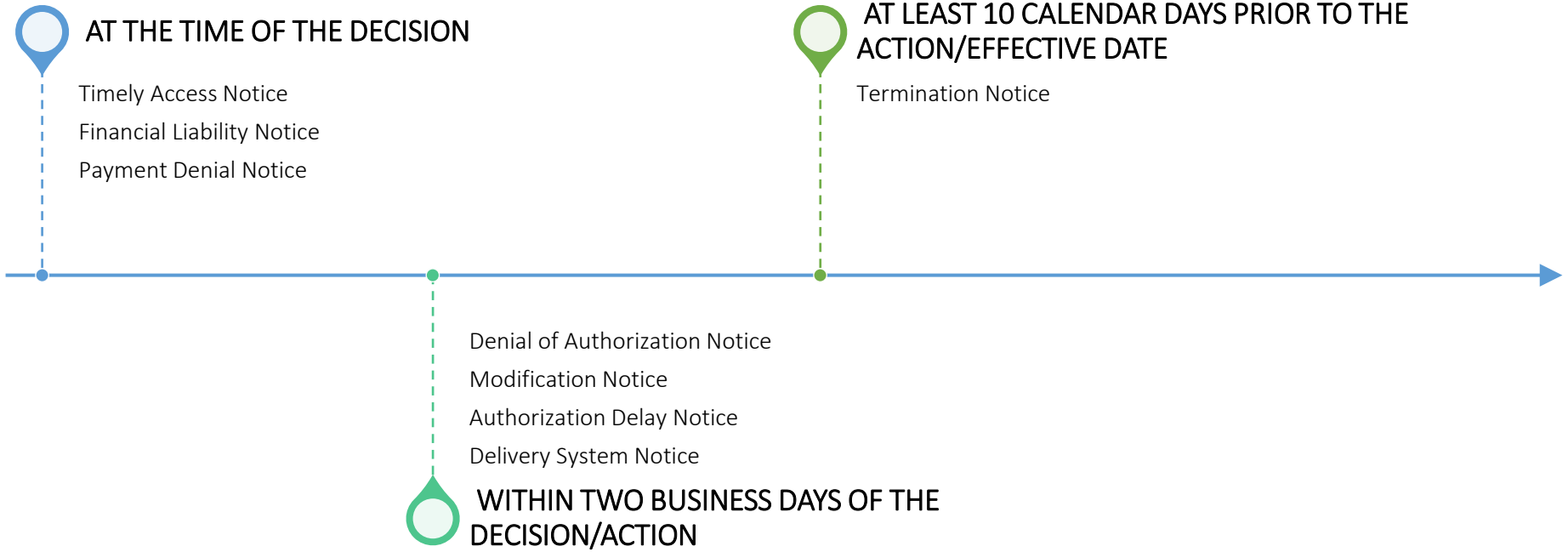
- **The Timely Access Notice- Completed by providers**
  - When requested services cannot be provided within timelines

NOABD: Choosing the Correct Notice

- **Denial of Payment for a Service Rendered by a Provider- Completed by County**
  - BHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a member.
- **Modification Notice- Completed by Optum**
  - When a BHP modifies or limits a requested services
- **Dispute of Financial Liability Notice- Completed by the County**
  - When the BHP denies a member's request to dispute financial liability, including cost-sharing and other member financial liabilities.
- **Delay in Processing Authorization Notice- Completed by Optum**
  - When requested services cannot be provided within timelines.
- **Delivery System Notice- Completed by providers**
  - When the member doesn't meet criteria for specialty mental health or SUD serviced through the BHP. Member is referred to the appropriate health care delivery system (i.e., Managed Care Plan, Medi-Cal Fee-for-Service, mental health, substance use disorder), or other services.
- **Failure to Timely Resolve Grievances and Appeals- Completed by Patient Advocacy (JFS & CCHEA)**
  - Issued when timeframes for standard resolution of grievances and appeals is not met.

NOABD Timeline

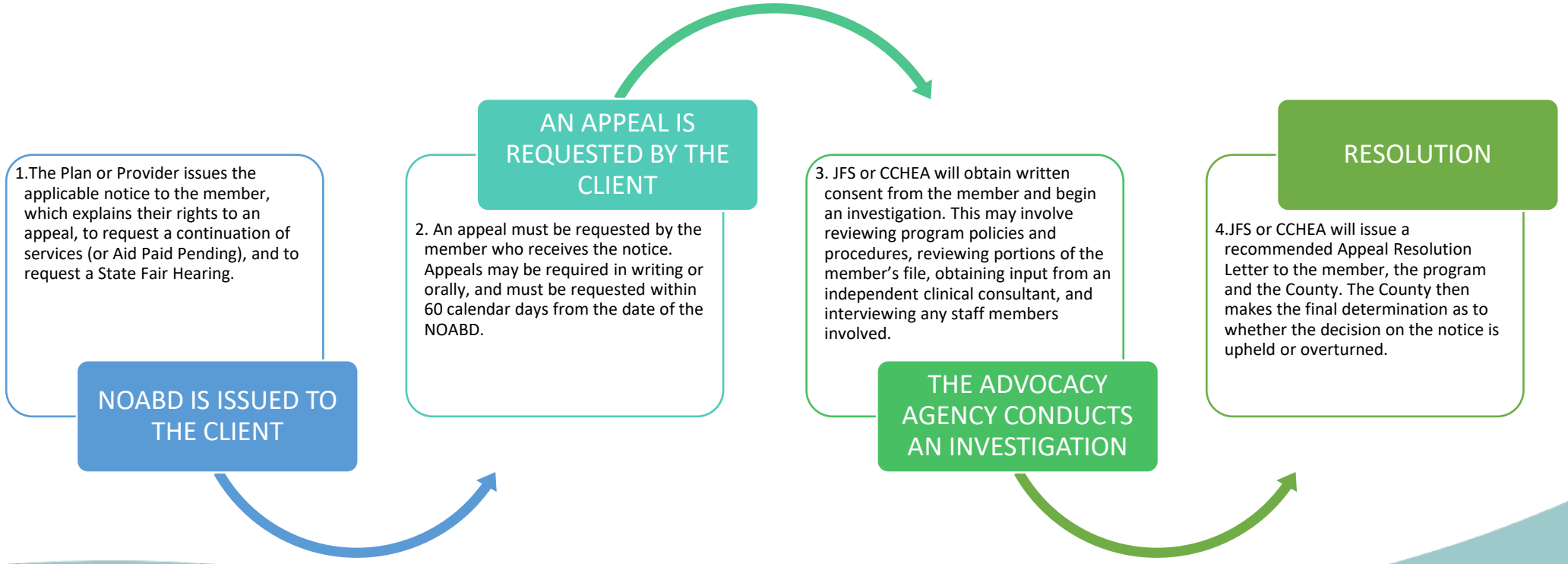
When does each notice need to be mailed/issued to the client?



Note: If a member appeals their discharge and requests Aid Paid Pending, the program should keep the case open until the resolution of the appeal.

NOABDs and Appeals

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



Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training Requirements

- When a member files a grievance claiming a BHP (or its subcontractors or staff) failed to provide trans-inclusive health care, the BHP must report that grievance DHCS every quarter.
- If the grievance is resolved in favor of the member:
- The person named in the grievance must retake the trans-inclusive cultural competency training (as specified in BHIN 25-019).
- This retraining must be completed within 45 days after the grievance resolution and before that person can have any direct contact with members again.

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

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

The purpose of this Behavioral Health Information Notice (BHIN)

- **Purpose** – Clarifies the responsibilities of MHPs and DMC-ODS when creating MOUs with MCPs.
- **Oversight** – Outlines compliance and reporting requirements to DHCS.
- **MOU Use** – Defines roles and responsibilities, and promotes coordination, information sharing, accountability, and transparency.

MOU Between MHP or DMC-ODS and MCP Requirements

- **MHP/DMC-ODS Role** – Provide medically necessary specialty mental health and substance use services, and coordinate beneficiary care.
- **MOU Purpose** – Ensure coordination of medical and social service needs when beneficiaries use both systems.
- **Service Coordination** – Define services, responsibilities, and oversight for each party.
- **Education & Training** – Require education for beneficiaries, providers, and subcontractors on accessing services and MOU requirements.
- Education resources for beneficiaries can be found on Optum Website under Health San Diego page. https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/healthy-san-diego.html

MOU Between MHP or DMC-ODS and MCP Requirements

- **Screening & Referrals** – Policies for screening/assessment, using required tools (e.g., SABIRT), and referring beneficiaries between parties.
- **Care Coordination** – Policies for coordinating access, treatment planning, ECM, Community Supports, prescriptions, and ongoing monitoring.
- **Emergency Planning** – Policies to maintain care coordination during disasters or emergencies.

MOU Between MHP or DMC-ODS and MCP Requirements

- **Quality Improvement** – Outlines QI activities to monitor and improve MOU compliance.
- **Data Sharing** – Defines required data exchange, allowable information sharing, and privacy law compliance (HIPAA, 42 CFR Part 2).
- **Dispute Resolution** – Explains processes for resolving conflicts and escalating unresolved issues to DHCS.
- **General Requirements** – Covers other contract requirements.

Healthy San Diego Managed Care Plans (MCP)

Healthy San Diego

Medi-Cal Managed Care Plan Contact Card

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

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

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

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

Healthy San Diego Managed Care Plans (MCP)- Resources

- Enhanced Care Management
  - A free Medi-Cal MCP benefit that provides a lead care manager to coordinate medical, behavioral, and social needs—like doctor visits, medications, hospital care, food, and housing.
  - More information on Optum: Enhanced Care Management for Medi-Cal Members

- Community Supports
  - Community Supports are free services from Medi-Cal MCP that can help with housing, in-home care, recovery, and healthy meals to support health and wellbeing at home and in the community.
  - More information on Optum: Community Supports for Medi-Cal Members

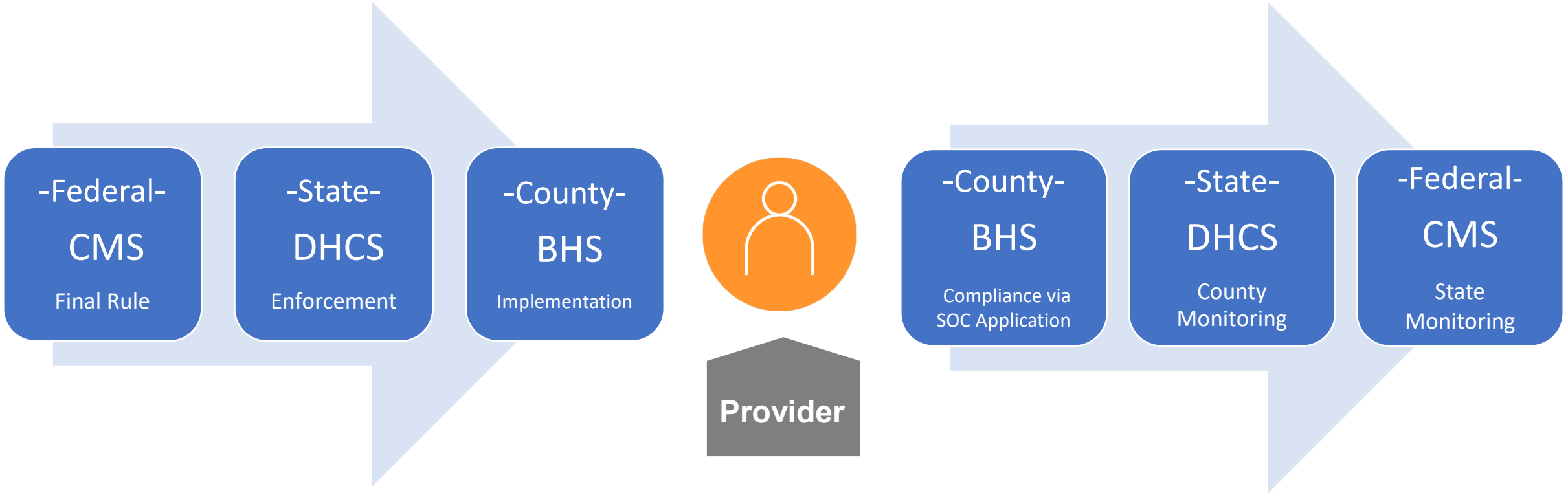
Optum San Diego Website
Healthy San Diego

- 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.

274 Expansion and The System of Care Application

274 Expansion (previously NACT) Background and Flow of Data



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

Reporting Standard

274 Expansion Project

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

- DMC-ODS Providers
  - 274 reporting requirements for DMC-ODS have been deployed into production since October 2023

Reporting Standard

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

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

Monthly SOC Attestation Process

Go to **www.OptumSanDiego.com**

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

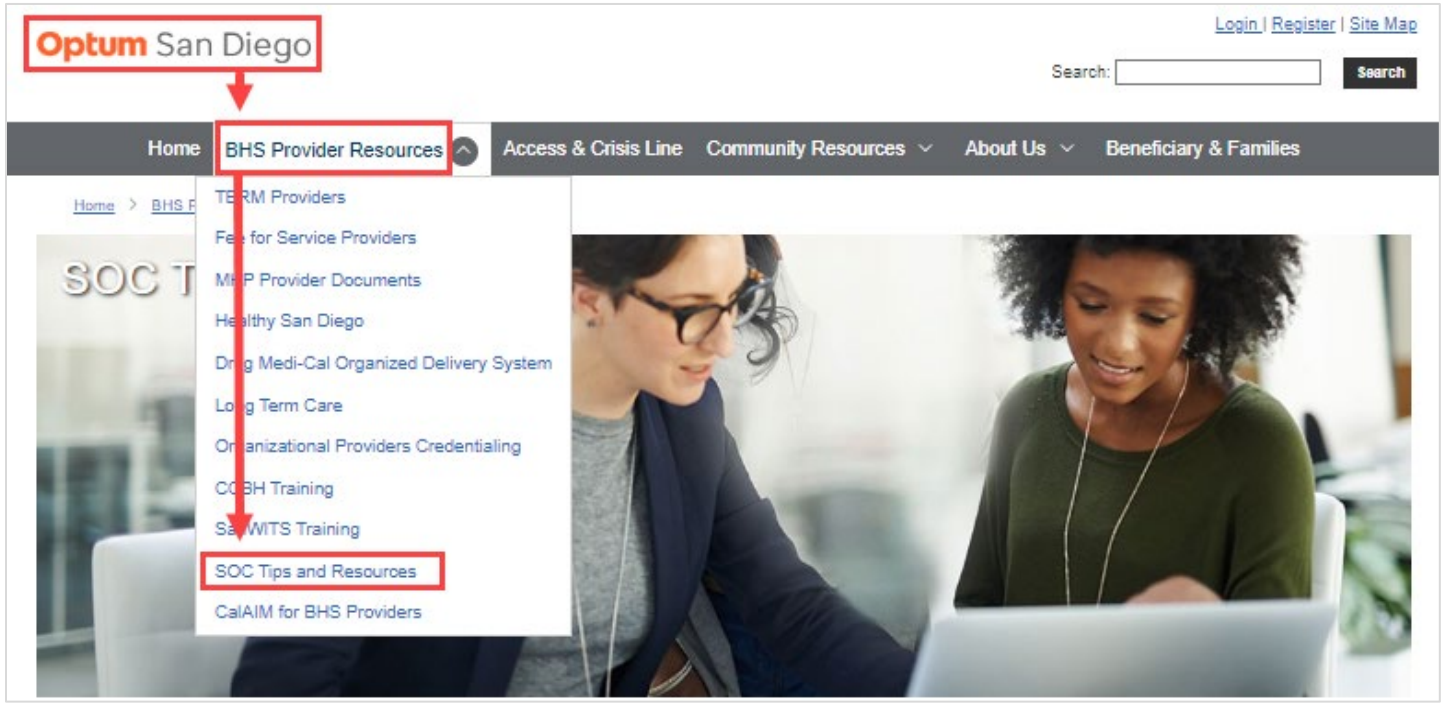
Click on the **SOC** link

Roles: Provider, Manager, Manager with provider update

Review information on **EACH** tab/subtab

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

Tips and Resources



OptumSanDiego.com

Optum Support Desk

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

Program Integrity

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 42 CFR guidelines:
  - Development of a code of conduct and compliance standards.
  - Assignment of a compliance officer who oversees/monitors compliance program.
  - A communication plan which allows workforce members to express complaints/concerns without fear of retribution.

Internal Compliance Program

(Continued)

- Create and implement training and education for workforce members regarding compliance requirements, reporting and procedures
- Development and monitoring of auditing systems to detect and prevent compliance issues
- Creation of discipline processes to enforce at the program
- Development of response and prevention mechanisms to respond to, investigate and implement corrective action regarding compliance issues.

Internal Compliance Program

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

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

Reporting Fraud, Waste & Abuse (FWA)

- Any concerns about ethical, legal and billing issues (or of suspected incidents of FWA) must be reported immediately to:
    - **Your program COR**
    - BHS QA Team at **QIMatters.HHSA@sdcounty.ca.gov**

- In addition, program must report to the **DHCS State Medicaid Fraud Control Unit** by any of the following ways:
    - Phone: 1 (800) 822-6222
    - Email: fraud@dhcs.ca.gov
    - Mail: Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations, P.O. Box 997413; MS 2500, Sacramento, CA 95899-7413

SmartCare Resources

- CalMHSA: https://2023.calmhsa.org/ to find:
  - Procedure Code Definitions (Service code crosswalk)
  - Clinical Documentation Guide 2025
  - …and so much more!

Resources

- Optum San Diego: https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers.html
- SUD Provider Operations Handbook: SUDPOH
- DHCS Behavioral Health Information Notices: https://www.dhcs.ca.gov/provgovpart/Pages/2025-BH-Information-Notices.aspx

Questions?

Email the SUD QA Team at
QIMatters.HHSA@sdcounty.ca.gov

Thank you for all that you do!