DMC-ODS Annual Training FY 25-26 Transcript

Glenda Baez: Hello good morning welcome to the DMC-ODS annual training. My name is Glenda Baez SUD-QA supervisor. I will go ahead and begin by going over housekeeping guidelines with you. All attendees will be muted upon entering the meeting to prevent any background noise. If you're calling from a phone line, please do not place the call on hold. We ask that if you need to take another call to please hang up and call back. Live captioning is available. If you click on the three dots at the top of your team's window that says more, you would scroll and select, turn on live captions. To help with connectivity issues and to easily be able to see the ASL interpreter, we ask the participants turn off their video upon entering the meeting. Live caption again is available. Please use the raise hand feature or actually, excuse me. So, we are actually not doing questions at this time, but you can add them into the chat, and we will be providing an FAQ after the training. Attendants will be taken from the username list. If your name does not appear, please send your name and the name of your program through the chat or the email the email to QI Matters and we can add you to the list. Thank you, everybody. If you can go ahead and put up the slides Trung. Okay, so once again, welcome to the annual DMC-ODS training, Fiscal year 25-26 for the County of San Diego held in Humans Services Agency for the Behavioral Health Services Unit, Health Plan Operations, for the Drug Medical Organized Delivery System Next slide, please. Okay, I stated earlier. Everybody is muted upon entry. Questions will not be answered during this training, but we do ask that if you have questions, please put these in the chat. There will be a Q&A sent out following this training with all questions addressed. This training is being recorded and will be available on Optum. All the information is accurate as of August 28, 2025. for any future updates, please reference any communications from BHS, including the monthly up to the minute, the UTTM also on Optum. Next slide, please, or Next slide, thank you.

So, this training will go over just big picture updates, both on the state and the county level. We will be reviewing DMC ODS requirements. BHIN's to Know, which are the behavioral Health Information notices, and other intergovernmental requirements. Next slide, please?

The BHS HPO DMC ODS Leadership Team is listed here. So first we have Tabitha Lang, who is our operations administrator. We currently have a vacant position for our behavioral Health program coordinator for the SUD-QA team. This was formerly Noel Vitor. She is currently left the county for other opportunities, so we have a vacancy in that position. The SUDQA supervisors are Diana Welch, and myself, Glenda Baez. The program coordinator for BHS quality assurance is Erin Shapira. The administrative analyst 3 supervisor is Malisa Touisithiphonexay. Alfie Gonzaga is the program coordinator for the Health Plan Administration Department. And Becky Ferry Rutkoff is the IT principal, Management Information System. Next slide, please.

And this is our SUD-QA team. We have several specialists, many of you might be familiar with. Many have probably been contacting you to schedule your annual QAPRs. So, we have Charissa Allen. Blanca Arias, Tara Benintende. Apologies to technical difficulty there. I'll start again. Carissa Allen, Blanca Arias, Tara Benintende, Natalie Capra, Melissa Geiger. David Kim, Helen Kobold. Kevin Kolodziej, Tammy Pham, and Jennifer Zapata. Next slide, please.

So now I'll be transferring over the presentation to Tabatha Lang, who will be going over BH Connect with you.

Tabatha Lang: Hi, everyone. I'm going to take my video off, but I just wanted to say hello and welcome to our annual training. So BH Connect, you can read here. It's the behavioral Health, community based, organized networks of equitable care and treatment. And I'll tell you all about it, but I'm only going to call it BH Connect moving forward. Next slide.

So, what is it? Basically, in a nutshell, it is an initiative that the state came up with to really develop a multi-prong approach to improving the behavioral health services for medical numbers. And they got very creative in how they approached the CMS, the federal government. So, they used what is called an 11-15 demonstration. That is a waiver that you all, I think, are very familiar with. That is what DMC-ODS was built upon. It was kind of a demonstration waiver, and that's an authority that allows us to do things that we typically cannot do. So, the state created an authority based on some waiver language. They also updated our state Plan Amendment. That's the contract that California has with the federal government. So, they put some of the changes for this initiative within that contract, and then they also pulled forward some existing Medicaid authorities and really are clarifying for counties, things that they can do under existing authority. So, they pulled all three of these key authorities together, and that's kind of the umbrella for the entire initiative and what they're hoping to do Next slide.

You'll see there are goals of the demonstration Project and of the initiative. So basically, CMS has said, you can do this initiative if you reduce utilization and lengths of stay in emergency departments. If you reduce preventable re-admissions to acute care hospitals and residential settings, if you improve availability of crisis stabilization and mobile crisis, outpatient services, they want improved access to community-based services and care coordination following episodes of acute care. So, in kind of a nutshell, what they're saying and what California is saying that we really want to build out our continuum of care on the outpatient level and support people, so they are staying for shorter stays in residential settings, acute care settings. And so, California specifically is requiring counties to expand community-based services and offer evidence-based practices that have been proven to be effective. They're looking at improved outcomes for members, and they are kind of having a focus in some lanes

and some work streams. A focus on those involved in child welfare, involved in the justice system, and those experiencing or at risk for homelessness. They are really working the state's really working hard to improve their technical assistance to counties and then also they're looking at incentives to support county infrastructure that's required to develop a continuum, to be sustainable, to develop the infrastructures needed. And then they're really very focused on expanding the behavioral Health workforce. We're all very aware of that shortage. And so, the state has said, through this demonstration waiver, they will prioritize some of the funding specific to workforce. Next slide.

And so, with San Diego specifically, all of those goals kind of roll down, and they really align nicely with our vision. We were already working towards expanding community-based services. You might have heard of the optimal care pathways vision. It continues our goal to improve outcomes, supporting our work as a health plan. It will support the Behavioral Health Services Act. That's the BHSA, the Prop One measure that was on the ballot, also known as Behavioral Health Transformation, that, again, is a funding source that's expanded for mental health and substance use services. And so, kind of they will intersect in some areas and really BH Connect will support those efforts to advance system integration. And as noted, really a key goal is expanding the Behavior Health Workforce and supporting our network adequacy as part of our health plan requirements, our providers need to be geographically located to be available to the members that we serve. We have to have access times within certain standards, and we need to have staffing ratios available. And so all of that is kind of combined into this network adequacy requirement that counties are working towards. And so, the state has outlined various requirements. You all know access times or very important. We're always looking at where our services are within the county. We're looking at the state is looking at where Medi-Cal members live within our county. They are looking at zip codes. They are, you know, mapping out where our programs are, which programs provide telehealth and really looking at counties to how we are maintaining that adequate network. And as noted, behavioral health workforce is that key foundation. And so, we're putting a lot of effort in that space. Next slide.

I noted quickly, so the eligibility populations of focus, the primary is individuals with significant mental health and substance use disorders, and then some work streams are specific to those with justice involvement, youth, in or at risk of child welfare involvement, and then those experiencing or at risk of homelessness. Next slide.

So, I mentioned it's a multi prong, multifaceted initiative, and you can see here, I've kind of put them into eight key work streams. So, one is the workforce support. As mentioned, California is putting dollars specific to the workforce efforts in training, and kind of loan forgiveness programs and we've sent out information about that previously and we'll continue to send anything that the state sends to counties. Also, moving to the

right support for children and youth, that is a specific work lane and they're going to be focused on working with child family, well-being, very collaboratively. They want to see a lot of support between BHS and child family well-being, and that they're going to have specific activity stipends and brand-new kind of ideas and initiatives in that workstream. They're also focusing on transitional rent assistance. This will be dollars available but requiring counties to work very closely with managed care plans as you know, there are some rent assistance programs available through the medical benefits that the managed care plans manage. And so, it's really, the state's really requiring the counties to work closely and make sure those benefits are exhausted prior to utilizing these dollars specific through BH Connect. The performance-based incentives, that really is more of the county infrastructure dollars that the state is offering. They are well aware that many counties have to improve infrastructure, get accredited, perhaps, by the NCQA, which is quality assurance standards. They're looking at our performance measures, the state's identifying specific performance measures, and will be measuring counties, and then dollars will be made available based on kind of those incentive dollars will be available based on progress that's demonstrated. Another workstream is community transition Services, as mentioned in one of the goals, a key focus is moving individuals from residential, acute care settings into the community. So, they are offering a new benefit, to provide assistance to those individuals who have been in long term stays in residential settings. They are now allowing us to bill Medical for services to help transition them into the community and make those transitions successful. Another workstream that you might hear a lot about is the short-term inpatient psychiatric care. We locally have several they're called IMDs or institutions for mental disease. These are acute psychiatric hospitals or some mental health rehab centers or long-term care facilities. This is a term that was established years and years ago, but it's basically an Institute for Mental Disease is a larger program that's primary focus is psychiatric care. And as such, if an entity is identified as an IMD, there has been no federal funding available in those settings. So, counties have had to use county funds, local funds to really support those levels of care. With this waiver, under BH Connect, one portion of the 11-15 demonstration waiver, I spoke about was federal government saying, okay, if facilities meet certain requirements and the stays are short term, counties and states can now claim federal dollars for these stays under this waiver. So, you'll hear it's the IMD, FFP, Federal Financial Participation, and it is a really big opportunity for counties to maximize revenues. Now, what the federal government and state said, though, was again to kind of support the goals of BH Connect. If we're now going to receive federal funding for these short-term stays, they're saying we also have to opt in and provide evidence-based services in the community again, with that goal to reduce readmissions and to support community-based care. So, you'll see new evidence-based services is listed there, any county that opts into the short-term inpatient care reimbursement is required to do a list of the evidence-based services I'll get into. And then they also, as I

mentioned previously, they are clarifying existing evidence-based services that are allowable and they are providing technical assistance and a lot of those are children focused, which is really going to be a great support. Next slide.

So, I mentioned the new evidence-based practices. You've probably heard of these County of San Diego does have some programs in these service lanes, but the difference now is going to be that counties, it will become a benefit because we're opting in. We will have to follow fidelity to the EBP model, which is a new requirement, and they state is looking at different ways to build for these services under BH Connect. So assertive community treatment that's, again, community based, high intensity model. Again, we offered that in San Diego. I'm sure you've heard the term ACT. They're also focused on Forensic ACT, and that's tailored for individuals who are involved in the justice system. They're looking at specialty care for first episode Psychosis. And again, these are all evidence-based practices that have been deemed effective. And this is one that is a community-based model, and it is really intended to be an early intervention with individuals with symptoms of early psychosis, and the goal is to help keep them in the community. Next slide.

They're also looking at individual placement and support model of supported employment. This is community, team based services, really helping our member population, lead functional productive lives, again, in the community, and looking at maintaining competitive employment, you'll see here, I made a note a lot of these are specialty mental health service, focused, still, as SUD providers, it's going to be very important for you to be aware of these resources and refer any co-occurring clients. But this one, the state has also said they're looking at how DMC-ODS providers can also participate in this IPS model. Clubhouse services. Again, we have clubhouses here locally. This will require us to follow some fidelity standards, and it'll be the first time we can bill Medical for these services. They are rehabilitative programs, again, in the community, and they really assist individuals with building relationships, engaging in work in education activities, and receiving some supportive services, and as noted here, we'll be following the international standards for fidelity and the work order day because that's what DHCS is requiring. We also have community health worker services, so this is a benefit through the managed care plans, but the state has said that it would be beneficial if behavioral health plans also provided community health worker services. They're calling them Enhanced CHW Community health workers in our behavioral health system. They're really focused on assisting individuals within our specialty system, our specialty mental health, and SUD or DMC-ODS System of Care. It's helping our clients navigate, right? The various delivery systems navigate their benefits through Medical and their managed care plans, really helping them access needed care, community resources, looking at social drivers of health, kind of what is needed. That, too, those Enhanced Community Health Worker Services will be available in specialty

mental health and DMC-ODS programs. The county recently put out information about these services and a really encouraging our providers to look at how these could potentially be beneficial within your programs and then talk to your CORs about potential contract amendments. If this is something you'd like to implement and hire staff and provide these new services, there are requirements, and again, all of that information is available. Next slide.

So, I mentioned briefly infrastructure incentives, really for counties, to utilize, to assist with building processes, building our monitoring, abilities. They're looking at us improving our access to behavior health services, right, expanding our network, seeing more people, having people engage in services, making sure that we meet timely access standards. They're looking at outcomes, quality of life measures, and then we, as a county, we had to submit kind of a baseline assessment with the National Quality Assurance Standards. We did that back in, gosh, almost, it was a year ago, almost. And what the state has said is counties can utilize those baseline results and then create goals to make improvements in those areas, and there will be funding available for that. And then they're really focused on improved data sharing. So those incentive dollars can be used for us to make sure we're talking with the managed care plans, talking with the network providers. We're moving towards perhaps using the health information exchange, really moving towards interoperability, and there will be some dollars available for that. I also mentioned the evidence-based practices, those, again, will be conducted to fidelity, and they will have outcome measures, and those measures will be reviewed as well, and dollars performance dollars will be tied to those also. Next slide.

So, county participation, we continue to wait for information. It's coming down in phases. We are aware there's policy guides available. We will need to tell the state which evidence-based practices that we intend to cover. We locally are moving forward with the IMD, FFP, and by default we'll be required to opt into all of the evidence-based practices. We don't yet have timelines for those. EBP starting. However, the state is offering technical assistance. As I noted, and they have contracted with, they're calling them Centers of Excellence. And so, we're starting meetings with those entities to see what's required for us to move forward with the EBPs I mentioned, right? ACT, FACT, Supported Employment, Clubhouses. So we are, again, kind of moving in phases. Next slide.

And just noting that the demonstration, again, is going to be over years. And so, this first year, the workforce dollars have been implemented at the state level. It's kind of phase one, the Centers of Excellence, the incentive program is starting up. We have to submit a plan. We're looking at the evidence-based practices for youth specifically, including high fidelity wraparound. There's multisystemic therapy and functional therapy. And again, these are evidence-based interventions that are available, and we are looking at kind of that technical assistance as well. And that's starting again in this demonstration

Year 1, which is really calendar year 2025. The activity stipends, we're still waiting for additional information from the state as well as how we're going to integrate child welfare and specialty mental health assessments. That's part of the state's goal to really have us work hand in hand for youth involved in both systems. So next calendar year, you'll see demonstration year two. They're looking at an incentive program that'll work across sectors to include child family well-being, BHS, and managed care plans. We don't yet have a lot of interesting information on that yet, but we're awaiting DHCS direction. And then they're also looking at evidence-based tools for us to use as level of care, guidance, and we're waiting for that, probably again, next calendar year. And then on a rolling basis, we are able. counties are able to opt in to the evidence-based practices, community-based services, locally, we are looking at timelines and also looking at how that intersects with the behavioral health transformation or BHSA timelines. So, a lot of behind-the-scenes kind of mapping out, currently happening. And then for, again, the IMD stays, we've done all of the steps to begin billing for that and needing to follow timelines specifically, so we have those evidence-based practices within our community, within the next year. And next slide.

Is kind of looking again at county specific. So, as I noted, we are going to participate in the incentive program. We already began providing peer services, and we're going to start making sure that there are peers with justice involved. specialization training, and then the Community Health Worker Services. We have begun a pilot within our county operated clinics and have sent the information out to our network providers for you all to kind of consider how those workers could potentially support your programs and the people you serve. We've also begun the technical assistance for ACT and FACT, as well as for some of the youth evidence-based interventions. And we will need to complete preliminary fidelity assessments, and that is currently on through several years, as you can see. And then once we have more information from the state about the other work streams, we will be kind of rolling those into our strategic plan. The state has given us deadlines within two years, within three years of Go-Live, but we're really looking to see if we can, you know, beat those and get some of these services up and going by next year. So, more information, definitely to come. This was really meant to be kind of an overview. So, when you hear like BH connect, you know just what it is and then you can use this as a reference and always, as always, you can reach out for any additional information. Next slide.

I'm going to turn it over. So, thank you all again for being here. and enjoy the rest of the training.

Jennifer Zapata: Hello, my name is Jennifer, and I am going to be going over the relevant Behavioral Health Information notices, also known as the BIHNs. There is one BHIN 25-0114. I'm not going to cover, but it will be covered under the three BIHNs and appeal section of the training. Next slide.

So, these are so BIHNs 24-001 is the DMC-ODS requirements from 2022 to 2026. It is updated and supersedes 23-001 and 21-024. It's basically bringing the regulations in alignment with BIHNs released throughout 2023. Some of the topics covered in the BIHN 24-001 is the EBSDT, the DMC-ODS program criteria for services covered DMC-ODS services, DMC-ODS MAT policy, justice involvement populations in Cal-Aim, justice involved initiatives, Indian healthcare providers, responsibilities of DMC-ODS plans for DMC-ODS benefits, EBP requirements, the quality Improvement and financing for DMC-ODS. Next slide.

For California outcome measurement system, you know it all as Cal-Aims BIHN 24-030 is updating the demographic data, BIHN 25-001 is updating the protocols for collecting and reporting. The discharge data in Cal-OMs. So, there is some new Cal-OMs treatment data collection guide, Section 8, discharge now has specific instructions on the discharge status and exit reasons and Cal-OMS is updated to mandate last data Service, primary exit reasons, etc. Next slide.

A lot for the BIHN 25-003 AOD certification. This is it supersedes 23-058 updates mandatory certification requirements and provides guidance for SUD programs already certified. Some of the areas in this BIHN that are covered are the certification process, compliance and enforcement, operational requirements, clients' rights and protections, Specialized Service Services facility Standards, staff, and personal requirements, Investigation, and complaints. So, it's really giving detailed requirements also for the initial certification, amendments, and renewals, compliance, enforcement so that no false statements about certifications status. It talks about the fines for noncompliance also as the daily fines and that certification can be revoked if noncompliant. It's going into the operational requirements, like counseling services. It's really defining the minimum and maximum hours for the level care. For example, residential must have a minimum of five hours per week. Outpatient maximum of nine hours per week. IOS intensive outpatient, there should be a minimum of nine hours, maximum 19 hours per week for counseling services. It's going over those staff and facility standards. It's also defining the detoxifications services and addresses MAT services and reporting standards. Next slide.

BIHN 25-007 is the traditional healthcare practice benefit implementation, which became effective March 21st, 2025, for DMC-ODS County shall provide coverage for traditional healthcare 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. This also is this information is reflected in our SUDPOH C8, regarding this BIHN. Next slide.

BIHN 25-008 is regarding narcotic treatment programs and regulation changes. This BIHN brings DHSCS into alignment with SAMSA guidelines from February 2024. It's

updating. The treatment standards to include admission criteria and screening. It's really eliminating that one year opiate addiction history before receiving MOUD. It also removes requirement for clients under 18 to have had two unsuccessful treatment attempts before receiving NTP care. It also likes expanding access to treatment. So, the telehealth capabilities expanded, you know, screening to initiate MAT services may be conducted via audio or audio-visual only telehealth if certain providers allow screening to initiate methadone via audio-visual is permissible given certain conditions in person exams, are still required within two weeks of admission. So, there's, you know, really focus on that updating treatment standards and access to treatment. Next slide.

The next BIHN 25-010, the peer support services, Medi-Cal peer support specialist I'm sorry. Medi-Cal peer support services specialists and certification program standards. So, there's the three service components as outlined in the California Medicaid plan on educational skill building groups engagement and therapeutic activity. Those educational skill building groups promote skill building in the areas of socialization, recovery, self- sufficiency, self-advocacy, development of natural supports, maintenance of skills, and which is limited to 2 to 12 medical members, engagement are activities are coaching the support participation and behavior health treatment, therapeutic activity, or those non clinical activities, which promote recovery, wellness, independent living. Peer support specialist qualifications, talking about those peer support supervisor requirements, and also sets forth the code of ethics for Peer support Services, and then it also defines which codes can be used. Also, wanted to note that BIHN 25-07, which there isn’t a slide, but it's going to reflect an increase in licensure and certification fees that went into effect July 1st, 2025, because DHCS has assessed higher fees for licensure and certification of residential and outpatient SUD recovery of treatment facilities, so I want to put that out there. Next slide please.

BIHN 25-019, transgender, gender diverse or intersex cultural competency, training requirements. Based on SB923, the transgender, gender diverse or intersex inclusive Care Act. It puts forth that all staff who are in direct contact with members, whether oral, written, or otherwise, in the delivery of services must complete evidence-based cultural competency training for the purpose of provider trans inclusive healthcare for individuals who identify it as TGI, transgender identity. Refresher training as required of a complaint about failure to provide trans inclusive care is failed and out help. We will go more over this later and detail in this training. Next slide.

BIHN 25-028 BH Connect, Enhance Community Health Worker services. What Tabatha went over also. Just remember that this is different than peer support services. Effective April 11, 2025, there is a new benefit and the specialty mental health and DMC-ODS. More information is in the state plan additament 24-0052 Enhance Community Healthcare Workers services are tailored and preventative services for members living with significant behavioral health needs, service focuses on supporting engagement and

chronic disease, management, conducting outreach to individuals with complex needs and facilitating improve mental health and SUD outcomes, among other diverse areas of focus. Two areas of service activities under health education and health and navigation. Group and individual services were up to six hours per year per member. Next slide.

BIHN 25-029, alcohol or other drug AOD counselor educational requirements, so this is going to become effective January 1st, 2026, first year it's updating the terminology. First year registered counselors registered less than one year and has not yet renewed status remains until first renewal, even as they transfer certifying organizations. Registered counselor is a registered one plus 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. The education requirement for the first time registers on or after July 1st, so it's already occurred. Must complete 80 hours of approved education, including court competencies within six 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, and then renewal first year counselors must apply for renew at least 120 days before their current expiration, certifying organization must notify within seven days of receipt and issue a decision, whether they're approving, deny, or incomplete within 40 days. Next slide.

In anticipated future information notices regarding the ASAM criteria fourth edition in December 2023, the American Society of Addiction Medicine released the ASAM Criteria Fourth Edition and Alignment with the goals of Cal-Aim and the evolving standards of care. The California Department of Health Care Services is anticipated to adopt the fourth edition of the ASAM criteria for who use the DMC-ODS soon. We’re just strongly encouraging all legal entities, you know, to begin to train your staff and your programs in advance of the implementation of those updated standards, and you can find information on our Optum page under the SUD resources, and then now I am going to turn it over to my colleague Melissa for other service reminders.

Melissa Geiger: Thank you, Jennifer. Good morning, everyone. This is Melissa Geiger and I'll be reviewing other service reminders. Next slide.

We're gonna begin with care coordination. CAR coordination consists of activities to provide coordination, of said 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. They're executed memoranda of understanding the contractors 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 LPHA or a registered certified counselor. Next slide.

Care coordination continued. Care coordination service shall include one or more of the following components. Coordinating with medical and mental health care providers to monitor and support home co-morbid health conditions. Discharge planning, including coordinating with said 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 service business 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. Next slide, please.

And for Peer Support Specialist services as of July 1st, 2023. These must be provided by a certified Peer Support Specialist. They can provide services and all levels of care other than recovery services, reminder per BIHN 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. These are further defined in BIHN 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 Cal-AIM for BHS Provider section of the Optum website. Next slide please.

Another resource is 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. It can be found in Section A. Remember, this is not for internal consultation. The contractors shall only allow DMC providers to bill for clinician consultation services. Next slide.

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. Next slide, please.

Recovery Services include the following, 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 set, and relapse prevention, which includes interventions designed to teach beneficiaries with said how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary set. Recovery services can be delivered in claims 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. Next slide.

Medications for addiction treatment or MAT. Medications for addiction treatment includes all FDA approved drugs and biological products to treat alcohol use disorder. Opioid use disorder, 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, prescribed and monitoring for MAT for OUD and AUD and non-opioid SUD, which is prescribing and administering, dispensing, ordering, monitoring, and are managing the medications used for MAT, for OUD, AUD, and non-opioid SUDs. Recovery Services, SUD Crisis intervention Services, and withdrawal management Services. Next slide.

And as a 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. Please continue to follow all requirements in BHIN 23-054 and your DHCS approved MAT policy and give written notice to DHCS for any changes. Next slide.

Contingency Management. Contingency management 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 contingency management as a benefit in the Medicaid program from the centers from Medicare and Medicaid services as part as the Cal-Aim 115 demonstration. The recovery incentives program is available in participating DMC-ODS Counties, including San Diego County and outpatient intensive outpatient and narcotic treatment program study. Next slide.

Eligibility for contingency management must be Medi-Cal enrolled in meeting criteria for individualized SUD treatment, reside in a participating DMC-ODS County, approved for

recovery incentives program, receive services and nonresidential DMC-ODS programs offering contingency management per DHCS rules. Members who are receiving care in residential treatment are not eligible for a dual enrollment in contingency management. For more information, contact your program COR or QI Matters. Next slide, please.

All right, 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 provider to initiate referral and coordination of care. This can be member consent, transition planning, ongoing care. Case, excuse me, contingency management completes intake. Maintain ongoing Care coordination, and for more information, please see BHS Info Notice dated 06/11/2025 on Optum. Next slide, please.

Telehealth Consents. As a reminder, per BHIN 23-018, we want to remind providers that under the county of San Diego, DMC-ODS, telehealth is an option for most services as a means of increasing accessibility to SUD services. BHS is responsible for ensuring that sub providers who are part of the county of San Diego, DMC-ODS Network, follow standard telehealth protocols for protecting member confidentiality. Contracted organizational providers and the county 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 unless 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 any time without affecting the beneficiaries' 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. Next slide.

I Believe this takes us to the end of other services reminders, so I'm gonna pass it on to my colleague, Helen Kobold

Helen Kobold: Hi. Um, I am Helen Kobold, and I will be going through justice involved initiative. As you can see, we have a slide here describing all the different pieces to the puzzle. Cal-AIM justice involved initiative is comprised of prerelease and pre-entry components. The Cal-AIM Justice involved initiative supports individuals having incarceration by ensuring they are enrolled in Medi-Cal, providing key services during the prerelease period and connecting them with behavioral health, social services, and other providers that can support their re-entry. Next slide, please.

Justice involved initiative. Looking at targeted prerelease services within the 90-day period prior to release to support transition from correctional facility and pre-release services provide to determine need for behavioral health links. Next slide.

Justice Involved Initiative. BH links promote continuity to treatment and correctional facilities are required to facilitate referrals links to post release behavioral health provider and share information with the individual health plan. Locally, BHS has established a referral pathway to ensure coordination of care and compliance with behavioral linkages. Three programs are in place to assist with these referrals. Two for adults, neighborhood house project in reach and project in reach. Whoops. ministries. And one for our youth up to age 21 and caused D next move. Although local correctional facilities estimate to go live with a prerelease services and referrals by October 2025. CDCR State Prison has already begun to send referrals to our local BH linkage providers. Next slide.

Residential authorization requirement. Next slide, please.

Initial authorizations, and this is for residential programs, who are required to turn in their authorizations. Initial authorizations, submit within 72 hours of submission. Enroll your client, enroll your client in SmartCare client program. Notify Optum via telephone of this. Complete your facts cover sheet, provide proof of insurance or no insurance. If this is an adult, complete the SUD residential authorization request. If adolescent, complete the initial level of care assessment for SUD residential authorization request. Next slide, please.

Continuing authorizations, please submit these within 10 days of admission. If the level of care or LLC change enroll the client in the new LOC in SmartCare. Again, complete the facts cover sheet. If an adult, complete adult ASAM criteria assessment or SUD residential authorization request. If this is an adolescent, complete the initial level of care assessment or SUD authorization request. Next slide, please.

Extension authorizations. Please submit these no later than 80 days from admission. If level of care or LOC change, enroll the client in new LOC in smart care, complete facts cover sheet. If an adult, complete SUD residential authorization request. If adolescent, complete the initial level of care assessment, or SUD residential authorization request. Next slide, please.

And I am now going to hand off to my colleague, David Kim. Thank you.

David Kim: Thank you, Helen. I'd like to go versus some important DMC-ODS program requirements. It's important to note to the programs that these required elements are informed by our intergovernmental agreement with the state. Next slide, please.

First, I'd like to look at DMC certification and enrollment. DHCS shall certified eligible providers to participate in the DMC program. The stage shall certify any contractor operated or non-government providers. The certification shall be performed prior to the date on which the contractor begins to deliver services under this agreement at any of their sites. Providers of perinatal DMC services will also be properly certified to provide

these services and comply with the applicable requirements. All providers of services must be licensed, registered, DMC certified, and approved in accordance with applicable laws and regulations. Contractors subcontracts shall require that providers shall comply with all applicable regulations and guidelines. Next slide please.

The contractor shall notify the provider enrollment division of any additions or change of information in a provider's pending DMC certification application within 35 days of receiving notice. The contractor shall ensure that a new DMC certification application is submitted to the enrollment division, reflecting this change. The same will go for any notification, for reduction of covered services, or relocations of the site, within 35 days of received notification of the provider’s intent to reduce covered services or relocate, the contractor shall submit or require the provider to submit a DMC certification application. The certification application shall be submitted to the enrollment division 60 days prior to the desired effect date of the reduction of cover services or said relocation. A provider certification to participate in the DMC program shall automatically terminate in the event that the provider or its owner's officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. A conviction shall include a plea of guilty, or nolo-condendary. Next slide, please.

I want to remind all of our providers that the DMC certification enrollment is separate from the AOD certification requirement that was covered earlier in this training during the BHIN section. But if you'd like more information here, you could please review it when the training is sent out. Next slide.

Now, I'd like for us to look at the professional staff requirements. We want to make sure that our programs ensure that all providers are licensed, registered, and enrolled, and are approved in accordance with all applicable state and federal laws and regulations. That all providers abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by DHCS. Our providers will be defined as any of the following: LPHAs, AOD Counselors, medical directors of the narcotic treatment program, who is a licensed physician in the state of California, or a Peer Support Specialist who is certified with the state approved Medi-Cal, peer support specialist certification program, and who meet all other applicable California state requirements, including ongoing education requirements, which we will be talking about shortly. Next slide.

Nonprofessional staff shall receive appropriate onsite orientation and training prior to performing assigned duties, a professional and or administrative staff shall supervise any and all nonprofessional staff. Professional and nonprofessional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of training, certifications, and licensures shall be contained in their personnel files at all times. Both physicians and professional staff, including LPHAs,

shall receive a minimum of five hours of continuing education related to addiction medicine each year. You would also want to ensure that documentation of the completed trainings are in their personnel files. Next slide, please.

Related to specific to medical director responsibilities, want to ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care. Medical directors will ensure that physicians do not delegate their duties to non-physician personnel, and that there is developed and implemented written medical policies and standards for the provider. Will ensure that physicians register, nurse practitioners, and physician assistants followed the provider's medical policies and standards and ensure that the medical decisions made by physicians are not influenced by fiscal considerations. We also want to make ensure that providers, physicians, and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries and determined services are medically necessary. Next slide.

Also want to ensure that providers, physicians are adequately trained to perform other physician duties as outlying 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 medical director would still remain responsible for ensuring that all delegated duties are properly performed. I want to remind our programs that written rules 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. This is a written policy and procedure that will be reviewed during our audits. Next slide.

I want to turn your attention to 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 documentations substantiate that the beneficiary's pregnancy and last date of pregnancy is maintained in the beneficiary record. Shall comply with the perinatal program requirements as outlined in the perinatal practice guidelines. Ensure that we comply with the current versions of these guidelines until new perinatal practice guidelines are established and adopted. Next slide.

So, the perinatal guidelines should include parent child habilitative and rehabilitative services, examples include development of parenting skills, training in child development, which may include the provision of cooperative childcare pursuant to Health and Safety Code Section 1596.792. Service Access. So, examples include 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. And last, a coordination of ancillary services, examples include assistance in accessing and completing dental services, social services,

community services, education, vocational training, and other services, which are medically necessary to prevent risk to fetus, or infant. Next slide, please.

Regarding record retention, records are required to be kept and maintained and shall be retained by the provider for a period of 10 years from the final date of the contract between the plan and the provider, or from the date of completion of any audit, or from the date of the service was rendered, whichever is comes later. Next slide.

Again, this summarizes the training requirements for personnel, all staff must receive compliance training within 30 days of their first day at work, and annually thereafter. As mentioned before, LPHAs and physicians will require a minimum five hours of addiction medicine, ongoing training, each calendar year. At least one staff will be trained in the administration of a Naloxone, or such as Narcan. All treatment staff receive ASAM training prior to providing services, all personnel who provide withdrawal management services or who monitor or supervise the provision of such service shall meet additional training requirements. Other requirements as documented are listed on the DMC-ODS required trainings website. You can reference that website for any and ongoing documentation of training requirements. Next slide, please.

Will also be required to track cultural competency training, cultural competence includes all services required that all services, policies and procedures be culturally and linguistically appropriate. We want to ensure that programs participate in the implementation of the most recent cultural competence plan. And that they also participate in the county's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients. This includes by, this includes clients who may experience limited English proficiency, come from diverse cultural and ethnic backgrounds, experience disabilities, regardless of gender, sexual orientation, or gender identity. A record of the annual minimum four hours of training shall be maintained through the staffing status report and System of Care application. These hours can be tracked, and we ask that program as attest to these hours monthly in the SOC application for reporting and tracking. Next slide, please.

Regarding access to services, programs must provide SUD services to individuals that meet access criteria and medically necessity requirement as specified in BHIN 25-001 clinical record as a whole would indicate that the client's presentation and needs are aligned with the criteria applicable to their age. Programs must have written admission criteria for determining eligibility and suitability for services documented in each client record. Programs will ensure that policies, procedures, practices, rules, and regulations do not discriminate against special populations. This ensures that parole and probation status is not a barrier to SUD services as well. When the program determines the needs of a client cannot be reasonably accommodated, a referral is made to appropriate programs. Next slide.

So, in these circumstances, transitions to other levels of care may be required. Programs must ensure the transition of the beneficiaries to appropriate LOCs include step-up or step down in covered DMC-ODS Services. Care coordinators shall provide warm handoffs and transportation to the new LOC when medically necessary. Still, care coordinators will ensure that these transitions to other levels of care occur no later than 10 business days from the time of assessment or reassessment without interruption of current treatment services. The initial treating provider shall be the one responsible for arranging care coronation services and communicating with the next provider to ensure smooth transitions and warm handoffs between levels of care. Next slide.

Lastly, covered DMC-ODS Services. Programs shall provide medically necessary covered SUD services as defined in the drug Medi-Cal billing manual to clients who meet criteria for receiving SUD services. Please also reference your contract and statement of work that was established with your COR for services to be provided by your program. Programs shall also observed and comply with any lockout and non-reimbursable service rules. Now I'd like to turn it over to my colleague Tammy Pham.

Tammy Pham: Hi David. Good morning, everyone. I'm Tammy and I will be sharing information with you all related to grievances and appeals, as well as NOABDs. Next slide, please.

First about client rights. programs must have written policies, guaranteeing the rights specified in 42 CFR, section 438.10. The programs must also comply with any applicable federal in state laws that pertain to beneficiary rights and ensure that employees and subcontracted providers observe and protect those rights. Programs also must ensure that clients receive information regarding contractors prepaid inpatient health plans, and plan. They must be treated with respect and with due consideration for their dignity and privacy, they should be able to receive information on available treatment options and alternatives presented in a manner that is appropriate to their condition and ability to understand clients also must be able to participate in decisions regarding their health care, including the right to refuse treatment and be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations. Next slide, please.

Clients may request and receive a copy of their medical records as specified in 45 CFR Section 164.524 and 164.526. They have the right to be furnished with healthcare services in accordance with 42 CFR, 438.206, and 438.210. Programs must ensure that each member is free to exercise their rights and that exercise of those rights does not adversely affect the way that providers treat the member. Also, cannot prohibit or restrict the provider acting within lawful scope of practice from advising a member who is their patient on health status, medical care, treatment option, information to decide on relevant treatment options, risks, benefits, and consequences of treatment or non-

treatment and the right to participate in decision of their own healthcare. Next slide, please.

For program complaints for residential adult alcoholism or drug abuse recovery, or treatment facilities, as well as counselor complaints. These can be made by using the complaint form, which is available on the DHCS website and may be submitted online using this hyperlink here. Any suspected Medi-Cal health fraud, waste, or abuse must and shall be reported to DHCS medical fraud at this phone number or this email address. Next slide, please.

More about the grievance and appeal process. So, providers are required to have available posted materials displayed in a prominent public place, such as the program waiting room or lobby and or be offered to the number in all threshold languages, which are on the Optum website, including grievance and appeal posters and brochures, self-address envelopes with grievance appeal forms. Interpreter services notification, toll-free numbers that have adequate TTY, TTD, and interpreter capability, Access in crisis line posters, integrated MHP and DMC-ODS member handbooks, denial and termination notices. Next slide, please.

Some information on NOABDs. First of all, what is a notice of adverse benefit determination? Notices inform the resident or clients about the adverse or unfavorable determination made the justification with a description of guidelines or criteria used and a citation to authority that supports that action as well as the resident or client's appeals rights. The requirements for these notices are required by both federal and state laws as notated here. Notices apply for all Medi-Cal covered benefits and services. The language on the NOABD must be clear and non-technical and providers should use forms translated into threshold languages when appropriate. Tracking, there is currently a manual process for reporting NOABD information, programs should be submitting the NOABD data on a quarterly basis, which are due to QA by the 15th of the month following the end of the quarter. Next side, please.

So, choosing the correct notice for an NOABD, there are nine different types of notices, so we will go over them briefly. First, the termination notice, which is completed by providers, like former “10-day notice” letter. This is the most commonly used notice, or when a provider terminates, reduces, or suspends a previously authorized service, such as residential, and it must be provided to the member when discharging for noncompliance for all DMC-ODS programs, as well as for unsuccessful discharges, such as if a client AWOLs. Another type of notice is the denial of authorization notice, and this is completed by Optum. This is when a member requests services, but is assessed and is not meeting medical necessity. When the provider denies a request for service, including denials based on type or level of service, medical necessity, appropriateness, effectiveness of the service. Another type of notice is the timely access

notice, which is completed by providers, and this is when requested services cannot be provided within timelines. Next side, please.

The next type of notice is denial of payment for a service rendered by a provider, which is completed by the county. This is when the behavioral health plan 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. Next, we have a modification notice, which is completed by Optum. This is when the Behavioral Health Plan modifies or limits a requested service. The next type is dispute of financial liability notice completed by the county. This is when the plan denies a member's request to dispute financial liability, including cost sharing and other member financial liabilities. Then we have the delay in processing authorization notice, and this is completed by Optum when requested services cannot be provided within timelines. We have the delivery system notice, which is completed by providers, and is required for DMC-ODS. When the member doesn't meet criteria for specialty mental health or SUD serviced through the plan. The members referred to the appropriate healthcare delivery system, such as Managed Care Plan, Medi-Cal fee for Service, mental health substance use disorder, or other services. The last one is failure to timely resolve grievances and appeals, and this is completed by patient advocacy. Next slide, please.

And then next slide again, please. Thank you.

So now we'll talk a little bit about the timeline for NOABDs and win each notice needs to be mailed or issued to the client. So, for the following notices or types of notices, these should be issued at the time of the decision, the timely access notice, financial liability notice, and payment denied denial notice. The following notices should be issued to the client within two Business days of the decision or action, so these would be the denial of authorization notice, modification notice, authorization delay notice, and the delivery system notice. And lastly, this notice should be issued to the client at least 10 calendar days prior to the action or effective date. And this would be the termination notice. And then, as a note, if a member appeals their discharge and requests a pay pending, the program should keep the case open until the resolution of the appeal. Next slide, please.

So, NOABDs and appeals. Any client or member who disagrees with their discharge or other adverse determination may file an appeal. Standard appeals take up to 30 days to resolve, and this is kind of the process that it goes through. First, the NOABD or the plan or provider issues the applicable notice to the member, which explains their rights to an appeal to request a continuation of services or a pay pending, and to request a state fair hearing. Then, an appeal must be requested by the member who receives the notice. Appeals may be required in writing or orally and must be requested within 60 calendar days from the date of the NOAPD. JFS or CCHEA will obtain written consent

from the member and begin reviewing program policies and procedures, reviewing portions of the members' file, obtaining input from an independent clinical consultant and interviewing any staff members involved. Then JFS or CCHEA will issue a recommended appeal resolution letter to the member, the program, and the county. The county then makes the final determination as to whether the decision on the notice is upheld or overturned. So, a brief summary, the NOABD is issued to the client. The appeal is then requested by the client, the advocacy agency then conducts an investigation, and then we come to a resolution. Next slide, please.

So, we spoke a little bit earlier in the training about BHIN 25-019 on slide 25, and this outlines the training requirements for transgender diverse or intersex or we'll refer to as TGI, cultural competency training requirements. So, when a member files a grievance claiming a plan or subcontractors or staff, failed to provide trans inclusive healthcare. The plan must report that grievance to DHCS every quarter. If the grievance is resolved in favor of the member or the client, the person named in the grievance must retake the trans inclusive cultural competency training, as specified in BIHN 25-019 and this retraining must be completed within 45 days after the grievance resolution, and before that person may have any direct contact with members again. And now, I will turn it over to my colleague, Kevin, to talk about MOU requirements.

Kevin Kolodziej: Thanks a lot, Tammy. Hi, everybody, this is Kevin. I'm gonna discuss a little bit about the MOU requirements that are between the specialty mental Health Services and DMC-ODS Services and the Medi-Cal Managed Care Plans. So, on the next slide,

We are going to look at DHCS's Behavioral Health Information Notices 23-056 and 23-057. These BHINs cover some different issues as related to MOUs, so going to be talking about the issue of purpose, which is clarifying the responsibilities of mental health plans and DMC-ODS, when creating MOUs with the managed care plans. Issues of oversight, outlining appliance and reporting requirements to DHCS, and issues around use, so it defines the roles of responsibilities and for most coordination, talks about information, sharing accountability, and transparency. And on the next slide, we'll look into these with a little bit more detail.

So, the mental health plans and DMC-ODS, the role is to provide medically necessary specialty mental health and substance use services and to coordinate beneficiary care. The purpose around the MOU, the MOUs to defined purpose is to ensure coordination of medical and social services needs when beneficiaries use both systems. Talking about service coordination is about defining services, the responsibilities, and the oversight for each party involved. The MOU also addresses education and training, so it's requiring education for our members, for providers, and for subcontractors on

accessing services and the MOU requirements. So, education resources for the beneficiaries can be found on the Optum website under the Healthy San Diego page at the included link down below. Next slide, please.

Some other topics that the MOU, that this addresses talks about screenings and referrals, looking at how policies are set for screening assessment, using required tools, such as the SABIRT and referring to beneficiaries between parties. It looks at care coordination, looking at policies for coordinating access, treatment planning. It has care management and community supports, prescriptions, and ongoing monitoring, and they explore emergency plannings, policies are set to maintain care coordination during disasters or during a larger emergencies. Next slide, please.

So other topics would include quality improvement and outlines, QI activities to monitor to improve compliance with the MOU. Exploring data sharing, defining the required data exchange, allowing information, sharing and privacy law compliance such as HIPAA, 42 CFR Part 2. It looks at dispute resolution. This explains processes for resolving conflicts and escalating unresolved issues to DHCS, and it explores some other general contract requirements. Next slide, please.

So here we can have a look at the four Healthy San Diego Managed Care Plans. This table here presents different phone numbers for member services, for behavioral health, medical advice, vision, etc., etc. It also has some different links to some supports both for advocacy and it has the phone number for accessing more information about from the county mental health plan. This is just a good reference for you guys to have with you on this contact card. Next page, please.

So, looking at Enhanced Care Management. Enhanced Care Management is a free Medi-Cal managed care plan benefit that provides a lead care manager to help coordinate medical behavioral and social needs. So, this includes doctor visits, medications, hospital, care, food, housing. Some more information on this, you can look at Optum under Enhanced Care Management for Medi-Cal members. Looking at Community Supports, well Community Supports are free services from the Medi-Cal managed care plans that could help with housing, in home care, recovery, and healthy meals to help support help and wellbeing, both at home and in the community. And you can find out more information on Optum under Community Supports for Medi-Cal members. Next slide, please.

So, the Optimum San Diego website, so it’s the Healthy San Diego website. Houses is its resources and educational materials for Medi-Cal specialty mental health service providers and for drug Medi-Cal organized delivery system providers. You can find us at http://www.optumsandiego.com at this link. Also, the MOUs covering Mental Health plans to care providers, to Medi-Cal care providers plans, and the DMC-ODS MOUs

these will be posted on the Optum website under the Healthy San Diego page as well. Next slide, please.

And with that, I have the pleasure of introducing Jane Maldonado from Optum San Diego, who will be presenting on a network adequacy. Thank you.

Jane Maldonado: Thank you, Kevin. Hi everyone, as Kevin said, I am Jane Maldonado, and I am from the Optum support desk. In May of 2016, the centers for Medicare and Medicaid Services, or CMS, published the Medicaid Managed Care Final Rule, which established network adequacy standards, which are time and distance requirements, availability or timely access of services, assurance of adequate capacity and services. Next slide, please.

As the mental health plan, the county is required to submit provider and program data to the Department of Healthcare Services that it has met these state standards. And this happens through the collection of the data from SmartCare and the SOC application, which was created by Optum. And Optum then collaborates with county CORs and units to ensure program compliance that data validation, accuracy, and currency. Next slide, please.

DHCS renamed NAT or NACT with 274 Healthcare Provider Directory. So, what was formerly called NAT is now known as a 274 expansion, but the objective stays the same to measure network adequacy. DHCS also expanded the requirements to have data submitted on a monthly basis for the mental health plan to make a provider directory available. So, often developed a searchable provider directory from the information gathered from SmartCare and the SOC application. Next slide, please.

We ask that new providers register for access to the SOC application for the monthly attestation process to review and or update the information in the application on their profile. Managers are expected to attest to the currency and the accuracy of program or facility information. The SOC application is updated regularly to add new fields or update existing ones per state requirements. So, for example, some fields that were previously not required became required, such as the ADA compliance field. The application includes other county data collection projects, such as the medical director fields, and there is a form to collect information about supervisors of peer support specialists. Previously, the SOC application was populated with information from CCBH and Sandwitz, and the data entered by the provider or manager. Since September of 2024, Optum has been working on updating those connections for the data to pull from SmartCare. So, you'll see new information in the SOC application if you log into it. So now, because of these new connections, it is more important for providers and managers to review and attest to the information in the SOC application, in the event that SmartCare information needs to be updated. Next slide, please.

The attestation process is as follows. If you're new to the SOC, start with registering in OptumSanDiego.com. And once you have an account, log in and click on the SOC link to attest to the application. Depending on your role at the program or the facility, you'll see a number of tabs to review and attest to. The more roles you have, like, if you're a provider, or if you're a manager that also provides some services, and the more sites you're associated with, the more tabs you'll see. Make sure you review the information and click on the save and attest button for each tab. It should take about 15 minutes for a provider to complete the attestation for their profile. Prior to submitting the data to the state, the data is reviewed, corrected if needed, Optum reaches out to programs to make sure that the information is accurate, then the data is also validated and reported to DHCS to show compliance with the network adequacy requirements, which again, are time and distance, timely access, and the adequate capacity. I mentioned earlier that the information from the SOC application is available in a public provider directory. These directories are accessible by anyone who visits the Optum or the county website. We ask that providers and managers participate in the attestation process every month or as changes occur to your profiles to ensure that the data collection is most current and accurate so that the provider directory reflects correct information so that clients can seek services at locations most convenient for them to travel to, to be able to attend appointments that fit their schedules, and to see providers who are appropriately certified or registered, or licensed, and who can speak their native language, so that we can provide excellent client care. Next slide, please.

To help you to do all of that, and to assist you through the attestation process, Optum provides trainings and walkthroughs of the application. In the Optum website, the SOC Tips and Resources page is full of guides and instructions. And if you want to reach Optum, the contact information is shown on the screen. Thank you. Next up is Blanca.

Blanca Arias: Good morning, my name is Blanca Arias, and I will be covering program integrity. Next slide.

We're going to talk about the internal compliance. It’s recommended that the program has an internal program integrity, compliant program, to measure it with the size and scope of their agency. So, contractors with more than $250,000 in annual agreements with the county, must have a compliance program that makes the following 42 CFR guidelines. The development of a code of conduct and compliance standards, assignment of a compliance officer who oversees/monitors compliance programs, and a communication plan that allowed the workforce members to express their complaints and concerns without fear of retribution. Next slide please.

Also to 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, and development of response and prevention mechanisms to respond to investigate and implement corrective action regarding compliance issues. Next slide.

Regardless of the size and scope, all programs shall have processing in place to ensure, at a minimum, that staff has the proper credentials, experience, and expertise to provide client services. Shall have document client encounters in accordance with the funding source requirements and health and human services Agency, policies and procedures. The staff shall bill client services accurately, timely and in compliance with all applicable regulations and HHSA policies and procedures. The staff promptly elevates concerns regarding possible deficiencies or errors in the quality of care, buying services, or client billing. The staff shall act promptly to correct problems if errors in claims or billings are discovered. Next slide.

Reporting Fraud, Waste and Abuse, as mentioned before. And this you more definitive ways to report that. So, any concerns about ethical, legal, and billing issues or of suspected incidents of Fraud, Waste and Abuse, must be recorded immediately to your program COR and QI Matters. In addition, the program must report to DHCS State Medicaid Fraud Control Unit, as listed here, with the phone number and the email. There's also a mail opportunity. And that's all for me, I'm going to introduce Glenda Baez to do the remainder of the slides.

Glenda Baez: Thank you, Blanca. So just as a final closing information, we have SmartCare resources listed here for you, which we encourage you to please follow up with. This includes the link to the CalMHSA site, and it has a lot of useful information, which includes things such as the procedure code definitions, clinical documentation guide for 2025 and a lot more items that we encourage you to look for. Next slide, please.

Additional resources include the Optum San Diego website, which is the link is listed here. The SUD provider operations handbook, and this has all of the up-to-date information which we reference, both in UTTMs and QIPs. We reference information from the SUDPOH and the DHCS Behavioral Health Information Notices are available at this link, which is the DHCS website, specifically for the 2025 BHINs and prior year, BHINs as well. So, for any questions, you can email the SUD-QA team, at the QI Matters website listed below. The next slide, please.

So, we want once again, thank you for joining us today and a reminder that this training and recording will be made available on Optum. Any questions that were entered into the chat will be answered in a Q&A that will be sent out following this training. Thank you again, everyone, and have a wonderful afternoon.