Inaugural Annual DMC-ODS Training

September 11, 2024

Training Overview

Agenda:

- DMC-ODS Overview
- DMC-ODS Policy Clarifications
- SmartCare

Notes/Reminders:

- Training slides will be shared with participants
- The training will be recorded and available to providers

DMC-ODS OVERVIEW

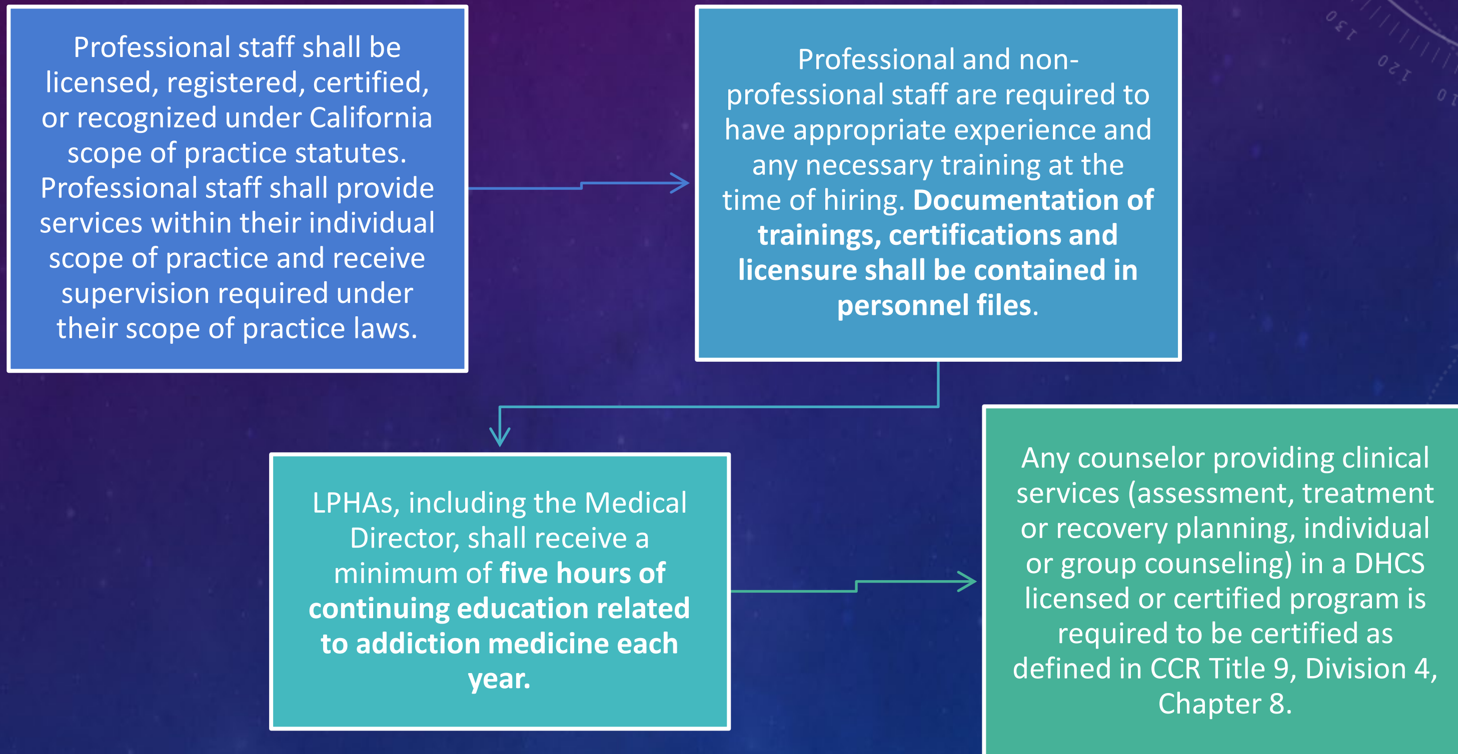
- Sonoma County will be going-live as a DMC-ODS County on December 1, 2024. The intent of the DMC-ODS waiver was to demonstrate how organized substance use disorder care improves successful outcomes while decreasing other system health care costs.
- DMC-ODS will improve access to and quality of care for Sonoma Medi-Cal members by:
  - Enhancing the **Continuum of Substance Use Disorder (SUD)Services** and expanding access to—and Federal Medicaid reimbursement for—services
  - Using the **American Society of Addiction Medicine (ASAM) Criteria** to ensure that members are in the most appropriate level of care
  - Coordinating with **mental health and primary care** to ensure integrated care
  - Requiring providers to deliver care **utilizing Evidence Based Practices (EBPs)**
  - Expanding **workforce capacity** by allowing licensed practitioners of the healing arts (LPHAs) to determine medical necessity and to direct treatment plans
  - Acting as a **managed care plan for SUD treatment** services
- DMC-ODS was renewed through 2026 as part of CalAIM
- Refer to BHIN 24-001 for DMC-ODS Requirements from 2022 - 2026

SONOMA DMC-ODS COVERED SERVICES

- ASAM 0.5: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (Under 21 Years)
- ASAM 1.0: Outpatient Treatment
- ASAM 2.1: Intensive Outpatient Treatment
- ASAM 3.1, 3.5: Residential Treatment (Must have an ASAM or DHCS Level of Care Designation)
- ASAM 3.2-WM: Withdrawal Management (Residential WM must have an ASAM or DHCS Level of Care Designation)
- Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP)
- Medications for Addiction Treatment (MAT)
- Recovery Services
- Care Coordination (formerly referred to as Case Management)
- Clinician Consultation (formerly referred to as Physician Consultation)
- Coordinate with other services, such as Inpatient Residential and WM

** Refer to BHIN 24-001 for updated definitions on the levels of care*

DMC-ODS: PROVIDER SPECIFICATIONS

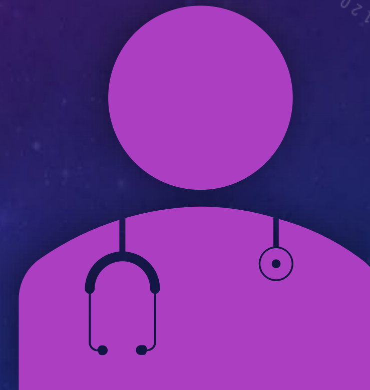


PROVIDER DIRECTORY

- Work with County QAPI staff to keep information up to date on your organization for our provider directory including organizational level and individual staff members.
- Link to Provider Directory:
- SONOMA COUNTY BEHAVIORAL HEALTH DIVISION (ca.gov)

MEDICAL DIRECTOR REQUIREMENTS

- **Code of Conduct**: Must be signed and dated by the Medical Director and Provider Representative
- **Written Roles and Responsibilities**: Signed and dated by the Medical Director and Provider Representative
- **Medical Policies and Standards**: Shall develop and implement written medical policies and standards. Evidence of developing and implementing medical policies and standards can include the applicable policies and standards being signed and dated by the Medical Director and a program representative. Medical Directors shall perform an annual review of medical policies and standards, with evidence being a signed and dated attestation of annual review from the Medical Director.
- **Continuing Education Requirements**: A minimum of five (5) hours of CME related to addiction medicine each year



DMC-ODS: REQUIRED TRAININGS

- Providers and staff are required to complete training in the ASAM Criteria from a licensed vendor (Prior to use of SmartCare)
- 42 CFR Part 2, HIPAA, Law & Ethics, Information Privacy and Security (Annual)
- SmartCare and CalOMS (Prior to use of SmartCare)
- LPHAs: Five hours/CEUs in addiction medicine (Annual)
- DMC-ODS Compliance (Annual)
- Other trainings as required by regulation (e.g., CPR and First Aid, Naloxone, Withdrawal Management)

TIMELY ACCESS TO SERVICES

- DMC-ODS Plans shall have a 24/7 Member Access Line. Sonoma ACCESS Line is 707-565-6900, or toll free 1-800-870-8786
- Members determined to be in crisis shall be immediately linked to appropriate support and management
- Members screened as having an urgent need shall be linked to care within 48 hours (96 hours for residential authorizations)
- For OTP, providers shall ensure a face-to-face appointment within three (3) business days of the initial request for services
- For all other DMC-ODS services, providers shall ensure an appointment within ten (10) business days of the initial request for services
- **Reminder**: Record Timely Access in SmartCare (Search "DMC-ODS")

ACCESS TO DMC-ODS SERVICES

Initial Assessment Process

- **Outpatient Programs** (Non NTP), to ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
  - The initial assessment using the CA-ASAM Criteria© embedded in SmartCare shall be completed in a timely manner following the first visit with an LPHA or registered/certified counselor.
  - If done by a registered or certified counselor requires LPHA consultation.
  - Covered, clinically appropriate and medically necessary services may be provided during the initial assessment period.
  - **Self Authorization**: Does not require County prior authorization

ACCESS TO DMC-ODS SERVICES

Initial Assessment Process

- **Narcotic Treatment Programs (NTP):** Health and Physical by prescriber for medical necessity and access to services. ASAM must be completed for level of care assessment for additional needs.
- **Self Authorization:** Does not require County prior authorization

ACCESS TO DMC-ODS SERVICES

Initial Assessment Process

- **Residential Programs:** providers submit authorizations to DHS-BH-BRS@sonoma-county.org securely (will confirm final email before 12/1/24)*
- Use SUD Residential Treatment Authorization Request (TAR), Continuation, and Extension form
- 24 hours to review (authorizations team)
- Approved TARS give 7 days to admit
- Initial Requests: Up to 90 days Adults, 60 days Youth
  - Good for 45 & 30 days respectively then require continuation
  - Extensions beyond 90 days and 60 days are in 30 day increments
  - Submit continuation and extension requests no later than 7 days out
- **Prior Authorization**: requires County prior authorization

MEDICAL NECESSITY

DMC-ODS services must be medically necessary. Pursuant to W&I Code section 14059.5(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

All DMC-ODS counties shall update policies and procedures, provider contracts, beneficiary handbooks, and related material to ensure the medical necessity standard is accurately reflected in all materials consistent with W&I Code section 14059.5 and the terms of this BHIN.

LEVEL OF CARE DETERMINATION (BHIN 24-001)

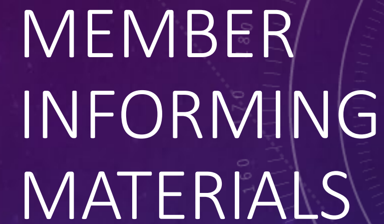
•The ASAM Criteria shall be used to determine placement into the appropriate level of care for all members, and is separate and distinct from determining medical necessity.

- For members 21 and over, a full assessment using the ASAM Criteria shall be completed
- A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for members under 21; a brief screening ASAM Criteria tool is sufficient for these services.
- To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
- A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
- A full ASAM assessment using the CA-ASAM embedded in SmartCare shall be repeated when a member's condition changes.
- These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

•Member placement and level of care determinations shall ensure that members are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition.

MEMBER INFORMING MATERIALS

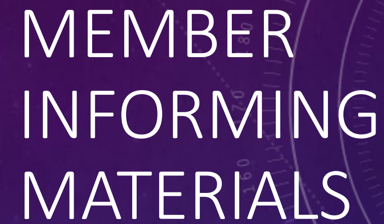
- Post and include in documents that are vital/critical to obtaining services (e.g., outreach and marketing materials, written notices to individuals):
  - A DHCS-approved **Nondiscrimination Notice** (at least 12-point font) that informs members, potential members, and the public about nondiscrimination, protected characteristics, and accessibility requirements. (**BHD 158**)
  - Complaint process and **grievance procedures and forms (BHD 406)**
  - **Language Assistance Taglines** – Informing of availability of no-cost language assistance services (at least 12-point font and in English and State's top 18 non-English languages) (**BHD 162**)
  - Other information including the appeal process for involuntary discharge, and program rules and expectations (including reasons for potential discharge)



MEMBER INFORMING MATERIALS

Provide the following to members/potential members, either in paper or in electronic format, at the time they are first required to enroll in the program.

- **Provider Directory**: Make available in electronic form and, upon request, in paper form. Medi-Cal Informing Materials
- **DMC-ODS Beneficiary Handbook**: Includes features of managed care, enrollment information, service area, covered benefits, how to access the Provider Directory and formulary, access to covered benefits and services, after-hours care, restrictions on freedom of choice, rights and responsibilities, coordination of care, access to language assistance, reporting suspected fraud, waste or abuse, and grievance and appeal processes. Medi-Cal Informing Materials

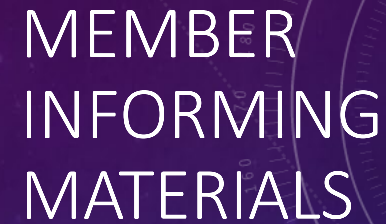


MEMBER INFORMING MATERIALS

Provide the following to members / potential members (continued)

- **HIPAA Provider's Notice of Privacy Practices** Medi-Cal Informing Materials
- **Client Rights and Grievance/Appeal Process and Form (BHD 406)** Medi-Cal Informing Materials
- **Acknowledgement of Receipt:** must be obtained from all members who are offered the identified informing materials SmartCare consent for Treatment form for all members.

MEMBER INFORMING MATERIALS



Informing Materials Postings for Medi-Cal Provider Lobbies: must be readily available in the lobbies of all provider sites:

- All materials listed on previous two slides
- Free Language Assistance Services (Taglines)
- Point to Your Language Poster
- SUD 400 Client Rights Poster
- Request for Change of Service Provider
- Non-Discrimination Notice (English & Spanish)

County will make all of these materials available in Spanish and 18 pt font.

MEMBER INFORMING MATERIALS – MEMBER HANDBOOK

- In accordance with 42 CFR § 438.10, BHPs must provide each member with a handbook at the time the member first accesses services.
- **The beneficiary handbook** will be considered provided if DMC-ODS provider:
  - Gives handbook directly to member and documents distribution; or
  - Mails a printed copy to the member's mailing address; or
  - Provides the information by electronic format (e.g., email, text that includes a hyperlink) after obtaining the member's agreement to receive the information electronically.
    - AND
  - Posts the information on its website and advises the member in paper or electronic form that information is available on the Internet and includes the applicable Internet address, informs members that the handbook is available in paper format without charge upon request and provides within 5 business days, and provides members with disabilities who cannot access this information online with auxiliary aids and services upon request at no cost. Medi-Cal Informing Materials

GRIEVANCE AND APPEAL REQUIREMENTS

- DMC-ODS Providers shall post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone.
- The County produces required member informing materials in English and Spanish.
- Providers shall request materials from the County as needed.
- Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.
- Link to Grievance Brochures: Medi-Cal Informing Materials (**BHD 406**)
- Link to training video: Quality Assessment & Performance Improvement (ca.gov)

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) REQUIREMENTS

- A NOABD is a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.
- Contracted Providers shall issue written NOABDs to the address on record should covered services be reduced, denied, modified, delayed or terminated.
- If a NOABD is applicable, the Provider shall complete the letter, with required documents (e.g., Your Rights, Non-Discrimination, Taglines), and provide to member within applicable timeframes.
- **Link to** Forms and Materials for Behavioral Health Contractors (ca.gov) (includes NOABD templates)
- Link to training video: Quality Assessment & Performance Improvement (ca.gov)

EXPANDING ACCESS TO MEDICATIONS FOR ADDICTION TREATMENT (MAT)

- NTPs are required to directly offer MAT to members with SUD diagnoses that are treatable with FDA-approved medications, including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone, and disulfiram.
- Members needing or utilizing MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.
- Per DHCS BHIN 23-054:
  - All Licensed and/or Certified SUD facilities must demonstrate that they either directly offer or have effective referral mechanisms to MAT to beneficiaries with SUD diagnoses that are treatable FDA-approved medications.
    - An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT. Providing contact information/referrals is not sufficient.
  - Implement and maintain a MAT policy approved by DHCS – Refer to BHIN 23-054 for required policy elements

CARE PLANNING REQUIREMENTS

- Prospectively completed, standalone treatment plans (DMC, DMC-ODS) are no longer required.
- Care planning is meant to be an ongoing and interactive component of care delivery, rather than a one-time event.
- There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities (NTPs, programs with SUBG funding, AOD certified programs)
- These requirements are noted in Enclosure 1a of BHIN 23-068 (may not be exhaustive list).
- For programs, services, and facility types that still require care plans and/or specific care planning activities, BHIN 23-068 establishes one standard for documentation of care planning.
- Conflicts with AOD Certification Standards 1.0 which is highly prescriptive as to treatment plan content. AODS Certification Standards when realized is much more flexible and in alignment with BHIN 23-068.

- Where a care plan or care planning activities are required:
- Providers must adhere to requirements in state/federal law;
- Required care plan elements must be documented within the member record (location is flexible); and
- The provider must be able to produce and communicate the content of the care plan.

QUALITY IMPROVEMENT COMMITTEE (QIC)

Attended by County, Contractors, Peers and Family Members

Combined QAPI WorkPlan with both MH and SUD

EQRO – external quality review organization

Plan, Design, and / or implement QI activities to improve quality of services

Review and Evaluate the Results

Review and collaborate on policies and procedures

Consumer Perception Surveys: annual consumer surveys

Reporting, discussing analyzing patterns in system – grievances, NOABDs, timeliness data.

Subcommittees QAPI led work on a single integrated project for positive system change. Example: clinical and non clinical PIPs.

Workgroups program led individual projects to tackle problems (like staffing and recruitment vacancies)

SMARTCARE REMINDERS AND RESOURCES

SMARTCARE UPDATES & TIPS

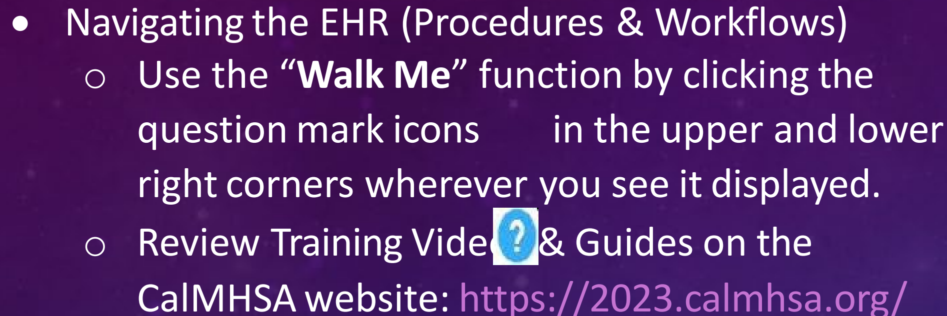
- **DMC Timely Access to Services**
- Links to Instructions:
    - https://2023.calmhsa.org/how-to-complete-the-dmc-outpatient-timeliness-record/
    - https://2023.calmhsa.org/how-to-complete-the-dmc-opioid-timeliness-record/
- This is required for State Reporting and important for assessing access to care and for continuous quality improvement

- **New Users and Staff Updates** (e.g. role change, updated certification/ licensure dates, etc.)
    - SmartCare Staff Request form is emailed to DHS-RMU-Credentialing@sonoma-county.org

SMARTCARE - SEEKING HELP

CalMHSA Support:

- Navigating the EHR (Procedures & Workflows)
  - Use the "**Walk Me**" function by clicking the question mark icons in the upper and lower right corners wherever you see it displayed.



  - Review Training Videos & Guides on the CalMHSA website: https://2023.calmhsa.org/

For additional support

- *Live Chat is available and preferred - 2023 CalMHSA Site*
- *EHR@calmhsa.org*

  * *This help is available from 7am – 7pm PST*
  - Additional help with procedures and workflows
  - Troubleshoot system related errors
  - Report system issues (glitches, bugs, etc.)

- Monthly SmartCare Superuser Meeting
- Support from QAPI Patient Care Analysts (smaller meetings, focused trainings, 1:1 support)

PREVENTING FRAUD, WASTE,
AND ABUSE

PREVENTING FRAUD, WASTE AND ABUSE

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. This is a criminal offense, resulting in imprisonment and/or fines.

Examples: misrepresenting duration of the session, billing for services that weren't rendered).

Waste refers to practices that, directly or indirectly, result in unnecessary costs to the Medi-Cal program, such as overusing services.

Examples: prescribing excessive services or ordering excessive testing.

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

Examples: Unknowingly billing for excessive services; unknowingly misusing claim codes.

PREVENTING FRAUD, WASTE AND ABUSE

Per 42 CFR §438.608, DMC-ODS Contractors: Sonoma County and its subcontractors shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures shall include the following:

- A compliance program
- Prompt reporting of all overpayments identified or recovered, specifying the
- overpayments due to potential fraud, to DHCS
- Prompt notification to DHCS when we receive information about changes in a member's circumstances that may affect the member's eligibility (including changes in the member's residence or the death of a member)
- Notification to DHCS when we receive information about a change in a network provider's circumstances that may affect their eligibility to participate in the DMC- ODS program, including contract terminations.
- Provision for the prompt referral of any potential fraud, waste, or abuse that we identify to DHCS Medi-Cal program integrity unit or any potential fraud directly to the State Medi-Cal Fraud Control Unit.
- Suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

REPORTING FRAUD, WASTE AND ABUSE

Suspected Medi-Cal fraud, waste, or abuse must be reported to:

- DHCS Medi-Cal Fraud:
  - Telephone: (800) 822-6222
  - Email: Fraud@dhcs.ca.gov
  - Mail: Medi-Cal Fraud Compliant – Intake Unit, Audits and Investigations
    - PO BOX 997413, MS 2500, Sacramento, CA 95899-7413
- Sonoma County DHS Compliance Hotline (Anonymous): Fraud, Waste, and Abuse Whistleblower Hotline Program (ca.gov)
- **Overpayments**: Contractor shall immediately report to the County of Sonoma Department of Health Services Compliance Officer via Compliance hotline 707 565 4999 when Contractor identifies an overpayment, excluding routine service corrections (if applicable) which are reported using Service Correction Form. 60 day window to return overpayments to County.

RESOURCES

- Sonoma County DHS Website: https://sonomacounty.ca.gov/health-and-human-services/health-services
- Contractor Resources – Policies & Procedures, SmartCare and Reporting Resources, Practice Guidelines, Contracting Documents: Contractor Resources (ca.gov)
- Member Resources – Provider Directory, Member Handbook, FAQs, Other Informing Materials: Medi-Cal Informing Materials
- CalMHSA Documentation Re-Design Resources
  - Documentation Trainings: https://moodle.calmhsalearns.org/
  - EHR Knowledge Base: https://2023.calmhsa.org/
- DHCS BHINs: https://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx
- DHCS CalAIM Resources: https://www.dhcs.ca.gov/calaim

ADDITIONAL PROVISIONS

- **Hatch Act**: All providers must comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
- **No Unlawful Use or Unlawful Use Messages Regarding Drugs**: No aspect of a treatment program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol.
- **Cultural and Linguistic Proficiency**: Each provider receiving funds from DMC-ODS shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.
- **Trafficking Victims Protection Act**: Providers shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702.
- **CalOMS Tx**: All data shall be entered within seven (7) days of the service, for all clients regardless of funding source.
- **DATAR**: Enter by the 10th of the month.

THANK YOU!