Annual DMC-ODS Training
FY 2023-24

County of San Diego Health and Human Services Agency

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

FY 23-24 DMC-ODS Annual Training

- Everyone is muted on entry
- Questions will not be answered during the training, put questions in the chat
- QA will send out a Q&A following the training
- The training is being recorded and will be available on Optum
- All information is accurate as of August 24, 2023
  - For future updates, please reference any communications from BHS, including the monthly Up To the Minute (UTTM)
- Attendance today is being tracked via Microsoft Forms (link and QR code in chat)

FY 23-24 DMC-ODS Annual Training

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

BHS HPO LEADERSHIP TEAM DMC-ODS

- Tabatha Lang, Operations Administrator
- Michael Blanchard, 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
- TBD, Senior MIS Manager
  - Cynthia Emerson, SUD MIS Manager, Principal Administrative Analyst

BHS QA SUD TEAM

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

STATE OF THE STATE
FY 2023-24

County of San Diego Health and Human Services Agency

Behavioral Health Services

Health Plan Operations Unit

How Busy Have We All Been….

And What is Still on the Horizon?

Accomplishments

Access Criteria for SMH and DMC/DMC-ODS

DMC-ODS Policy Improvements

No Wrong Door

Standardized Screening and Transition Tools

Documentation Redesign

Purpose

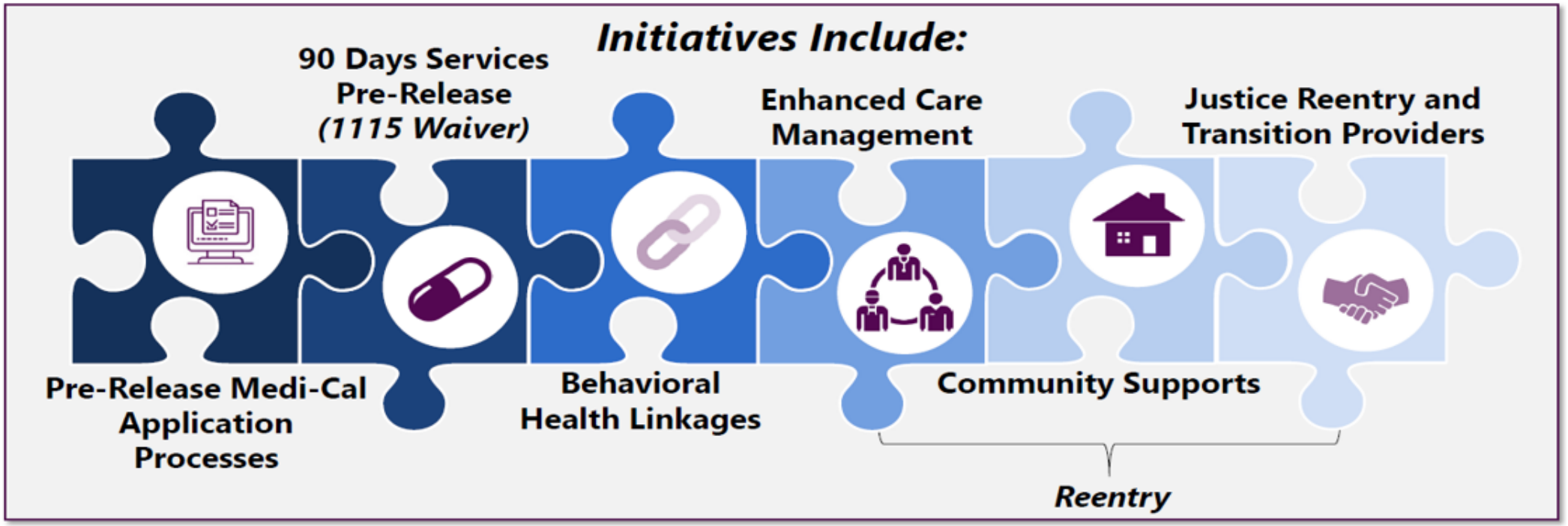
- Expand access to care
- Improve Beneficiary Experience
- Increase delivery system efficiency | Streamline, Simplify, Modernize
- Lay a strong foundation to support focus on quality of care and client outcomes

In progress…

- Mobile Crisis Benefit Implementation
- Recovery Incentives (Contingency Management)
- Behavioral Health Payment Reform
- Justice Involved Initiatives
- Behavioral Health Administrative Integration
- BH-CONNECT Demonstration
- Community Assistance, Recovery & Empowerment (CARE) Act

CalAIM Justice-Involved Initiatives

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their reentry.



BH-CONNECT Demonstration

The central goal is to expand a robust continuum of community-based behavioral health care services for Medi-Cal members living with SMI or SED

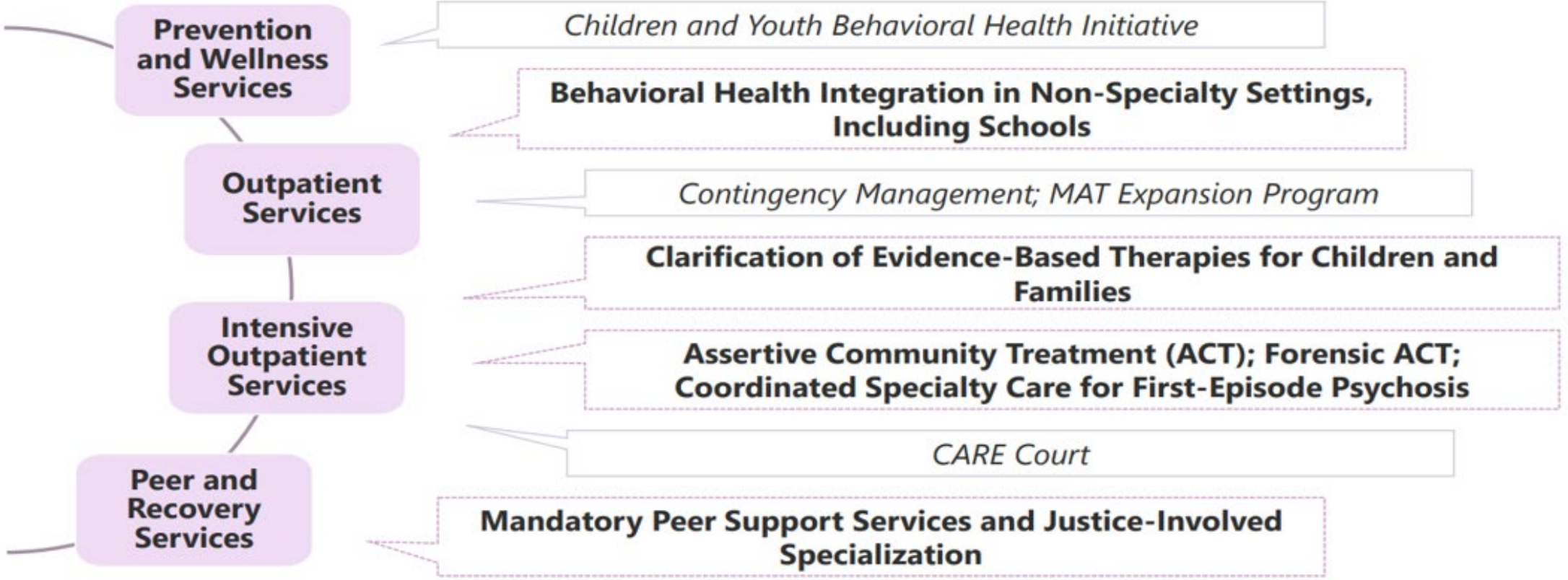
1. Amplify the state's ongoing investments in behavioral health and further strengthen the continuum of care.

2. Meet the specific mental health need of children, individuals who are justice-involved, and individuals experiencing homelessness.

3. Ensure care provided in institutional settings is high quality and time-limited.

BH-CONNECT Demonstration

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



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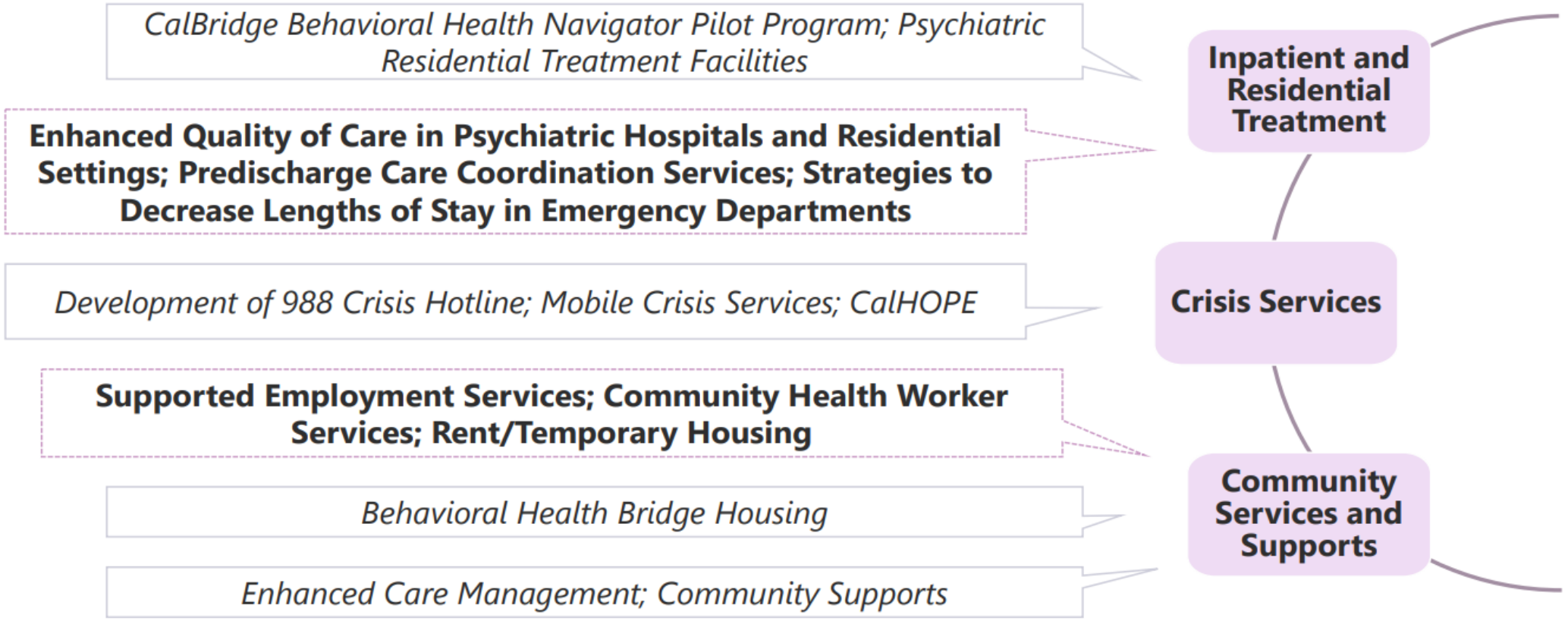


BH-CONNECT Demonstration Populations of Focus

- Children and Youth
- Individuals Experiencing or at Risk of Homelessness
- Individuals who are Justice-Involved

11 Components of BH Administrative Integration by CY 2027+

Streamlining the Beneficiary Experience

1. County-operated 24/7 Access Line
2. Screening, Assessment & Treatment Planning
3. Beneficiary Materials, Appeals & Grievances

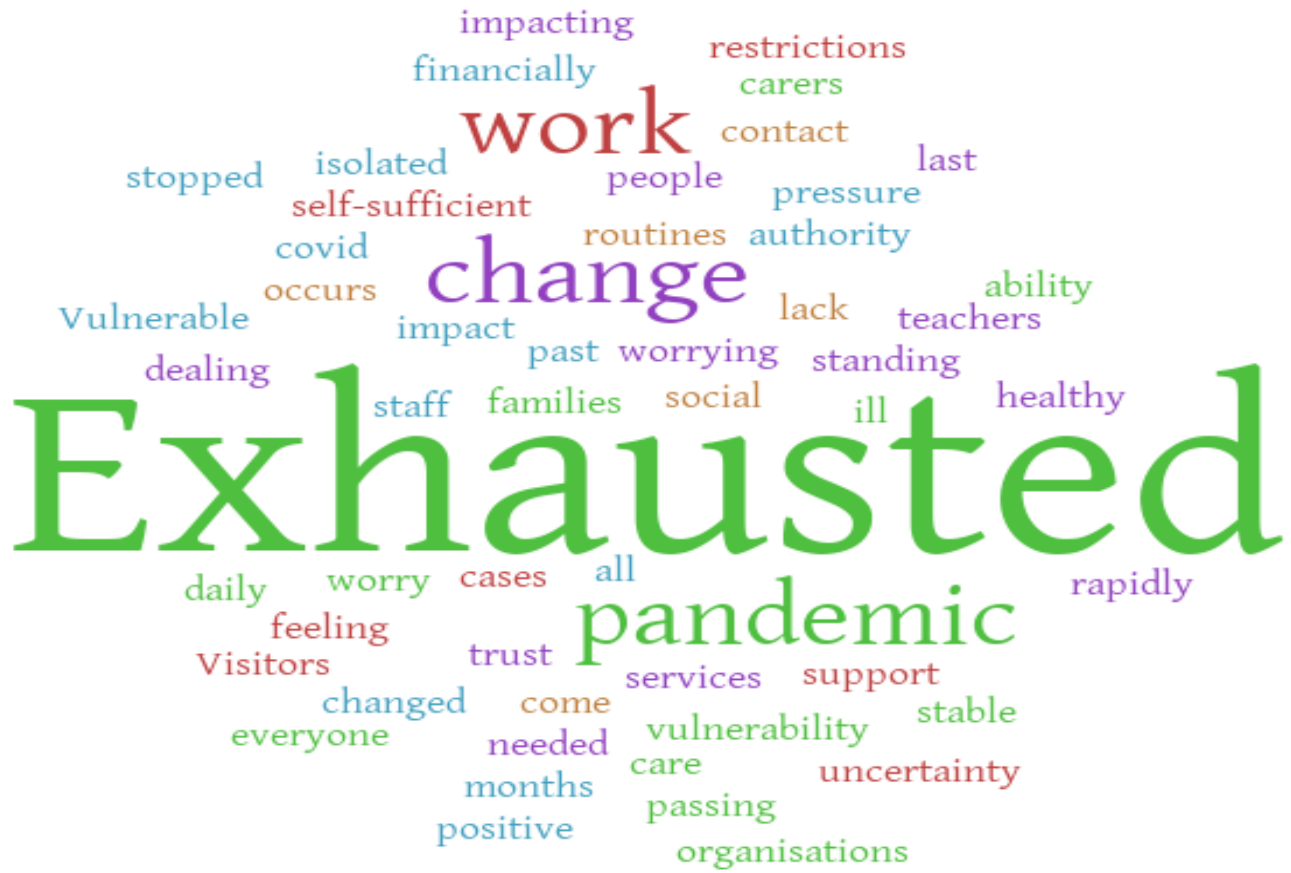
Integrating County Structures and Processes

4. DHCS-County Contracts
5. Data Sharing & Privacy
6. Cultural Competence Plans
7. Quality Improvement

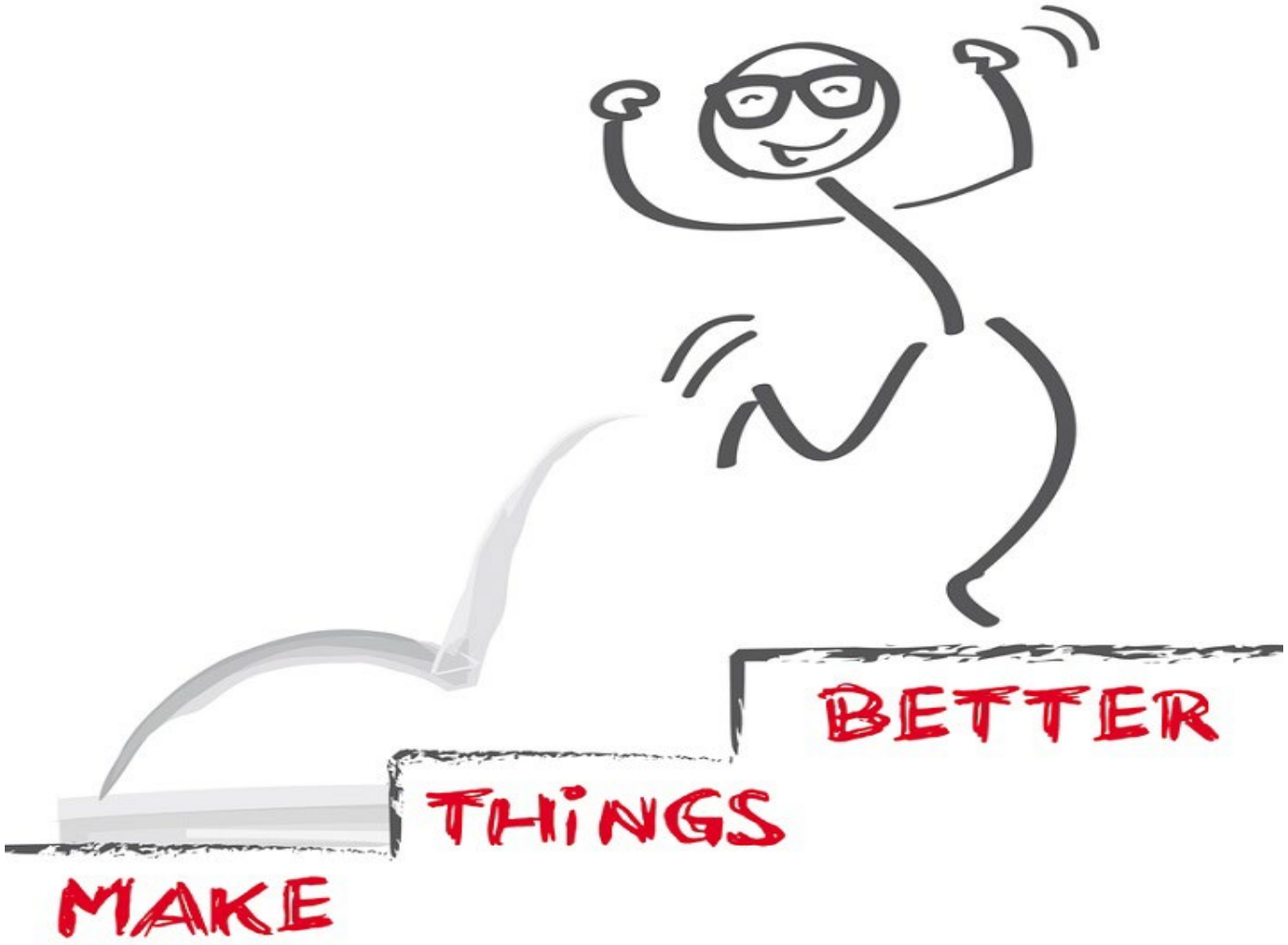
Integrating DHCS Oversight Functions

8. External Quality Reviews
9. DHCS Compliance Reviews
10. Network Adequacy
11. Provider Oversight

While all of this can be overwhelming…



Your work is crucial – and so appreciated!



Thank you

Q&A

Send any additional questions to

QIMatters.HHSA@sdcounty.ca.gov

Key Information Notices from 22-23

23-001

- Updates and Supersedes BHIN 21-075
- Consolidates language from Information Notices and other updates since the release of 21-075 to align with new and updated requirements
- Provides information on Medical Necessity for Services, Covered DMC-ODS Services including detail on all Levels of Care, Peer Support Services, MAT Policy Clarifications, Practice Requirements

23-018

- Providers updated telehealth guidance for all programs
  - Telehealth is not a distinct service, but a mechanism to provide services
  - Outlines who can be a telehealth provider to Medi-Cal beneficiaries
  - Effective no sooner than 1/1/24:
    - If providing services via synchronous audio-only interaction (i.e. telephone), must also offer the same services via synchronous video interaction
    - If providing telehealth, must also offer the same services via in-person face to face contact OR arrange referral to, and facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange care (i.e. just provide a list of referrals/programs)
  - Must obtain and document client's verbal and written consent to receive telehealth services and explain (DHCS has provided model verbal and written consent language):
    - They have a right to in-person covered services
    - Telehealth is voluntary and consent may be withdrawn at any time
    - Non-medical transportation benefits are available for in-person visits
    - Potential limitations and risks to telehealth as compared to in-person services, as applicable

Anticipated future Information Notices

- Updated Documentation Reform
  - Currently anticipated by 1/1/24 with a draft for review Summer 2023
- MAT Services Requirements for SUD Recovery or Treatment Facilities
  - Feedback was requested from counties and stakeholders by 8/8/23, no timeline on final version
- Residential Authorizations
  - No draft has been provided and no timeline has been mentioned; however state solicited conceptual feedback in early 2023
- AOD certification standards are being updated to align with CalAIM

Documentation Requirements (BHIN 22-019)

Assessments

- ASAM Criteria assessment is required
- Must include determination of medical necessity and recommendation for services
  - Problem list and progress note requirements shall support the medical necessity of each services provided
- Assessments shall be updated as clinically appropriate when the beneficiary's condition changes
- If beneficiary withdraws prior to a DSM dx being established, and later returns, the 30/60-day timeline starts over (outpatient only)

Adult Assessments

- Adult programs use the Adult ASAM Criteria Assessment
  - Modified version of the UCLA Adult ASAM Interview Guide
    - Originally a joint effort between UCLA and ASAM
  - Health Questionnaire is still required
  - Outpatient: Must be completed within 30 days of the first visit with an LPHA or SUD counselor (60 days for those under 21 or documented as experiencing homelessness)

Youth Assessments

- Youth Programs will continue to use the Adolescent ILOC and YAI
  - We are anticipating a version of the UCLA/ASAM interview guide for those under 18, but no timeline has been given
  - Outpatient: Must be completed within 30 days of the first visit with an LPHA or SUD counselor (60 days for those under 21 or documented as experiencing homelessness)
  - The paper version has smoking cessation questions and an optional diagnosis narrative to Adolescent ILOC (will not be updated in SanWITS)
  - Health Questionnaire is still required
  - Adolescent ILOC will be used for updated assessments

Problem List

- List of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other service encounters
- The problem list shall include, but is not limited to, the following:
  - Diagnoses identified by a provider acting within their scope of practice, if any.
    - Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
  - Problems identified by a provider acting within their scope of practice, if any.
  - Problems or illnesses identified by the beneficiary and/or significant support person, if any.
  - The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Problem List

- Must be updated on an ongoing basis to reflect the current presentation of the beneficiary
- Must add or remove problems when there's a relevant change to the beneficiary's condition
- DHCS has not specified a timeframe or requirement for how frequently the problem list should be updated. However, providers shall update the problem list withing a reasonable time and in accordance with generally accepted standards of practice.

Progress notes

- Progress Notes shall include:
  - Type of service rendered, date the service was provided, duration of the service, and location of the beneficiary at the time of service
  - Narrative describing the service, including how the service addressed the beneficiary's behavioral health need
  - Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s), and any update to the problem list as appropriate
  - Typed or legibly printed name, signature of the service provider, and date of signature
    - Signature and date must still be a "wet" signature, or part of a valid electronic signature
- Must be completed within 3 days (day of service + 2 days) of providing the service, or 24 hours for crisis services
- If billing on a daily basis (Residential, Withdrawal Management), must complete a daily note

Progress Notes

- A “unified” progress note template will be used for all services rendered, unless a Peer Support Specialist Plan of Care is also being documented
- Outpatient providers will continue to document a progress note for each service provided
- Those billing daily services (residential, withdrawal management), will still need to document Case Management/Care Coordination, Clinical Consultation, and Peer Support Services as separate services

Peer Support Services Plan of Care

- Uses the “unified” note template, with two additional fields:
  - Peer Support Services Plan of Care: Shall include specific, individualized goals that have measurable results
  - Co-Signature by “any treating provider who can render reimbursable Medi-Cal services” only when documenting the Peer Plan of Care. Must follow other signature requirements (printed name, “wet” or valid electronic signature and date)

Group Services

- A list of participants is required to be documented and maintained
- More than one provider can render the service, but only one progress note per beneficiary is required
  - The specific involvement and time of involvement of each provider should be clearly documented
- All other progress note requirements remain

Other Documentation Reminders

- Programs are required to continue providing and tracking the number of hours per week based on the client's Level of Care
  - During Medical Record Reviews, QA staff will ask for P&P and evidence of the required hours.
- Physician Direction form has been updated to include all required elements related to physical exam requirements
- Per BHIN 22-019, NTPs are required by Federal law to create treatment plans for their beneficiaries, and documentation and program requirements were not changed under the BHIN

Billing/Payment Reform

- A reminder that the current billing manual is currently posted to the Billing tab on the Optum website, and there is a crosswalk available under the Toolbox tab
- These will continue to be updated as DHCS provides additional guidance and makes changes to the billing manual.

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 in order to ensure a beneficiary-centered and whole-person approach to wellness.
- Care coordination services shall be provided by an LPHA or a registered/certified counselor.

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)
- Must be supervised by a Peer Support Specialist Supervisor
- For more information, please refer to the Peer Support tab on 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
  - 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)

- All DMC-ODS providers, at all levels of care, shall demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not they seek reimbursement through DMC-ODS. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to be tapered off medications as a condition of entering or remaining in the program. The Contractor shall monitor the referral process or provision of MAT services.

Residential Authorization Requirements

Residential Authorizations

- Initial Authorizations (within 24 hours of admission)
  - Notify Optum via telephone
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- Continuing Authorizations (within 10 days of admission)
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- Extension Authorizations (no later than day 80 from admission)
  - Initial Level of Care Assessment or SUD Residential Authorization Request
  - Fax coversheet
- All forms available under the SUDURM tab on the Optum website

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

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.

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

- 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.

Medical Director Responsibilities

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

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

Client Rights

- Must have written policies guaranteeing the rights specified in 42 CFR 438.100
- Comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensure employees and subcontracted providers observe and protect those rights
- Receive information regarding contractor's PIHP and plan
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
- Participate in decision regarding their health care, including the right to refuse treatment
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in Federal regulations

Client Rights

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

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 client, in all threshold languages, including:

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

NOABD

What is a Notice of Adverse Benefit Determination?

Notices

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

Requirements

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

Language

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

NOABD: Choosing the correct notice

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

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

NOABD: Choosing the correct notice

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

NOABD

Timelines

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

AT THE TIME OF THE DECISION:

Timely Access Notice
Financial Liability Notice
Payment Denial Notice

WITHIN 2 BUSINESS DAYS OF THE DECISION/ACTION:

Denial of Authorization Notice
Modification Notice
Authorization Delay Notice

Delivery System Notice

AT LEAST 10 CALENDAR DAYS BEFORE THE ACTION/EFFECTIVE DATE:

Termination Notice

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

NOABDs and Appeals

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

1.

The Plan or Provider issues the applicable notice to the client, which explains their rights to an appeal, to request a continuation of services (or Aid Paid Pending), and to request a State Fair Hearing.

2.

An appeal must be Requested by the client who receives the notice. Appeals may be requested in writing or orally, and must be requested within 60 calendar days from the Date of the NOABD.

3.

JFS or CCHEA will obtain written consent from the client and begin an investigation. This may involve reviewing program policies and procedures, reviewing portions of the client's file, obtaining input from an independent clinical consultant, and interviewing any staff members involved.

4.

JFS or CCHEA will issue a recommended Appeal Resolution Letter to the client, the program, and the County. The County then makes the final determination as to whether the decision on the notice is upheld or overturned.

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

Access to Services

- Must provide SUD services to individuals that meet access criteria and medical necessity requirement as specified in BHIN 23-001
  - Clinical record as a whole indicates that the client's presentation and needs are aligned with the criteria applicable to their age
- Must have written admission criteria for determining eligibility and suitability for services. This must be documented in the client's record
- Ensure that policies, procedures, practices, rules and regulations do not discriminate against special populations. When the needs of a client cannot be reasonably accommodated, a referral(s) is made to appropriate programs
- Ensure that Parole and Probation status is not a barrier to SUD services

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

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

DHCS Behavioral Health Information Notice

- The purpose of this new Behavioral Health Information Notice (BHIN) is to clarify the responsibilities of Medi-Cal Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) when entering into a Memorandum of Understanding (MOU) with Medi-Cal Managed Care Plans (MCPs).

- The BHIN also issued the MOU Template that is required to be utilized for MOU's between MHPs/DMC-ODS and MCPs.

- The BHIN documents the oversite and compliance requirements as well as reporting requirements to the Department of Health Care Services (DHCS).

- The MOU is intended to clarify roles and responsibilities between MHPs/DMC-ODS and MCPs and support local engagement, care coordination, information exchange, mutual accountability and transparency.

- MHPs/DMC-ODS must execute MOUs with MCPs by January 1, 2024

MOU Between MHP or DMC-ODS and MCP Requirements

- MHPs/DMC-ODS are responsible for providing medically necessary covered Specialty Mental Health Services and Drug Medi-Cal services to beneficiaries set forth in the State Plan and the DMC-ODS Intergovernmental Agreement, MCP Boilerplate Contract, including the coordination of a beneficiary's care.

- The MOU between the MHP or DMC-ODS and MCP shall serve as the primary vehicle for ensuring coordination of medically necessary services, including health-related social service needs, when beneficiaries are accessing services from both systems.

- Describes the services that each party must coordinate for beneficiaries.

- Describes each party's provision of services and oversight responsibilities.

- Requires each party to provide educational materials to beneficiaries and network providers about accessing medically necessary services. Train network providers, subcontractors and downstream subcontractors on MOU requirements and services provided by each party.

MOU Between MHP or DMC-ODS and MCP Requirements

- Describes required policies and procedures covering beneficiary screening and assessment, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services and administering Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) to DMC-ODS beneficiaries ages 11 and older. The MOU requires each party to refer beneficiaries to the other party as appropriate and describes each party's referral process.

- Describes the requirements for coordinating beneficiary access to care and describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination. Includes requirements for parties to coordinate provision of medically necessary services, treatment planning, clinical consultation, Enhanced Care Management (ECM), Community Supports, and prescription drugs.

- Requires parties to have policies and procedures to ensure the continued care coordination for services in the event of a disaster or emergency.

- Describes the parties' quality improvement (QI) activities to ensure oversight and improvement of the MOU requirements.

MOU Between MHP or DMC-ODS and MCP Requirements

- Requires MHP or DMC-ODS to retain all documents related to the MOU requirements for at least ten years.

- Describes the minimum data and information that the parties must share to ensure the MOU requirements are met and describes the data and information the parties may share to improve care coordination and referral processes, and requirements for parties to share information about beneficiaries as set forth in the MHP-MCP MOU and DMC-ODS-MCP MOU template and in accordance with federal and state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2.

- Describes the policies and procedures for resolving disputes between the parties and the process for brining the disputes to DHCS when the parties are unable to resolve disputes between themselves.

- Describes additional general contract requirements.

MOU Compliance and Oversight Requirements

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

MOU Compliance and Oversight Requirements

- MHPs and DMC-ODS Counties must work collaboratively with MCPs to establish dispute resolution processes and timeframes within the MOU.
  - Includes how the MHP or DMC-ODS County will work with the MCP to resolve issues related to coverage or payment of services under conflicts regarding respective roles for case management for specific beneficiaries, or other concerns related to the administered services to beneficiaries.

- MHPs and DMC-ODS Counties and MCPs must complete the plan-level dispute resolution process. If the parties fail to resolve the dispute, either party must submit a written “Request for Resolution” to DHCS. If the MHP or DMC-ODS County submits the Request for Resolution, it must be signed by the county behavioral health director.

- MHPs and DMC-ODS Counties must provide training and orientation of MOU requirements with subcontractors, downstream subcontractors, and network providers, as applicable, on an annual basis, at a minimum. The training must include information on MOU requirements and the services that are provided or arranged for by each party and how those services can be accessed or coordinated for the beneficiary.

- Starting January 1, 2025, MHPs and DMC-ODS Counties must submit an annual report that includes updates from the quarterly meetings with the MCP and the results of their annual MOU review to DHCS.

Healthy San Diego Managed Care Plans (MCP)

Healthy San Diego

Health Plan Contact Card

Health Plan	Member Services/ Transportation	Magellan RX	Telephone Advice Nurse	Behavioral Health Dept.
Aetna Better Health	1-855-772-9076	800-977-2273	1-855-772-9076 Opt. 4	1-855-772-9076
Blue Shield CA Promise Health Plan	1-855-699-5557	800-977-2273	1-800-609-4166	1-855-321-2211
Community Health Group	1-800-224-7766	800-977-2273	1-800-647-6966	1-800-404-3332
Health Net	1-800-675-6110	800-977-2273	1-800-675-6110	1-888-426-0030
Kaiser Permanente	1-800-464-4000	800-977-2273	1-800-290-5000	1-877-496-0450
Molina Healthcare	1-888-665-4621	800-977-2273	1-888-275-8750	1-888-665-4621
Medi-Cal Managed Care Plans cover transportation to all Medi-Cal Covered Services. Pharmacy benefits for all Medi-Cal beneficiaries are covered by the State's Medi-Cal Rx Program (800) 977-2273				
Jewish Family Services of San Diego Patient Advocacy (619) 282-1134		San Diego County Access & Crisis Line (888) 724-7240		Consumer Center for Health Education & Advocacy (877) 534-2524

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

Drug Medi-Cal Quick Guide

Health Plan	Medi-Cal Specialty Mental Health and Drug Medi-Cal Services	Medi-Cal Managed Care Plan Behavioral Health Services (For Mild to Moderate Mental Health Conditions)
Aetna Better Health AetnaBetterHealth.com	San Diego Access & Crisis Line (888) 724-7240	Aetna Better Health (855) 772-9076
Blue Shield CA Promise Health Plan Blueshieldca.com/promise	San Diego Access & Crisis Line (888) 724-7240	Blue Shield CA Promise Health Plan (855) 321-2211
Community Health Group Chgsd.com	San Diego Access & Crisis Line (888) 724-7240	Behavioral Health Services (800) 404-3332
Health Net HealthNet.com	San Diego Access & Crisis Line (888) 724-7240	Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente KP.org	San Diego Access & Crisis Line (888) 724-7240	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare MolinaHealthcare.com	San Diego Access & Crisis Line (888) 724-7240	Molina Healthcare (888) 665-4621

Optum San Diego Website
Health 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.

Network Adequacy/System of Care Application

NEW NACT REPORTING STANDARD

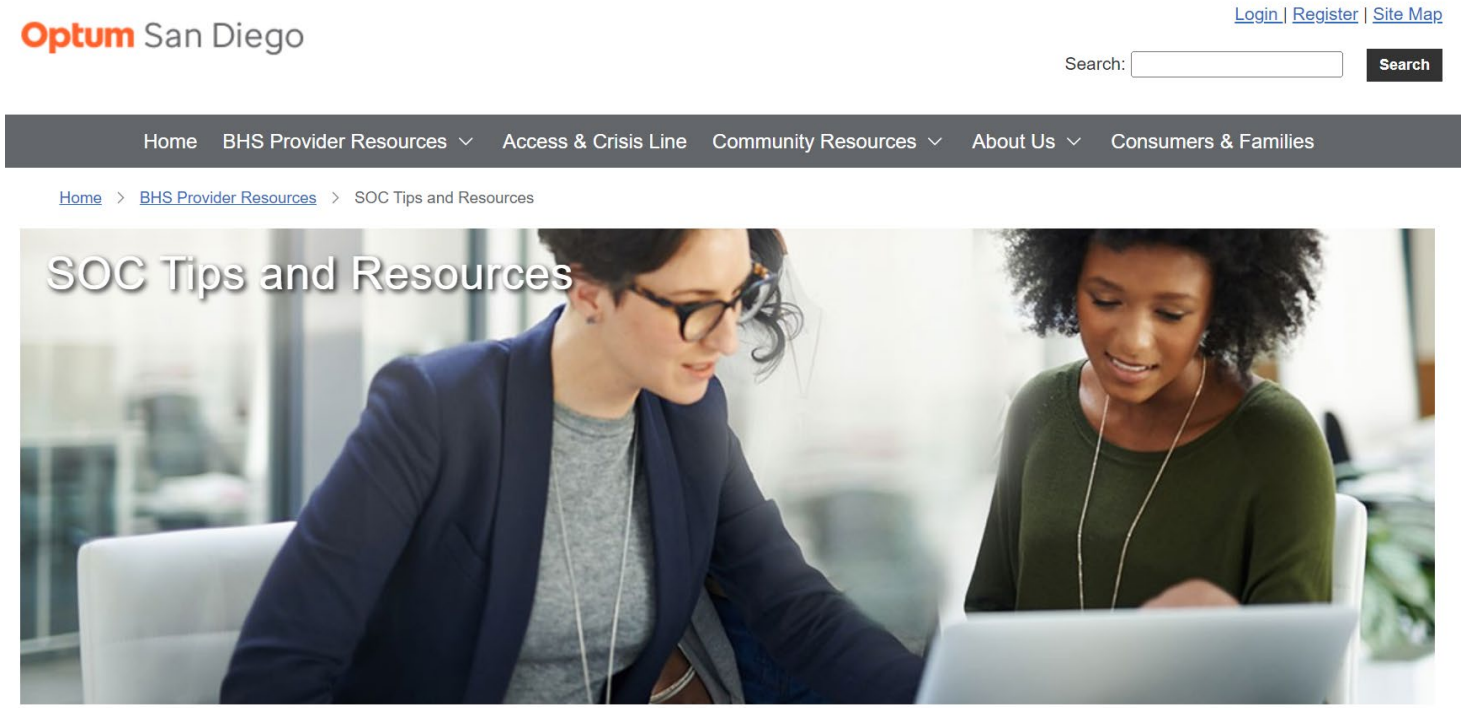
- Registration
  - New hires and program transfers are required to **register promptly and** attest to information once registration is completed.

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

NEW NACT REPORTING STANDARD

- 274 Expansion Project
  - Based on X12 274 Health Provider Directory standard selected by DHCS to ensure all provider network data is consistent, uniform, and aligns with national standards. (BHIN 22-032)
  - DMC-ODS Providers
    - 274 reporting requirements for DMC-ODS are in development, rollout date TBD.

TIPS



OptumSanDiego.com

Optum Support Desk

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

Program Integrity 101

INTERNAL COMPLIANCE PROGRAM

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

INTERNAL COMPLIANCE PROGRAM

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

INTERNAL COMPLIANCE PROGRAM

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

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

REPORTING FWA

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

REPORTING FWA

- In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit.

  Reporting can be done:

  - By phone: 1-800-822-6222
  - Online form
  - fraud@dhcs.ca.gov
  - Medi-Cal Fraud Complaint – Intake Unit

    Audits and Investigations
    PO Box 997413, MS 2500
    Sacramento, CA 95899-7413

PAID CLAIMS VERIFICATION

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

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

Utilization Management Program

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

DMC-ODS Required Trainings (sandiegocounty.gov)

DHCS Information Notices

DMC-ODS on Optum

CalAIM for BHS Providers

Email the SUD QA team at:

QIMatters.HHSA@sdcounty.ca.gov

THANK YOU!

The end.

THANK YOU FOR ATTENDING!