Annual DMC-ODS Training
FY 2026-2027

County of San Diego Behavioral Health Services
Health Plan Operations Unit
Drug Medi-Cal Organized Delivery System

August 20, 2026

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Welcome

- Everyone is muted upon entry.
- Questions will not be answered during this training, please put all questions in the chat.
- There will be a Q&A sent out following this training where all questions addressed.
- The training is being recorded and will be available on the Optum website.
- All information is accurate as of August 20, 2026
  - For future updates, please reference any communications from BHS, including the monthly Up To the Minute (UTTM), and the Optum website

Annual DMC-ODS Training Agenda

1. State Updates
2. Credentialing Completion Date & SmartCare Access
3. H.R.1 and it's Impacts to San Diego Behavioral Health
4. BHINs to know
5. BHP, DMC-ODS & MCPs
6. Service Reminders
7. Contingency Management
8. Justice Involved Initiatives
9. Residential Authorization Requirements
10. DMC-ODS Program Requirements
11. Grievance/Appeals & NOABDs
12. Eleos
13. 274 Expansion and the SOC Application
14. ASCMI
15. ASAM 4th Edition
16. Program Integrity
17. Resources and Closing

BHS HPO DMC-ODS Leadership Team

- **Tabatha Lang,** Operations Administrator
- **Nikki Watkins**, Behavioral Health Program Coordinator, SUD QA Team
- **Diana Daitch Weltsch** and **Glenda Baez**, SUD QA URQIS Supervisors
- **Erin Shapira**, Agency Program & Operations Manager, Quality Assurance
- **Malisa Touisithiphonexay**, Admin Analyst III, Quality Assurance
- **Lorena Gonzalez-Fabiny**, Admin Analyst III, Quality Assurance
- **Alfie Gonzaga**, Agency Program & Operations Manager, Health Plan Administration
- **Becky Ferry-Rutkoff**, IT Principal, Management Information Systems (MIS)

SUD QA Team

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

State Updates

Tabatha Lang, LMFT, Operations Administrator

BHS Health Plan Operations

Behavioral Health Services

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

Evidence-Based Practices (EBPs)

- To support Medi-Cal members living with significant behavioral health needs:
  - Assertive Community Treatment (ACT)
  - Forensic ACT (FACT)
  - Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
  - Individual Placement and Support (IPS) Supported Employment
  - Enhanced Community Health Worker (CHW) Services
  - Clubhouse Services
- Coverage requirements for children and youth:
  - Multisystemic Therapy (MST)
  - Functional Family Therapy (FFT)
  - Parent-Child Interaction Therapy (PCIT)
  - High-Fidelity Wraparound (HFW)

BH-CONNECT, cont.

- Access, Reform, and Outcomes Incentive Program
  - Measurable improvements in access to behavioral health services, health outcomes, and quality improvement and population health capabilities.
- Workforce Initiative
  - Medi-Cal Behavioral Health Student Loan Repayment Program (MBH-SLRP)
    - HCAI issued award letters to 1,615 grantees in Jan 2026 (over $134M)
  - Scholarship Program- launched Feb 2026
  - Community-Based Provider Training Program
    - AOD Counselors, CHW/Promotores, Reps and Peer Support Specialists
  - Fellowship Training Program (second cycle was Mar 2026)
    - Child and Adolescent Psychiatrists, Addiction Psychiatrists and Addiction Medicine Physicians

Behavioral Health Transformation (BHT) Goals and Performance Measures

Through BHT, California is establishing a population behavioral health approach to improve outcomes across 14 statewide behavior health goals:

↑ Goals for Improvement
Care experience
Access to care
Prevention and treatment of co-occurring physical health conditions
Quality of life
Social connection
Engagement in school
Engagement in work

↓ Goals for Reduction
Suicides
Overdoses
Untreated behavioral health conditions
Institutionalization
Homelessness
Justice-Involvement
Removal of children from home

Health equity is incorporated in each of the BH Goals

BHT Performance Measures

DHCS is developing 1-5 BHT performance measures for each of the statewide goals.

DHCS will calculate these measures using Medi-Cal and BHSA data, as well as data from other state agencies (e.g., Vital Records, HDIS).

Rates will be refreshed for county BHPs and MCPs monthly, and shared at least annually with the public.

BHT Performance Measures

How Measures Will Be Used

Planning
To inform planning, resource allocation, and population health initiatives

Population Health
To inform outreach, engagement, and interventions, using relevant individual-level data provided via Medi-Cal Connect

Accountability
To evaluate county BHP's use of BHSA funding and to monitor BHP and MCP performance on delivery of Medi-Cal services

BHT Performance Measures, cont.

DHCS will release the final BHT performance measures in the BHSA Policy Manual over the coming months.

DHCS will also release a specifications manual and a document summarizing how BHPs and MCPs can improve outcomes on each statewide goal.

DHCS is planning to release the first set of BHT Performance measure rates in 2026.

DHCS Implementation of ASAM 4th Edition

Draft BHIN updates forthcoming later this year

DHCS anticipates making updates to the State Plan, applicable waiver language and the DMC and DMC-ODS rates and billing manuals to reflect ASAM 4 implementation

DHCS ASAM-related guidance posted for final publication by **January 1, 2027**.

DHCS system updates and ASAM 4.0 policy changes go live, with ASAM 4.0 requirements effective **July 1, 2027.**

CalAIM Section 1115 Waiver Renewal

- This includes new initiatives and services that go beyond the traditional doctor's office or hospital setting to address social, physical, and mental health needs.
- DHCS is transforming Medi-Cal to ensure Californians can get the care they need to live healthier lives.
- CalAIM is a multi-year initiative to build a more coordinated, person-centered, and equitable health system that works for everyone.
- CalAIM is authorized through a variety of federal Medicaid authorities, including the **CalAIM Section 1115 demonstration, the CalAIM 1915(b) waiver, Medicaid State Plan, and managed care contracts.**
- In 2021, DHCS received authority for the CalAIM Section 1115 demonstration. DHCS is now seeking to renew the CalAIM Section 1115 demonstration for another five years to **build upon and consolidate the successes of the CalAIM initiative**

Updated CalAIM 1115 Demonstration Goals

» Strengthen the ability of DHCS, plans, and providers to identify and intervene early to manage member risk and need through whole person care approaches that optimize member experience.

» Continue to move Medi-Cal to a more consistent and seamless system by further reducing complexity, strengthening accountability, and improving program efficiency.

» Continue to improve quality outcomes and drive delivery system transformation and innovation through value-based initiatives that allow members to receive the right care, at the right time, in the right place, at the right cost.

Reentry Services for Justice-Involved Populations 90-Days Pre-Release

- Request: Continue to cover **targeted Medi-Cal services for justice-involved individuals for up to 90 days prior to release** from a state prison, county jail, or youth correctional facility.
- **Covered Services:**
  - Comprehensive reentry care management.
  - Medications for Addiction Treatment (MAT).
  - Physical and behavioral health clinical consultation.
  - Laboratory and radiology.
  - Medications and administration of covered medications.
  - Services provided by Community Health Workers and/or Peer Support Specialists with lived experience.
  - Provision of medically necessary durable medical equipment (DME) and medications in-hand upon release.

DMC-ODS – Waiver of IMD Exclusion for SUD Services

Request: Renew authority to waive the IMD exclusion* and permit federal reimbursement of short-term residential treatment services provided to eligible individuals with a SUD.

** The IMD exclusion prohibits use of federal Medicaid funds to pay for treatment delivered to individuals ages 21 through 64 residing in qualifying institutions with more than 16 beds.*

County Option to Cover Select Outpatient SUD Services

Request:

- Continue authority to allow counties to opt-in to provide Peer Support Services, which are culturally competent services that promote recovery, to Medi-Cal members receiving care in the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or DMC-ODS delivery systems*.
- While not relevant to County of San Diego, DHCS is also requesting:
  - New authority for DMC counties to opt-in to cover Mobile Crisis Services.
  - New authority to allow DMC counties to opt in to cover certain outpatient SUD services that are currently limited to the DMC-ODS delivery system:
    - Care Coordination
    - Recovery Services
    - Peer Support Services
    - Partial Hospitalization
    - Withdrawal Management

**Delivery system authorities for SMHS and DMC-ODS are authorized through California's CalAIM 1915(b) waiver.*

Recovery Incentives (Contingency Management)

- **Objective:** Promote recovery among Medi-Cal members living with stimulant use disorder by promoting longer retention in treatment and reduced drug use to: Improve members' health outcomes.
- Reduce rates of ED utilization and inpatient stays.
- Increase community engagement.
- **Request:** Continue authority for Recovery Incentives, which are an evidence-based practice to reward participants with stimulant use disorder for meeting treatment goals, and expand opt-in option to DMC State Plan Counties.

Traditional Healers and Natural Helpers

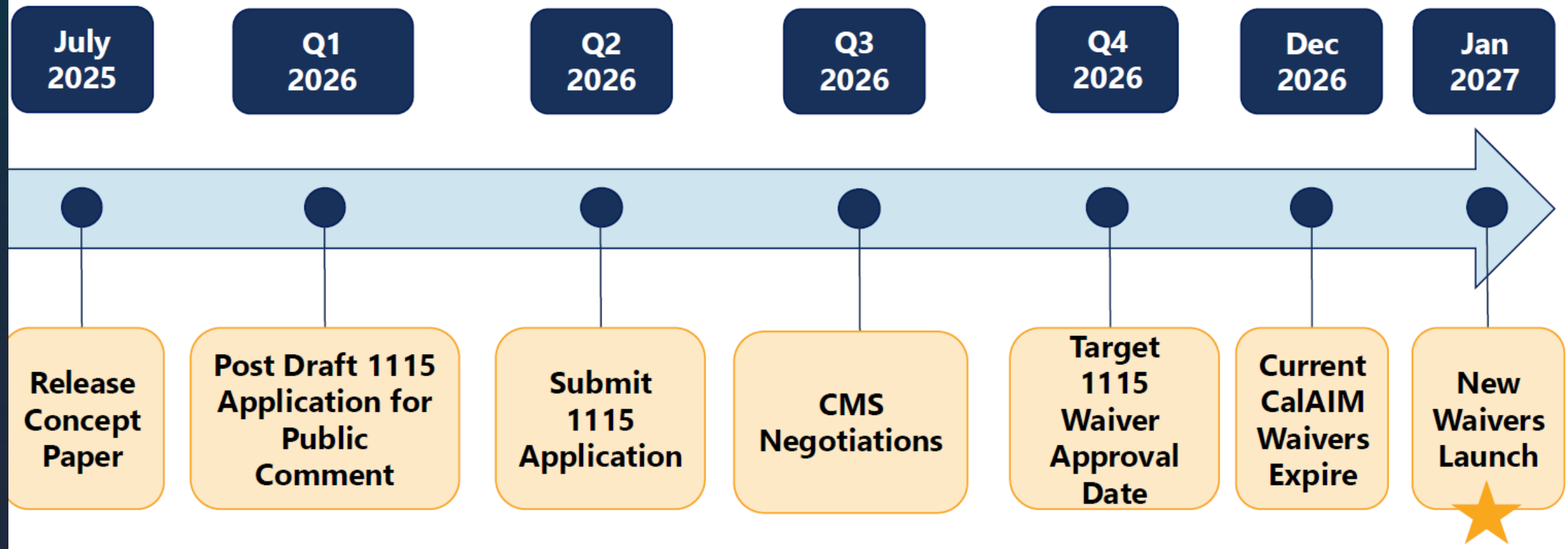
- **Objective:** Improve access to SUD treatment for American Indians and Alaska Natives through Indian Health Care Providers (IHCP) and promote access to culturally appropriate and evidence-based SUD treatment.
- **Request:** Continue to provide **coverage for culturally responsive SUD treatment** through IHCPs under the DMC-ODS delivery system.
- Retain authority to cover Traditional Healer and Natural Helper services for other conditions beyond SUD and for other delivery systems.

Covered Services:

- **Traditional Healer services**, which may use an array of interventions, including music therapy (such as traditional music and songs, dancing, drumming), spirituality (such as ceremonies, rituals, herbal remedies) and other integrative approaches.
- **Natural Helper services** may assist with navigational support, psychosocial skill building, self-management, and trauma support to individuals that restore the health of eligible Medi-Cal members

Waiver Renewal Timeline

California plans to submit its comprehensive application to renew its 1115 waiver by the end of Quarter 2 (Q2) 2026. California is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of the proposed demonstration.



Credentialing Completion Date & SmartCare Access

Effective July 1, 2026
Applies to all BHS Medi-Cal Providers
rendering Direct Services

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COUNTY OF SAN DIEGO
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Credentialing Requirements for Providers

Credentialing is required under:

- 42 CFR §438.214
- BHIN 18-019

Credentialing is required for:

- Participation in the County's provider network
- Reimbursement for services

Providers must ensure that:

- ALL Medi-Cal providers rendering direct services are credentialed
- Services are delivered by appropriately credentialed staff
- Credentialing is completed and verified prior to service delivery
- Credentialing is reverified every 3 years
- Staff maintain valid credentials at all times
- Credentialing compliance is documented, verifiable, and available upon County's request

What's Changing v. Not Changing

What's NOT Changing	What is Changing
• No new credentialing requirements are being introduced; Expectation is being clarified and enforced (not newly created) • Credentialing must be initiated upon hire	• Adding credentialing completion date and credentialing entity in ARFs • ARFs will be returned and not processed by MIS if there is missing information

No additional administrative burden beyond existing requirements

Who Conducts Credentialing?

Optum: BHSCredentialing@optum.com

County's Credentialing Delegates:

- Family Health Centers of San Diego
- Fred Finch Youth Center
- Health Right 360
- Mission Treatment Services / San Diego Health Alliance / San Diego Treatment Services
- San Diego Center for Children
- San Diego Youth Services
- Telecare

If your organization is *not* a Credentialing Delegate, enter "Optum" as the Credentialing Entity on the ARF.

Call to Action

Starting Now:

Align onboarding and credentialing workflows

When Effective:

All ARFs must include credentialing completion date and credentialing entity

For questions regarding ARFs or SmartCare access

BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Note: Credentialing is NOT the same as Provider Enrollment (DHCS PAVE)

Credentialing	Provider Enrollment (PAVE)
• "Is this provider qualified to participate in the BHS provider network?“ • Verifies qualifications such as licensure, registration, certification, or waiver status. • Managed by Optum or a Credentialing Delegate.	• "Is this provider enrolled with Medi-Cal?“ • Screens and enrolls applicable providers in the Medi-Cal program. • Managed by DHCS through PAVE.

Credentialing and Provider Enrollment (PAVE) are separate requirements. Completion of one does not satisfy the other. The Credentialing Completion Date required on the ARF refers to completion of the credentialing process, not PAVE enrollment. Do not use a PAVE enrollment date as the Credentialing Completion Date on an ARF.

H.R.1 and its Impacts to San Diego Behavioral Health

County of San Diego
Behavioral Health Services

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Health Plan Administration (HPA)
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H.R.1 & Behavioral Health Coverage Stability

As of May 2026, DHCS estimates H.R.1 will cause **up to ~1.1 million Medi-Cal disenrollments statewide**, largely due to new requirements:

- Work reporting
- Six-month renewals
- Automated address, death-file, and duplicate-enrollment checks

At the same time, DHCS intends to make eligibility continuation as seamless as possible by using automated Medi-Cal data systems to identify individuals who qualify to be exempt from work reporting requirements, including those who are medically frail.

For San Diego BHS, coverage retention depends on whether qualifying SMH and SUD services are delivered and reflected in Medi-Cal data. DHCS is expected to use Medi-Cal data to help identify individuals who may qualify for exemptions.

Who is Regulated — and Who is Affected?

Federally regulated

The New Adult Group subject to work rules, six-month renewals, reduced retroactivity, and cost sharing (Oct 2028)

- Ages 19–64
- Under 138% FPL

Important clarification on the “New Adult Group” referenced in H.R.1

- In California, this generally means adults ages 19–64 with incomes up to 138% of the federal poverty level, unless they qualify for an exemption.
  - The 2014 Affordable Care Act (ACA) created a new category for Adults ages 19–64 solely based on income (≤138% FPL), not based on disability or parent status or age.
  - The same group is also subject to six-month renewals beginning in 2027

H.R.1 Work Reporting Requirements

Beginning January 1, 2027, affected Individuals aged 19-64 (who are not pregnant, are not eligible for Medicare, or who qualify for Medi-Cal based on income alone) **MUST** meet a monthly work and community engagement requirement to keep Medi-Cal coverage**:

- Monthly income of at least 80x the federal hourly minimum wage (currently $580) *or*
- A combination of qualifying activities totaling 80 hours per month:
  - Work
  - Community service
  - Participation in a work program
  - Enrolled at least half-time in an educational program

***unless exempted*

“Medically Frail” | DHCS Determination

Adults are exempt from work rules if they are **medically frail**, including people with:

- Mental illness or substance use disorder
- Disability, functional impairments, or complex medical conditions, pregnancy
- Recent inpatient psychiatric or residential SUD treatment records

Medi-Cal eligibility will automatically continue if related claims data available

Eligibility rules by age:

- Under 19 → Protected
- 65 and over → Protected
- Ages 19–64 → Subject to work reporting and six-month renewals unless medically frail or otherwise exempt

“Medically Frail” | DHCS Determination

- DHCS is proposing to use backend **automation** to check whether qualifying evidence already exists in Medi-Cal data systems. These systems form the exemption engine:
    - Short-Doyle
    - Claims & encounters
    - Inpatient psych & SUD residential treatment records
    - via MCPs
        - ECM & Community Supports
        - Medi-Cal Rx
- If qualifying Behavioral Health data is present in these systems, the person is treated as **medically frail and exempt from work reporting**.
- An accepted behavioral health claim can trigger an exemption.
- **Data integrity** now has direct Medi-Cal eligibility impacts, not just financial and clinical consequences.

Data Quality Risks

New Adult Group members must renew **twice per year**.
If data cannot verify income or frailty, members must respond or are terminated.

This doubles the number of times the Member must complete re-eligibility steps.

Key operational concerns: outreach, renewal support, data quality, and monitoring coverage churn.

Lack of Medi-Cal claims or incomplete data will require work activity reporting every six months and may result in disenrollment

Timeline

June 1, 2026:

CMS issued the Interim Final rule implementing Medicaid work requirements

1 Jan. 2027***

California begins work requirements and six-month renewals for affected adults.

Mid-2026 – Dec-2026: DHCS refining California implementation and awaiting additional CMS clarification

Now – Dec-2026

*****Federal framework issued; state implementation details continue to evolve**

- California operational details may continue to evolve as DHCS finalizes workflows, data matching, notices, and verification processes ahead of January 1, 2027.

Key Takeaway

Under the current federal framework: San Diego BHS's clinical, documentation, and billing systems support both care delivery and helping ensure qualifying BH info is available for Medi-Cal eligibility verification.

Questions?

Health Plan Administration (HPA) Team

BHS-HPA.HHSA@sdcounty.ca.gov

Relevant Behavioral Health Information Notices (BHINs)

Fiscal Year 2026-2027 and beyond

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COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

BHIN 25-034

Medication-Assisted Treatment (MAT) also referred to as Medications for Opioid Use Disorder (MOUD) Treatment for Incarcerated Patients

The purpose of this Behavioral Health Information Notice (BHIN) is to provide treatment options and requirements for incarcerated patients diagnosed with an opioid use disorder (OUD).

- MAT provided under the CalAIM Justice Involved Reentry Initiative in a Correctional Facility must be delivered in a manner consistent with federal and state regulations.
- Buprenorphine and methadone are approved by the FDA for treatment of OUD and withdrawal.
- Providers who have a current DEA registration may prescribe buprenorphine.
- Methadone is typically dispensed at licensed Narcotic Treatment Programs (NTPs) in California. There are, options available for delivering methadone to incarcerated patients in CFs when clinically indicated.

BHIN 25-036 *(Supersedes BHIN 25-007)*

Traditional Health Care Practices Benefit Implementation

To provide guidance regarding the implementation of the traditional health care practices benefit in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

- IHCPs that provide traditional health care practices are required to enroll as Medi-Cal providers.
  - IHCPs that provide only traditional health care practices, and do not provide other DMC-ODS services are not required to complete Drug Medi-Cal (DMC) Certification.
  - HCPs that provide traditional health care practices AND other DMC-ODS Services must be enrolled as Medi-Cal providers through the DMC Certification process, per BHIN 24-001.6.

BHIN 26-004 *(Supersedes BHIN 25-017)*

Substance Use Disorder (SUD) Recovery or Treatment Facilities' Licensure and Certification Fee Increase Beginning Fiscal Year (FY) 2026-2027

To provide notification of the Department of Health Care Services (DHCS) licensing and certification fee increase for residential and outpatient SUD facilities.

- ❑ Licensed and/or certified SUD recovery or treatment facilities, with an expiration date on or after July 1, 2026, that have already submitted biennial extension fees will be invoiced for the additional amount owed due to the increased fees and must be submitted within 60 days of the invoice date.

- ❑ DHCS will assess the following fees for licensure and certification of residential and outpatient SUD recovery or treatment facilities:

BHIN 26-004 *(Cont'd.)*

RESIDENTIAL LICENSURE FEES		
APPLICATION TYPE	**FY 2025-26 FEE**	**FY 2026-27 FEE** ***(Beginning July 1, 2026)***
Initial Residential Licensure Application Fee	$5,270	**$6,061**
Application for Existing Licensee to Obtain Initial Licensure for New Facility	$5,270	**$6,061**
Initial Biennial Residential Licensure Fee	$560 (per bed)	**$644 (per bed)**
Biennial Residential Licensure Extension Fee	$560 (per bed)	**$644 (per bed)**
Adolescent Waiver Application Fee	$2,604	**$2,995**
Dependent Children Application Fee (if not requested during initial licensure application)	$1,822	**$2,095**
Supplemental Application Fee (Increase or Decrease in Bed Capacity, Target Population Change, Removal of Address or Suite, Integral Facility, Program Name Change, Legal Entity Name Change, Addition or Removal of Services - i.e., Incidental Medical Services, Detoxification, Co-ed, Prorated Bed(s), etc.)	$1,787 (per requested amendment to licensure and/or certification)	**$2,055 (per requested amendment to licensure and/or certification)**
Facility Address Update (Facility Relocation,	$1,742 (per requested	**$2,003 (per requested**

BHIN 26-004 *(Cont'd.)*

CERTIFICATION FEES		
APPLICATION TYPE	**FY 2025-26 FEE**	**FY 2026-27 FEE *(Beginning July 1, 2026***
Initial Outpatient Certification Application Fee	$5,064	**$5,824**
Initial Application for an Existing Certified Program to Obtain Initial Certification for New Program	$5,064	**$5,824**
Initial Biennial Outpatient Certification Fee	$6,564	**$7,549**
Biennial Outpatient Certification Extension Fee	$6,564	**$7,549**
Biennial Residential Certification Fee (for facilities having a residential license issued by another State Department). The maximum fees for beds will not exceed the biennial certification fee.	$560 (per bed, with a maximum of $6,564)	**$644 (per bed, with a maximum of $7,549)**
Amendment(s) Application Fee (Change, Removal of Address or Suite, Program Name Change, Legal Entity Name Change, Addition or Removal of Services - i.e., Detoxification, Medication for Addiction Treatment (MAT), Co-ed, etc.)	$1,787 (per requested amendment to certification)	**$2,055 (per requested amendment to certification)**
Facility Address Update (Facility Relocation, Adding Additional Address or Suite Number(s))	$1,742 (per requested amendment to certification)	**$2,003 (per requested amendment to certification)**

BHIN 26-004 *(Cont'd.)*

COMBINED RESIDENTIAL LICENSURE AND CERTIFICATION FEES		
APPLICATION TYPE	**FY 2025-26 FEE**	**FY 2026-27 FEE *(Beginning July 1, 2026)***
Initial Combined Residential Licensure and Certification Application Fee	$7,030	**$8,085**
Initial Biennial Combined Residential Licensure and Certification Fee	$560 (per bed)	**$644 (per bed)**
Biennial Combined Residential Licensure and Certification Extension Fee	$560 (per bed)	**$644 (per bed)**
All other fees are as stated in the 'Residential Licensure Fee' box		

BHIN 26-006

Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment

To notify SUD facilities of updates to requirements for admission agreements and "return to use" plans.

- AB 1037 amended Health and Safety Code section 11834.26, subdivision (c)(2) to state that a licensee shall not deny admission to any person seeking treatment based solely on that person having consumed, used, or otherwise been under the influence of alcohol or other drugs.
- SUD recovery and treatment facilities shall develop and maintain policies that address when a resident returns to use, including when that occurs on the licensed premises.

BHIN 26-007

Reporting Requirements for Substance Use Disorder (SUD) Recovery or Treatment Facilities

To notify SUD recovery or treatment facilities of updates to reporting requirements regarding the death of a resident.

- ❑ AB 1356 expands Health and Safety Code section 11830.01 (also known as “John’s Law”) to require SUD recovery or treatment facilities to report additional information about deaths to DHCS.

- ❑ Within 30 days of a resident’s death, a report of any relevant information not known at the time of the initial incident must be reported. Failure to report will result in DHCS issuing a written notice of deficiency.

BHIN 26-013

California Advancing and Innovating Medi-Cal (CalAIM) Real Time Behavioral Health Data Sharing Policy

Updated procedural requirements for data exchange that have not been detailed in previous BHP or DMC County guidance to ensure timely care coordination.

The updated procedural BHP and DMC County responsibilities and requirements described in this guidance are:

- ❑ Bidirectional data exchange for care coordination must be done in real time
- ❑ Data elements that must be exchanged between BHPs, DMC Counties, MCPs, and Medi-Cal Partners
- ❑ Standardizing how BHPs and DMC Counties share member rosters
- ❑ Adopting the Authorization to Share Confidential Medi-Cal Information (ASCMI) form as a statewide, standardized “consent to share information” form

BHIN 26-019 *(Supersedes BHIN 25-025 & BHIN 25-004)*

Mental Health Consumer Perception Survey (CPS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Treatment Perception Survey (TPS) Data Collection

Provides guidance on Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan requirements for CPS and TPS data collection and submission.

The CPS and TPS requirements were previously issued under two separate BHINs (BHIN 25-025 and BHIN 25-004) and are now combined into a single BHIN.

- ❑ MHPs shall administer the CPS surveys - Third Week in May (annually)
- ❑ DMC-ODS Plans shall administer the TPS surveys - Third Week in October (annually)
- ❑ Detailed instructions, as well as data collection materials, are updated regularly and posted on the following UCLA-ISAP https://uclaisap.org.

BHIN 26-020

Guidance for Requesting Inactive Status for Alcohol or Other Drug (AOD) Licenses and Certifications Following Declared Emergencies or Disasters

To provide guidance to licensed AOD recovery or treatment facilities and certified alcohol or other drug programs re: requesting inactive license or certification status following a declared emergency or disaster.

Criteria:

- ❑ The emergency/disaster is identified by the Governor of California or the President of the United States through a formal proclamation or declaration of emergency, as defined in Health and Safety Code Section 1797.81.
- ❑ The destruction or damage to the building and/or surrounding property renders the building uninhabitable or threatens the health and safety of the residents/clients; AND operations are planned to resume at the same location.

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

County of San Diego Behavioral Health Plan (BHP)

Mental Health Plan (MHP)

Drug Medi-Cal Organized Delivery System (DMC-ODS)

and

Medi-Cal Managed Care Plans (MCPs)

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Behavioral Health Services

Community Health Group
KAISER PERMANENTE
MOLINA HEALTHCARE
blue california
Promise Health Plan

PURPOSE

This presentation provides guidance, regulatory information, and reference resources to support care coordination, collaboration, and service delivery across the Behavioral Health Plan and Managed Care Plan systems serving Medi-Cal members in San Diego County.

REGULATORY REQUIREMENTS: COUNTY AND MCP COORDINATION

DHCS Screening & Transition Tools

APL 25-010 / BHIN 22- 065: Incorporate the DHCS standardized tool for initial screening for adults & youth (for new members) and transitions of care referral (TOC) form (for existing patients).

No Wrong Door - Non-Specialty & Specialty MH Services

BHIN 22-011 / APL 22-005 / APL 26-002: Increased coordination & billing between MCP & the County so that members can access or transition services to the appropriate delivery system.

Eating Disorders (EDO)

APL 22-003 / BHIN 22-009 MCPs and MHPs share a joint clinical responsibility to "provide medically necessary services to Medi-Cal beneficiaries with eating disorders" and shared financial responsibility for eating disorders, including "partial hospital and residential eating disorder programs" as the "treatment typically involves blended physical health and mental health interventions."

Pharmacy

DHCS Pharmacy homepage

Transportation

APL 22-008 / BHIN 22-031

Enhanced Care Management (ECM) & Community Supports (CS)

DHCS ECM & CS homepage

Medications for Addiction Treatment (MAT)

APL 21-014 / APL 22-005 / BHIN 21-024 : Individuals can access MAT (alcohol, opioid & stimulant medications) services through MCP and County

SUD Screening & Early Intervention

APL 21-014 / BHIN 24-001: SUD screening for all Medi-Cal members age 11+ along with brief interventions.

NO WRONG DOOR

These requirements establish how MCPs and County Behavioral Health Plans coordinate care, referrals, and member transitions.

APL 22-005 No Wrong Door was developed as part of California's CalAIM initiative to improve coordinated, whole-person behavioral health care by ensuring Medi-Cal Members can access timely mental health services regardless of whether they first present to the county or to the managed care plan. MHPs are required to provide or arrange for the provision of medically necessary specialty mental health services (SMHS) for beneficiaries in their counties who meet access criteria for SMHS as described in BHIN 21-073, whereas MCPs are required to provide or arrange for the provision of the non-specialty mental health services (NSMHS).

As described in APL 22-028 and BHIN 22-065, when a member contacts the mental health delivery system directly about care, services may begin prior to diagnosis determination, during the assessment period, consistent with the NWD Policy APL 22-005 and BHIN 22-011. A Member who is not currently receiving mental health services that contacts the County and/or MCP for mental health services, must be screened to guide a referral to the appropriate Medi-Cal mental health delivery system (i.e., MCP or MHP).

As a member may move between different levels of care, it is vital that service providers complete a **warm hand off** with each other to provide continuity of care.

ASSESSMENT OF BEHAVIORAL HEALTH CONCERNS

When members are screened and assessed for Behavioral Health concerns, including Substance Use Disorders, there is a determination of acuity: Mild, Moderate, Severe to indicate the appropriate delivery system

- Criteria 21+ years old is based on impairment severity, NOT diagnosis
- Criteria under 21 years old is based on risk or potential harm. NO diagnosis is required
- Clinical judgement and team-based care is used to determine severity

Clinical Need	Service Type	Delivery System
Mild to Moderate Mental Health	Non-Specialty Mental Health (NSMH) Services**	Medi-Cal Managed Care Plan (MCP) Providers
Moderate to Severe Mental Illness (SMI)	Specialty Mental Health (SMH) Services	County Mental Health Plan (MHP) Providers
Substance Use Disorder (SUD)	Drug Medi-Cal Organized Delivery System (DMC-ODS) Services	County DMC-ODS Plan Providers

**For additional information, refer to APL 26-002 Medi-Cal Managed Care Health Plan Responsibilities for Non-specialty Mental Health Services

MEDI-CAL BEHAVIORAL HEALTH SERVICES

Substance Use Disorder (SUD) services through County Drug Medi-Cal Organized Delivery System (DMC-ODS) Providers = *County BHS providers*

Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (for members under age 21) - ASAM Level 0.5	Early Periodic Screening, Diagnosis, and Treatment	Enhanced Community Health Worker Services	Justice Involved BH Linkages	Certified Peer Support Services (delivered within treatment programs)	Withdrawal Management Services (residential and ambulatory)
Medications for Addiction Treatment (also known as Additional Medication Assisted Treatment or MAT)	Residential Treatment Services – ASAM Levels 3.1, 3.3, and 3.5	Partial Hospitalization – ASAM Level 2.5	Narcotic Treatment Programs	Outpatient Treatment Services – ASAM Level 1	Intensive Outpatient Treatment Services – ASAM Level 2.1
Contingency Management Services (delivered through select providers as part of the pilot period)	Care Coordination (delivered within treatment programs)	Recovery Services	Clinician Consultation	Traditional Health Care Practices	Supported Employment (Planned for FY26-27)

Intensive Inpatient Services – ASAM Levels 3.7 and 4.0 (Planned for FY26-27)

MEDI-CAL BEHAVIORAL HEALTH SERVICES

Specialty Mental Health (SMH) services through County Mental Health Plan (MHP) Providers = *County BHS providers*

Mental Health Services	Medication Support Services	Crisis Intervention (including mobile crisis services)	Crisis Stabilization	Assertive Community Treatment (ACT)	Forensic Assertive Community Treatment (FACT)
Adult Residential Treatment Services	Crisis Residential Treatment Services	Psychiatric Health Facility Services	Psychiatric Inpatient Hospital Services	Targeted Case Management	Certified Peer Support Services (typically delivered within treatment programs)
Day Treatment Intensive Services	Day Rehabilitation	Justice Involved BH Linkages	Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)	Clubhouse Services	Enhanced Community Health Worker (CHW) Services
		Supported Employment			

MEDI-CAL BEHAVIORAL HEALTH SERVICES

For members under the age of 21, all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welf. & Inst. Code 14184.402 (d)), in addition to:

Specialty Mental Health (SMH) services through County Mental Health Plan (MHP) Providers
= County BHS providers

Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (for members under age 21) - ASAM Level 0.5	Intensive Home- Based Services	Intensive Care Coordination	Therapeutic Behavioral Services
Therapeutic Foster Care	Parent-Child Interaction Therapy	Functional Family Therapy	Multisystemic Therapy

MEDI-CAL BEHAVIORAL HEALTH SERVICES

Non-specialty Mental Health (NSMH) services through Medi-Cal Managed Care Plans (MCPs)
= Blue Shield, CHG, Kaiser, Molina

Mental health evaluation and treatment, including individual, group and family psychotherapy	Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition	Outpatient services for purposes of monitoring drug therapy	Psychiatric consultation
Outpatient laboratory, drugs, supplies, and supplements	Care in Emergency Departments	Additionally, Medication for Addiction Treatment (MAT) provided in primary care, inpatient hospital, EDs, and other medical settings	Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) in Primary Care settings

SCREENING FOR MEDI-CAL MH SERVICES

Adult and Youth Screening Tools: The Adult and Youth Screening Tools help decide which mental health system a member should be referred to when they are not currently receiving mental health services and contact the MCP or MHP for help.

As described in APL 25-010 and BHIN 22-065, when a member contacts the mental health delivery system directly about care, services may begin prior to diagnosis determination, during the assessment period, consistent with the No Wrong Door Policy APL 22-005 and BHIN 22-011.

TRANSITION OF CARE FOR MEDI-CAL MH SERVICES

The Transition of Care Tool (Adult and Youth) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed.

The Transition of Care Tool's intended use is for transitions between providers. It is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs **and** 1) their existing services need to be transitioned to the other delivery system **or** 2) services need to be added to their existing mental health treatment from the other delivery system.

Process: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with the Plan's protocols. Once the decision has been made to transition care or refer for services, all the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the Plan the member is being referred to. Use the Screening and Transition of Care Contact Card for Plan contact information.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving Plan, including follow up to ensure services have been made available to the individual.

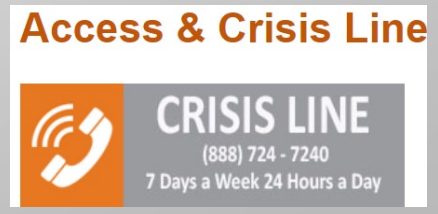
Transition of Care Process Maps are available for reference on the HSD BH Ops webpage:

- Transition of Care Process Map - County Provider Identifies Member (pdf)
- Transition of Care Process Map – MCP identifies a member (pdf)

EATING DISORDERS

Reference APL 22-003 and BHIN 22-009:

- MCPs are responsible for the physical health components of eating disorder treatment and NSMHS and MHPs are responsible for the SMHS components of eating disorder treatment.
- MHPs must provide, or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
- Any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both the MCP and the MHP.
- DHCS recommends that MCPs and MHPs agree on the division of the financial responsibility and requires that MCPs and MHPs have a memorandum of understanding (MOU) in place.
- Should disputes arise between parties that cannot be resolved at the MCP and MHP level, MCPs are required to follow the dispute resolution process contained in APL 21-013. MHPs are required to follow a parallel dispute resolution process contained in BHIN 21-034.



MEDI-CAL TRANSPORTATION BENEFIT

Nonemergency medical transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for members who cannot use public or private transportation to get to and from covered Medi-Cal services, and who need assistance to ambulate.

- NEMT is available to all members when their medical and physical condition does not allow them to travel by bus, passenger car, taxicab, or another form of public or private transportation. Services must be prescribed by a health care provider.

Nonmedical transportation (NMT) is private or public transportation to and from covered Medi-Cal services for eligible members.

- NMT services are available to all members with full-scope Medi-Cal and to pregnant women, including to the end of the month in which the 60th day postpartum falls. Members will need to verbally let the transportation provider know that there is no other way for them to get to their appointment.
- Members will need to attest to the provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted. Reasons for needing NMT can include any of the following:
  - No valid driver's license.
  - No working vehicle available in the household.
  - Not being able to travel or wait for covered Medi-Cal services alone.
  - Having a physical, cognitive, mental, or developmental limitation.
  - No money for gas to get to appointment.

MEDI-CAL TRANSPORTATION BENEFIT *(CONTINUED)*

Transportation is only available to and from covered Medi-Cal services, which includes:

- Medical appointments, including family planning, mental health, and substance use disorder services
- Dental appointments
- Picking up prescriptions
- Picking up medical supplies and equipment

Who can provide NEMT and NMT Services? Licensed, professional medical transportation companies approved and enrolled by Medi-Cal. In addition, Medi-Cal managed care plans also directly contract with other transportation providers for services for plan members.

When to request transportation? Be sure to contact a transportation provider as soon as an appointment is made. It is helpful to request the service at least five business days before an appointment. If there are more than one appointment that is ongoing, transportation can be requested to cover those appointments. ***Note:*** One assistant, such as parent/guardian or spouse, may accompany a member on a trip provided by NMT. However, transportation is not available for more than one assistant.

To access transportation benefits, call the health plans member services department:

- Community Health Group (1-800-224-7766)
- Blue Shield CA Promise Health Plan (1-855-699-5557)
- Kaiser Permanente (1-800-464-4000)
- Molina (1-888-665-4621)

MEDI-CAL PHARMACY BENEFIT (MEDI-CAL RX)

Effective January 1, 2022 all pharmacy benefits for Medi-Cal members including those in a Medi-Cal Managed Care Plan will be covered by the Department of Health Care Services (DHCS) stated-wide pharmacy benefit called Medi-Cal Rx.

The change to a state-wide pharmacy benefit does not apply to the following: Programs of All-Inclusive Care for the Elderly (PACE) plans, Senior Care Action Network (SCAN), Cal MediConnect health plans, Major Risk Medical Insurance Program (MRMIP)

DHCS has contracted with Magellan Medicaid Administration to provide administrative services and supports relative to the Medi-Cal pharmacy benefit.

Medi-Cal Rx will be responsible for managing and resolution of complaints and grievances raised by Managed Care Plan members, their Authorized Representatives, or other interested parties, regarding a Medi-Cal Rx complaint or grievance as well as managing member appeals involving disagreement with benefit-related decisions, such as coverage disputes, disagreeing with and seeking reversal of a request involving medical necessity etc.

Resources:

- Medi-Cal Rx
- DHCS Medi-Cal Rx Customer Service (800) 977-2273
- Consumer Center for Health Education & Advocacy (877) 734-3258
- Medi-Cal Managed Care Plan Customer Service Health Plan ID Card
- San Diego County Access & Crisis Line (888) 724-7240

MCP ENHANCED CARE MANAGEMENT (ECM)

ECM is available for select Medi-Cal members with complex needs. Enrolled members receive comprehensive case management from a lead care manager who coordinates health and social services.

To connect an individual to ECM

1. Confirm the individual has active Medi-Cal and identify their Managed Care Plan (MCP).
2. Ensure the individual meets the eligibility criteria for ECM in the ECM Policy Guide.
3. Complete the universal or plan specific ECM referral form linked below and email the form to the assigned MCP's designated email address.
   The Universal ECM Referral Form (Child/Youth) and Universal ECM Referral Form (Adult) are accepted by all plans.

MCP	Email Address	Member Services Phone Number
Blue Shield	ECM@blueshieldca.com	1-855-699-5557
Community Health Group	ecm-cs@chgsd.com	1-800-224-7766
Kaiser	RegCareCoordCaseMgmt@KP.org	1-800-464-4000
Molina	MHC_ECM@Molinahealthcare.com	1-888-665-4621

Note that the MCP should authorize ECM services within 5 working days for routine authorizations and within 72 hours for expedited requests. If you have not received a response, email or call the MCP for an update.

MCP COMMUNITY SUPPORTS (CS)

CS are medically appropriate and cost-effective services provided by MCPs to help members address their health-related social needs. CS are available to a wide range of members, including those with complex needs and those who are enrolled in ECM. However, members do not need to be enrolled in ECM to access Community Supports.

To connect an individual to Community Supports:

1. Confirm the individual has active Medi-Cal and identify their Managed Care Plan (MCP).
2. Ensure the individual meets the eligibility criteria for Community Supports in the Community Supports Policy Guide.
3. Complete the plan specific Community Supports referral form linked below for each service needed and email the form(s) to the assigned MCP's designated email address.

MCPs	Link to Referral Form	Email Address	Member Services Phone Number
Blue Shield Promise	Community Supports Referral Form (blueshieldca.com)	SDCommunitySupports@blueshieldca.com	1-855-699-5557
Community Health Group	Community Supports Referral Form (chgsd.com)	ecm-cs@chgsd.com	1-800-224-7766
Kaiser Permanente	Community Supports Referral Form (kaiserpermanente.org)	RegCareCoordCaseMgmt@KP.org	1-800-464-4000
Molina	Community Supports Referral Forms (molinahealthcare.com)	MHC_CS@MolinaHealthcare.com	1-888-665-4621

MCP COMMUNITY SUPPORTS (CS)

Community Supports Available through all San Diego MCPs

Housing Transition/ Navigation
Housing Deposits
Housing Tenancy & Sustaining Services
Short-Term Post Hospitalization Housing
Recuperative Care (Medical Respite)
Respite Services
Day Habilitation Programs
Nursing Facility Transition/ Diversion
Community Transition Services/ Nursing Facility Transition to a Home
Personal Care and Homemaker Services
Environmental Accessibility Adaptations
Medically- Supportive Food/ Meals/ Medically Tailored Meals
Sobering Centers
Asthma Remediation

Source: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf

DATA EXCHANGE

- Goals include improving care coordination and referral processes, in accordance with federal and state privacy laws, including but not limited to (HIPAA) and 42 CFR Part 2. Data exchange also assists with population health management and outcome metrics.
- Additional information about each plan, its provider network (directory), and patient portal are available, as follows:

	BlueShield	CHG	Kaiser	Molina	County of San Diego Behavioral Health Plan
Provider Network Search Link	Blue Shield Provider Search	CHG Provider Search	Kaiser Provider Search	Molina Provider Search	County of San Diego Behavioral Health Provider Directory
API Provider Directory		CHG Provider Directory API			County of San Diego Behavioral Health Provider Directory API
Patient Portal	Blue Shield Patient Portal	CHG Patient Portal	Kaiser Patient Portal	Molina Patient Portal	
General Info/Plan Home Page	Blue Shield Home Page	CHG Home Page	Kaiser Home Page	Molina Home Page	County of San Diego Behavioral Health Services
Behavioral Health Landing Page	Blue Shield BH Page	CHG BH Page	Kaiser BH Page		County of San Diego Behavioral Health Services

DISPUTE RESOLUTION

- County and MCPs collaborate to resolve issues related to coverage or payment of services, conflicts regarding the respective roles for care management for specific members, or other issues.
- If there is a dispute, County and MCPs shall complete the plan-level dispute resolution process.
- Pending resolution of any such dispute, services & payments must continue to be provided without delay.
- Unresolved disputes are reported to the State.

Click here for Healthy San Diego Behavioral Health Operations page

-Forms -Contact Cards -Signed MOUs -P&Ps

RESOURCES

Healthy San Diego

Medi-Cal Managed Care Plan Contact Card

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

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

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

blue california Promise Health Plan · Community Health Group · Kaiser Permanente · Molina Healthcare

10/2025 Medi-Cal Managed Care Plans cover transportation to all Medi-Cal covered services including Specialty Mental Health, Drug Medi-Cal Organized Delivery System and Denti-Cal

- Click here for the most recent version(s) of the Contact Card

RESOURCES

SB 1019 Non-Specialty MH Services Outreach and Education Plan

- Effective January 1, 2025, SB 1019 requires MCPs to develop a DHCS-approved outreach and education plan for members and primary care physicians regarding covered mental health benefits.
- APL 24-012: Provides guidance to MCPs regarding requirements for member outreach, education, and assessing member experience for Non-Specialty Mental Health Services as required by SB 1019.
  - Stigma reduction resources are available at:
    - https://www.nami.org/Get-Involved/Pledge-to-Be-StigmaFree
    - Stigma and Discrimination Research Toolkit - National Institute of Mental Health (NIMH) (nih.gov).

Other Service Reminders

Tara Benintende, LCSW
Quality Assurance Specialist
Behavioral Health Services

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Care Coordination

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

Care Coordination (Cont'd.)

Care coordination services shall include one or more of the following components:

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

Peer Support Specialist Services

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

Clinician Consultation

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

Recovery Services

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

Recovery Services (Cont'd.)

- 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) (Cont'd.)

- Reminder that all programs are required to have an effective referral process to MAT providers in alignment with BHIN 23-054, including an established relationship with a MAT provider and transportation to appointments, if MAT is not available at the facility

- Continue to follow all requirements in BHIN 23-054 and your DHCS approved MAT policy and give written notice to DHCS for any changes

Telehealth Consents

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

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

Contingency Management

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Utilization Review Quality Assurance Supervisor
Behavioral Health Services, Quality Assurance, SUD

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Contingency Management

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

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

Contingency Management: Eligibility

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

Contingency Management: Process and Requirements

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

Justice Involved Initiatives

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HPO - SUD QA
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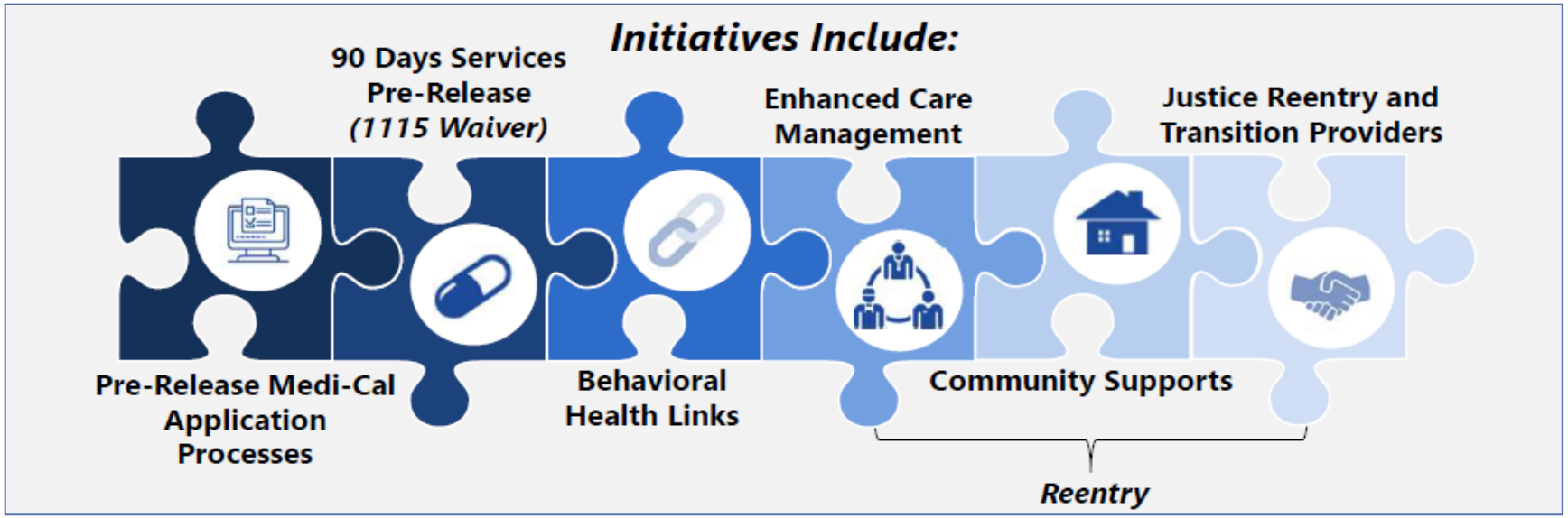
COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Justice Involved Initiative

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

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



Justice Involved Initiative

- Targeted pre-release services within the 90-day period prior to release to support transition from correctional facility

- Pre-release service providers will determine need for Behavioral Health Links

Justice Involved Initiative

- BH Links promote continuity of treatment and correctional facilities are required to facilitate referrals/links to post-release behavioral health provider and share information with the individual's Health Plan
- Locally, BHS has established a referral pathway to ensure coordination of care and compliance with BH linkages.
- Three programs are in place to assist with these referrals: two for adults (Neighborhood House's Project In-Reach and Project In-Reach Ministries) and one for youth up to age 21 (CoSD Next Move).
- Local correctional facilities and CDCR (state prisons) have gone live with pre-release services and referral to our local BH-Linkage providers.

Residential Authorization Requirements

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Residential/ECT Supervisor, Utilization Management
Public Sector, San Diego
Optum Whole Health Solutions

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Residential Authorization Requirements - Initial

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

Residential Authorization Requirements - Continuing

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

Residential Authorization Requirements - Extension

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

Important DMC-ODS Program Requirements

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HPO - SUD Quality Assurance (QA)
Behavioral Health Services

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

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.

AOD Certification

- References: BHIN 25-003;HSC Chapter 7.1
- All programs are required to obtain and maintain an AOD Certification from DHCS.
- **Initial Certification:** Required before providing services.
- **Re-Certification:** Providers are eligible to renew certifications every two years provided the programs remains in compliance with the Standards set forth in BHIN 25-003.
- In accordance with the Alcohol and/or other Drug Program Certification Standards, Section 3000(b), the program shall submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation and renewal fees to the department 120 days prior to the expiration date reflected on the certificate. Failure to provide all necessary documentation shall result in the termination of the certification in accordance with Section 3000(d).
- Per Erin: do we need to include not providing svcs if not certified

Professional Staff Requirements

Professional staff shall:

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

Professional Staff Requirements

Professional staff shall (continued):

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

Medical Director Responsibilities

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement written medical policies and standards for the provider.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine services are medically necessary.

Medical Director Responsibilities Cont'd

- 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.

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

DMC-ODS & SUBG AUDIT

- DHCS facilitates annual audits for both DMC-ODS and SUBG requirements.
- San Diego programs are randomly selected by DHCS for the review.
  - If selected, programs shall provide all requested Policies & Procedures as well as needed supporting documentation as evidence of compliance with requirements.
  - Programs shall ensure all P&P's are accurate and compliant.
- Top P&P's with quality concerns from this past review:
  - DMC-ODS: G&A (processes, auxiliary aids and interpreter requests)
  - SUBG: Counselor certification/re-certification
- Review elements change annually.

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 Cont'd.

Shall include:

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

Record Retention

Records are required to be kept and maintained under this section and shall be retained:

- by the provider for a period of 10 years from the final date of the contract period between the plan and the provider,
- from the date of completion of any audit,
- or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations.

Training Requirements

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

Cultural Competence

- All services, policies, and procedures must be culturally and linguistically appropriate.
- Must participate in the implementation of the most recent Cultural Competence Plan.
- Must participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients.
  - Including those with limited English proficiency, diverse cultural and ethnic background, disabilities, and regardless of gender, sexual orientation, or gender identity
- A record of the annual minimum four hours of training shall be maintained on the Staffing Status Report (SSR) and System of Care (SOC) application.

Access to Services

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

Transitions to Other Levels of Care

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

Grievances and Appeals

NOABD

Natalie Capra, LMFT
SUD - Quality Assurance Specialist
Behavioral Health Services

Client Rights

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

Client Rights

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

Program Complaints

- Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.

- Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

Grievance & Appeal Process

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

- Grievance/Appeal Posters
- Grievance/Appeal Brochures
- Self-addressed envelopes with grievance/appeal forms
- Interpreter services notification
- Access and Crisis Line Posters
- Integrated MHP and DMC-ODS Member Handbook
- Denial and Termination notices

Grievances – Overall Themes

Top 3 areas of Grievances (from most to least)

1. Quality of Care
2. Customer Service
3. Case Management (Care Coordination)

Grievances – Overall Themes

Quality of Care

Grievances related to treatment in terms of effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care.

Examples include:

- Lack of trauma-informed care
- Members report program has not made them feel safe
- Staff failed to address inappropriate/abusive behavior of another resident
- Medication issues
- Member's rights to privacy not respected
- Member declined access to their records
- Poor food quality/lack of food/member has special dietary needs or medical condition(s) that require attention to their diet

Grievances – Overall Themes

Customer Service

Grievances about provision and delivery of services, professionalism, helpfulness, poor handling of members' needs, communication. Includes interactions with the Plan's Member Services department, provider offices or facilities, Plan marketing agents, or any other Plan or provider representatives.

Examples include:

- Staff rudeness/unhelpful/ poor communication
- Ignoring members' questions/feedback
- Members have difficulty reaching someone for assistance

Grievances – Overall Themes

Case Management (Care Coordination)

Grievances for services related to coordinating with other providers, discharge planning, and coordinating with ancillary services.

Examples may include, but are not limited to:

- Coordinating with medical and mental health providers to monitor and support health conditions
- Discharge planning
- Coordinating with ancillary services including community-based services such as childcare, transportation, and housing.

NOABDs

What is a Notice of Adverse Benefit Determination?

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

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

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

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

NOABD: Choosing the Correct Notice

There are (9) different types of notices

1. The Termination Notice- Completed by providers

- Like former “10-day Notice” letter. This is the most commonly used notice.
- When a provider terminates, reduces, or suspends a previously authorized service (i.e. residential)
- Must be sent to the member when discharging for non-compliance (all DMC-ODS programs) as well as for unsuccessful discharges (i.e. AWOL)

2. The Denial of Authorization Notice- Completed by Optum

- When member requests services but is assessed as not meeting medical necessity.
- When the provider denies a request for service, including denials based on type/level of service, medical necessity, appropriateness, setting, or effectiveness of the service

3. The Timely Access Notice- Completed by providers

- When requested services cannot be provided within timelines

NOABD: Choosing the Correct Notice

4. Denial of Payment for a Service Rendered by a Provider- Completed by County

- BHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a member.

5. Modification Notice- Completed by Optum

- When a BHP modifies or limits a requested services

6. Dispute of Financial Liability Notice- Completed by the County

- When the BHP denies a member's request to dispute financial liability, including cost-sharing and other member financial liabilities.

7. Delay in Processing Authorization Notice- Completed by Optum

- When requested services cannot be provided within timelines.

8. Delivery System Notice- Completed by providers

- When the member doesn't meet criteria for specialty mental health or SUD serviced through the BHP. Member is referred to the appropriate health care delivery system (i.e., Managed Care Plan, Medi-Cal Fee-for-Service, mental health, substance use disorder), or other services.

9. Failure to Timely Resolve Grievances and Appeals- Completed by Patient Advocacy (JFS & CCHEA)

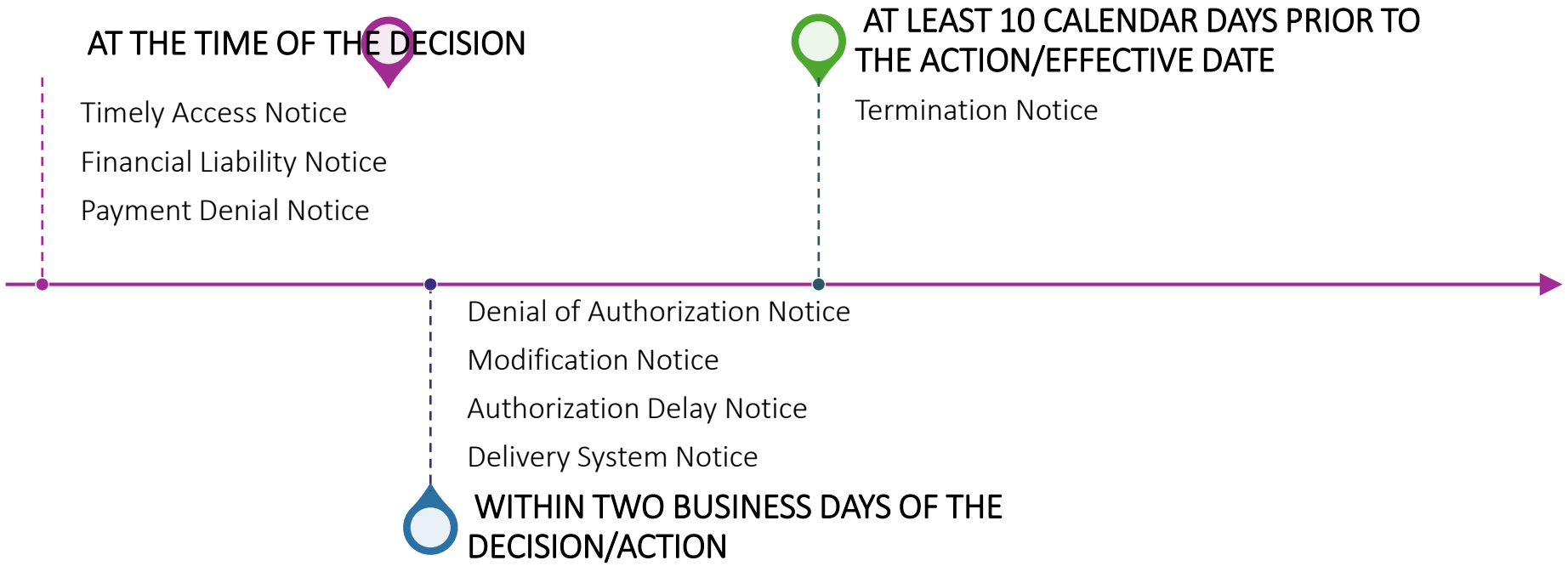
- Issued when timeframes for standard resolution of grievances and appeals is not met.

NOABD: Choosing the Correct Notice

- **The Timely Access Notice**
  - When requested services cannot be provided within timelines
  - Completed by providers
- **Modification Notice**
  - When a BHP modifies or limits a request services
  - Completed by Optum
- **Payment Denial Notice**
  - When the pay denies, in whole or part for any reason, a provider's request for payment for service that has already been delivered to a member.
- **Financial Liability Notice**
  - When the provider's plan denies a member'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 Timeline

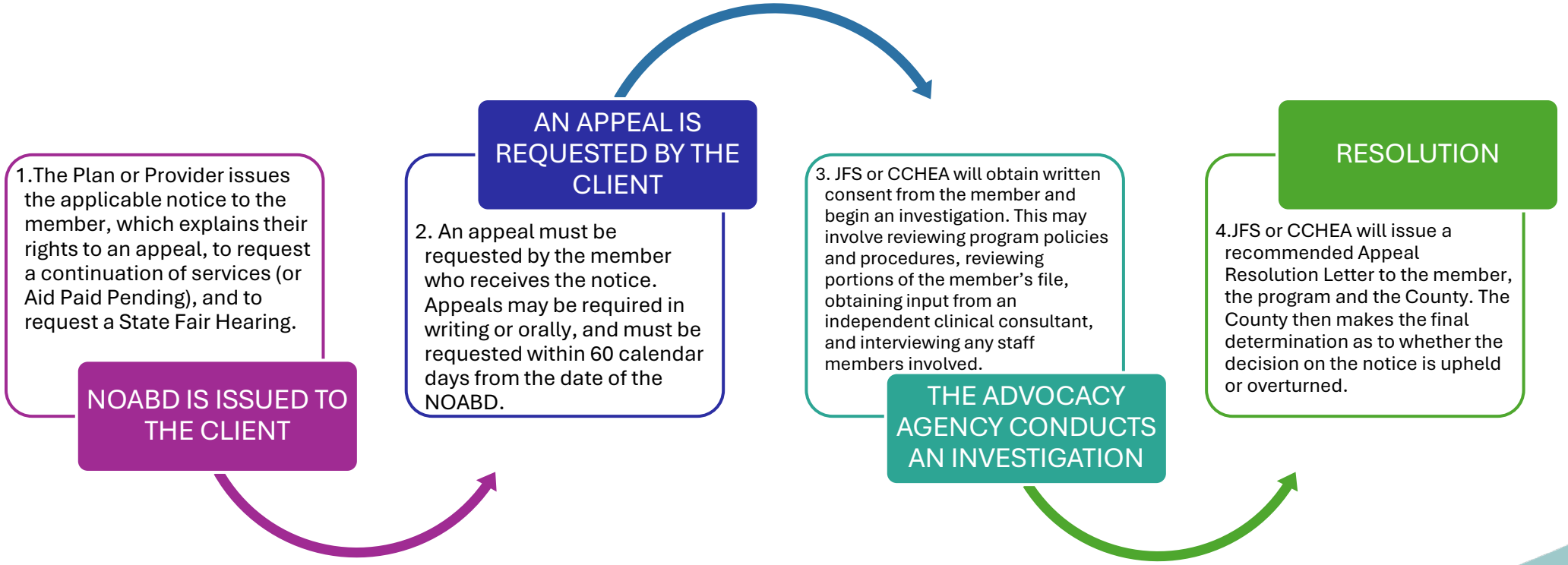
When does each notice need to be mailed/issued to the client?



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

NOABDs and Appeals

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



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

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

Eleos SMARTscribe and SMARTcomply

Eileen Quinn-O'Malley, LMFT
Chief, Agency Operations
EHR Project Team

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Eleos Overview

Eleos Ambient AI	• SMARTscribe • SMARTcomply
Improves Documentation	• Quality and compliance • Integrates with SmartCare EHR
Implementation Plan	• Weekly meetings with Eleos • Super user testing • SOC training • Go-Live

What is Eleos SMARTscribe?

- AI-Driven Note Generation: Provides real-time suggestions for clinical notes, assessments, and treatment plans, helping clinicians capture accurate and comprehensive documentation
  - Converts audio session or provider-supplied key points into structured, clinically relevant and compliant note suggestions
  - Provider is required to review and select content using clinical expertise to complete final documentation.
  - Embedded solution with SmartCare via a browser extension – does not require API
    - Supports 110+ languages

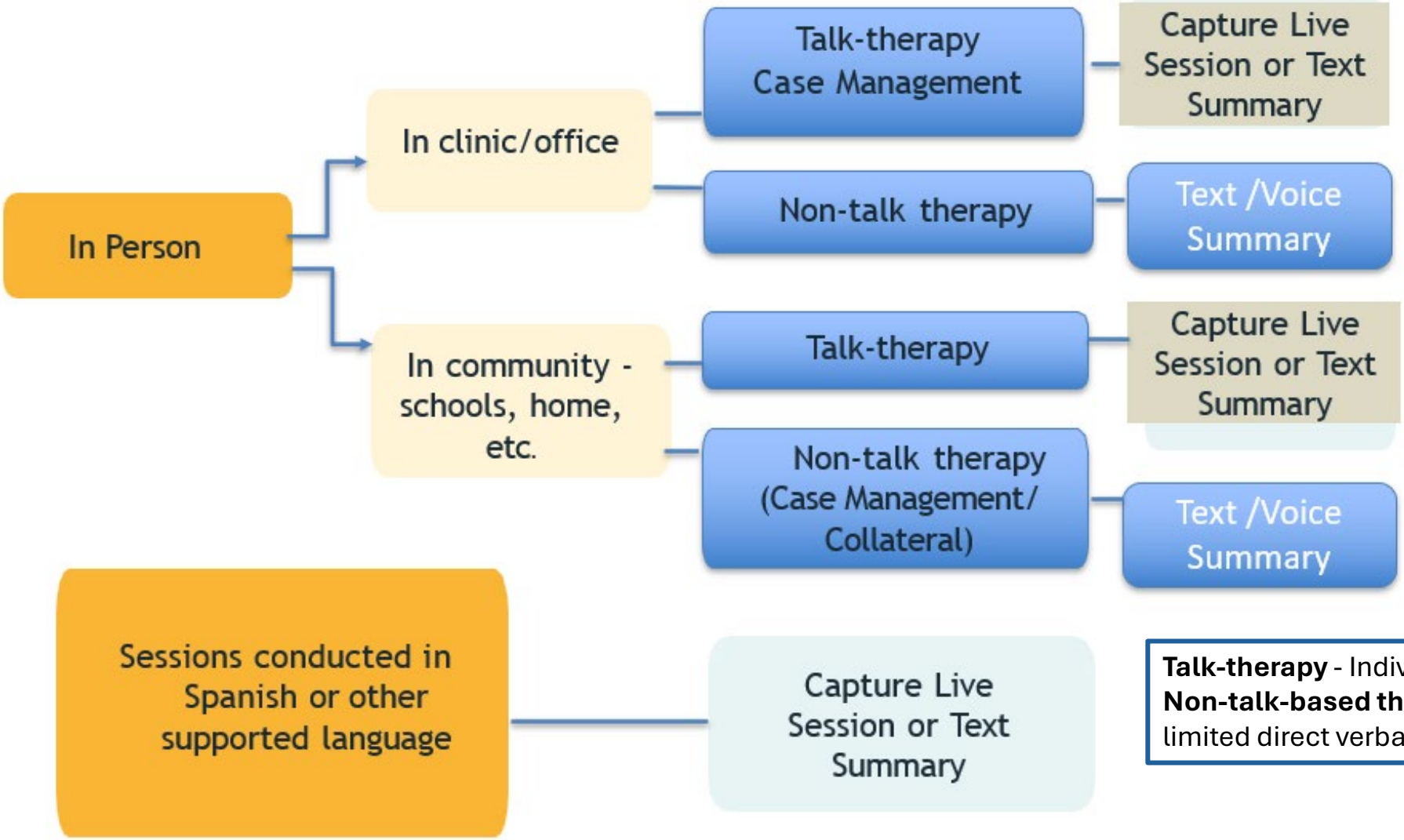
Eleos SMARTscribe Outcomes

- More Time with Clients
  - 70% Less Admin Time
- Eleos populates 80% of progress note content in minutes
- 90% of Eleos users report less daily stress due to documentation
- Opportunities for increased Medi-Cal revenue through more complete and timely documentation

SMARTscribe in Practice

- Eleos can be utilized during Individual therapy, groups, rehab, planning, peer support, medical services, mobile case management
  - Live desktop feature
  - Mobile feature: Text and Voice Summary
- Adjusts documentation by service type and provider role

Eleos User Mapping



Talk-therapy - Individual and group talk-based therapy
Non-talk-based therapy - Play Therapy, art/media therapy, limited direct verbal interaction with client

What is Eleos SMARTcomply?

- SMARTcomply integrates real-time compliance checks directly into clinical workflows, ensuring that documentation is accurate, complete, and audit-ready before submission
  - Checks completeness of note for interventions, progress, care plan alignment, client response
  - Automatically scans 100% of eligible progress notes for documentation errors
  - Catches documentation issues early and reduces the need for error corrections and/or recoupment of services

SMARTcomply Key Features

- Automatic detection of potential documentation gaps
- Real-time feedback directly within the note
- Flags high-risk elements (missing interventions, incomplete goals, etc.)
- Clear, actionable recommendations for correction
- Verifies ‘Golden Thread’ alignment

SMARTcomply Outcomes

- Accurate documentation
- Lower compliance risk
- Higher organizational performance
- Better support for providers and clients

AI Policy, Consent, Ethical Use

- Required AI policies for Legal Entities
  - County Board Policy A-140
- CalMHSA AI Consent
- Verbal consent reviewed and documented each session.
  - Clients may opt out
- Review all session summaries prior to pulling in progress note

Next Steps: Training and Resources

- Trainings
  - Live Virtual and recorded webinars
- Provider resources
  - Scripting examples
  - FAQs

Introducing Eleos to Clients

If a client asks about the use of Eleos—or if you just want to get ahead of any questions you may receive—here are some ideas for approaching the conversation.

Our organization wanted us to be able to focus more on client sessions, so they found this awesome new tool to help us take notes.

Think of Eleos as a note-taking robot.

Eleos is completely secure.

Eleos doesn't record our conversation. It just creates a written summary to help me write the note that I'm required to submit.

When I don't have to worry about taking notes during our session, it's easier to focus on you and the conversation we're having.

There are a lot of requirements for these notes, and it can add a lot of hours to my week. Eleos helps make sure I don't have to spend time writing notes after hours.

I still review and sign off on every note. Nothing gets submitted without my approval.

Thank you!

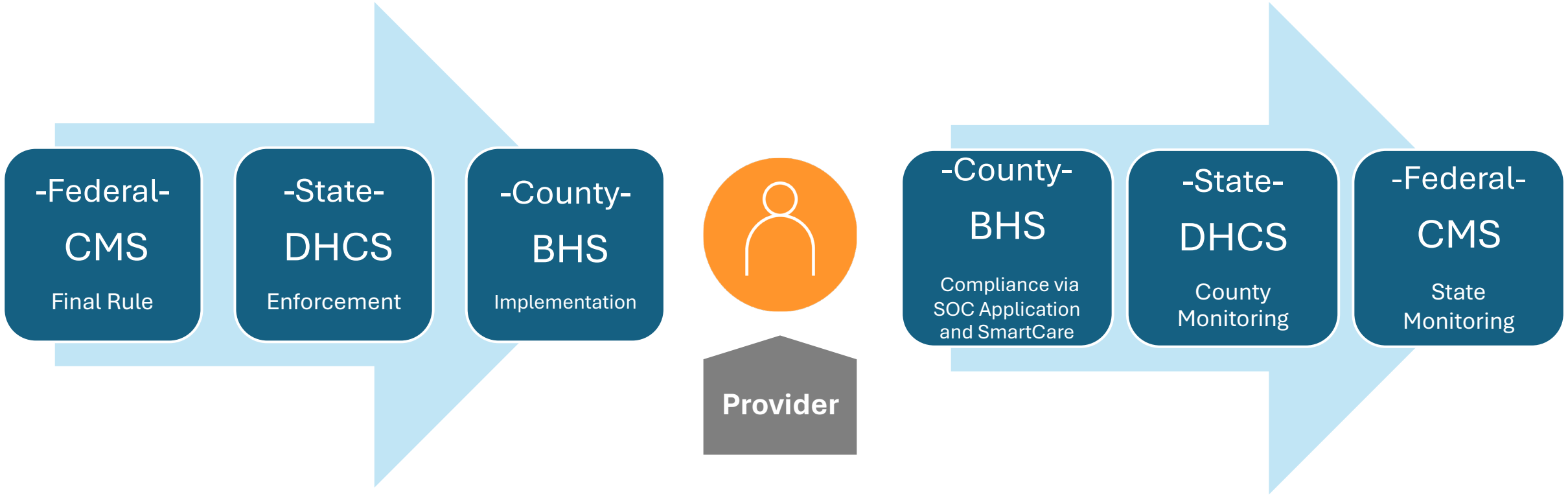
Eileen.quinn-omalley@sdcounty.ca.gov

274 Expansion and The System of Care Application

Jane Maldonado
Manager, Support Desk
Optum Public Sector, San Diego

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

274 Expansion (previously NACT) Background and Flow of Data



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

Reporting Standard

274 Expansion Project

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

- DMC-ODS Providers
  - 274 reporting requirements for DMC-ODS have been deployed into production since October 2023. (BHIN 23-042)

Reporting Standard

Registration

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

Monthly attestations

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

Monthly SOC Attestation Process

Go to **www.OptumSanDiego.com**

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

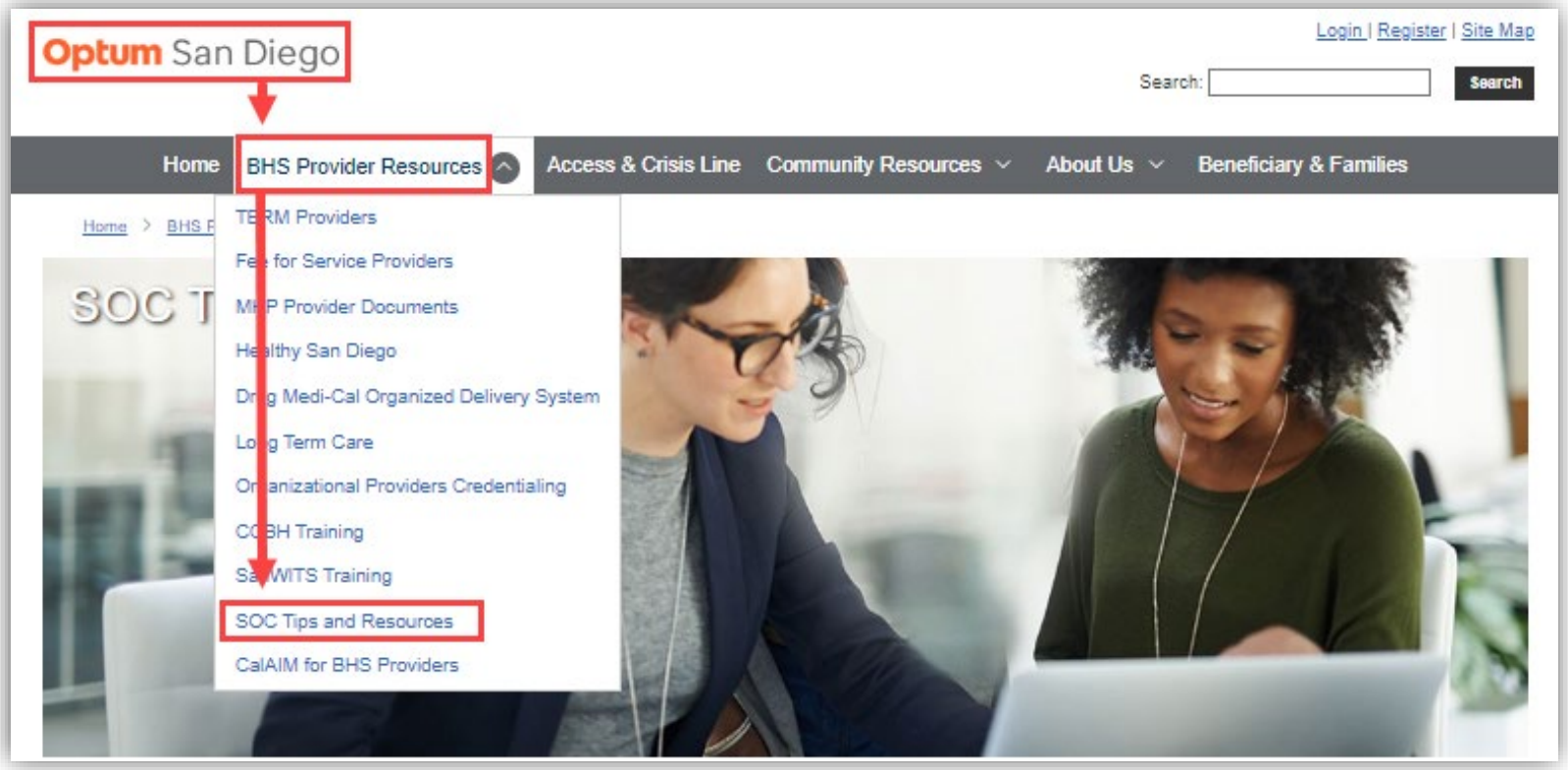
Click on the **SOC** link

Roles: Provider, Manager, Manager with provider update

Review information on **EACH** tab/subtab

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

Tips and Resources



OptumSanDiego.com

Optum Support Desk

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

Information Guide

Provider Directory accuracy depends on:

- **SmartCare data integrity**
  - Source of truth
  - ARF information
- **SOC application attestations**
  - Pulls information from SmartCare
  - Provider/Manager review and updates
  - Provider information per site
- **274 reporting validations**
  - Information from SmartCare and SOC
  - Reporting requirements set by DHCS
  - Three levels of reportability
    - Organization
    - Site
    - Provider

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Authorization to Share Confidential Member Information (ASCMI)

Jill Michalski, LCSW
Behavioral Health Program Coordinator
BHS EHR Project Team, Clinical Lead

ASCMI Overview

- Statewide standardized consent form for sharing client physical health, behavioral health, and social services information between authorized Care Partners.
- Supports coordination of care, treatment delivery, payment, and operations.
- Meets all HIPAA and 42 CFR Part 2 requirements and functions as a legally valid Release of Information (ROI).
- Designed to reduce consent-related barriers, outdated workflows, and fragmented information-sharing systems

Implementation Timeline

- April 1, 2026: ASCMI replaced Coordinated Care Consent in SmartCare for county-operated and contracted providers.

- January 1, 2027: Required statewide for MHPs, DMC-ODS, DMC State Plan Counties, and MCPs (BHIN 26-013).

ASCMI Form Versions: AB 133 vs Non-AB 133

AB 133 Version

- For Medi-Cal managed care enrollees, Medi-Cal behavioral health clients, and justice-involved reentry populations.
- Allows certain sharing without signed client consent under AB 133 rules.

Non-AB 133 Version

- Valid for all Californians regardless of insurance or Medi-Cal status.
- CalMHSA has approved Non-AB 133 for use in SmartCare for all clients.

When to Use Non-AB 133

Use the Non-AB 133 version to:

- Obtain written consent to share information with care team partners.
- Coordinate care across physical health, mental health, SUD, dental, and social services.
- Support service linkage and billing needs.
- Eliminate the need to verify or track Medi-Cal status before completing the form.
- Maintain compliance with all federal and state consent rules.

Data Types Covered (Non-AB 133)

The Non-AB 133 form can authorize sharing of:

- SUD information (Part 2-protected and non-Part 2).
- Mental health information.
- Housing-related information outside CoC NPP.
- Intellectual and developmental disability records.
- HIV test results*
- Genetic test results

Note: HIV and genetic test data are currently suppressed in the CMP pending DHCS legal review. Local processes must be used for HIV disclosures when using the CMP.

Consent Management Portal (CMP)

- Statewide database for verifying whether a client already has a valid ASCMI from another county.
- ASCMI is a client-level document; only one valid form is needed statewide.
- Piloting in Stanislaus and Placer counties; statewide launch TBD.
- HIV and genetic testing preferences temporarily suppressed pending DHCS review.
- SmartCare/CDAG implications forthcoming.

ASCMI Key Rules: Consent, Signatures & Validity

- Check whether an ASCMI already exists and confirm client preferences.
- Complete a new ASCMI only if the client changes or revokes preferences.
- Do not backdate forms.
- Consent lasts one year (age 18+).
- For minors, consent lasts until they turn 18 or guardianship changes.
- Client signature must be on paper or electronic form; verbal consent cannot be used for client signature.
- Electronic version must be completed in SmartCare.
  - Upload scanned forms into SmartCare; ensure all dates for provider and client signatures match the completion date.

ASCMI Key Rules: Revocation, Expiration & Part 2 Notes

- Document consent preferences even if the client declines all data types.
- Signing is optional and not required for treatment.
- Do not alter or modify any ASCMI sections.
- ASCMI authorizes information disclosure only—not treatment.
- Part 2 providers: If the client declines ASCMI but you need to bill, obtain a separate payment-specific authorization.

BHS Specific Requirements

- Organization Name Field
  - Remove prepopulated “County of San Diego” and enter your program name.
    - Your program information will be used throughout the ASCMI form
- Care Partner Information Field
  - Care Partner – provider completing form, this will prepopulate
  - NPI Number – complete using Program NPI Number
    - Use NPI Information Help to identify program NPI Number
  - Taxpayer Identification Number (TIN) – not required, leave blank

ASCMI Non-AB 133

Effective 08/04/2026 | Status New | Author Michalski, Jill

General

AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: NON-AB 133[1] (VERSION 2.0)

Organization Name: County of San Diego

The "ASCMI Form: Non-AB 133" can be used to authorize data sharing for individuals residing in California who do not meet the criteria to use the ASCMI Form: AB 133. This includes all individuals that are:

1. Not enrolled in a Medi-Cal managed care plan.
2. Not receiving behavioral health services under Medi-Cal.
3. Not involved in the criminal legal system that qualify for pre-release Medi-Cal benefits.

County of San Diego wants to help coordinate your health and social services so that you can live a healthier life. Your Care Partner may ask you to sign the Form when they need your consent to share your information with other people or organizations you are receiving care or services from. The Form is not intended to authorize the general release of your information when not required for coordinating your care. Please see below for further detail on the purpose of information sharing and who can share and receive your information.

This ASCMI Form will:

- Explain what information about you may be shared to help coordinate your care.
- Explain how your information may be shared and used.
- Ask for your permission to share certain types of your information. The types of information are listed in Section 1.3 of the ASCMI Form.

---

[1] AB 133 refers to California Assembly Bill 133.

Care Partner Information

This should be completed by the Care Partner obtaining consent from the Client above to disclose their information.

Care Partner Name: Michalski, Jill

Organization Name: County of San Diego

National Provider Identifier (NPI) Number (as applicable):

Taxpayer Identification Number (TIN):

Phone Number:

Fax Number (optional):

Mailing Address

Street Address:

City:

State:

Zip Code:

NPI Information Help

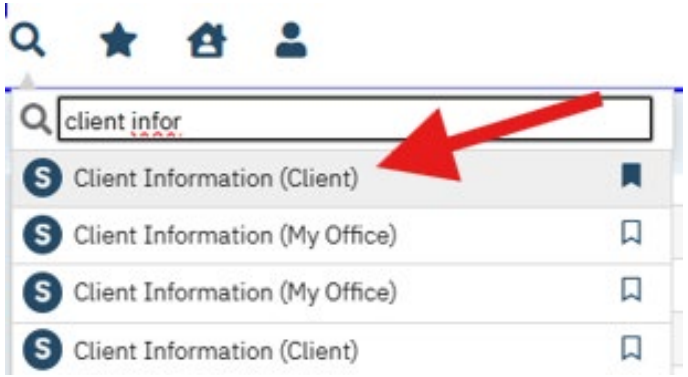
TIN Information Help

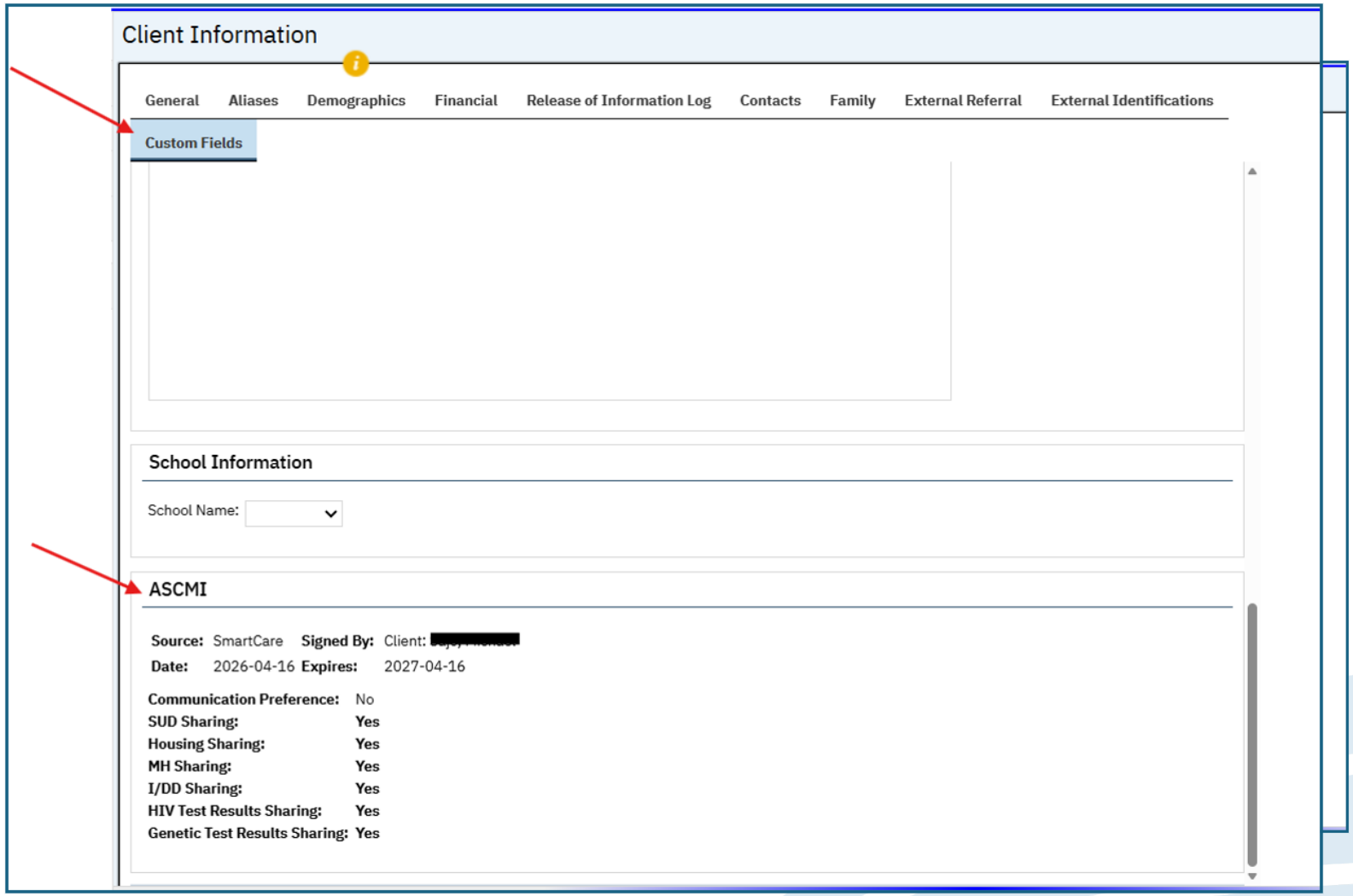
County of San Diego NPI: 1225255375 ||| Program NPI not found. Please associate a program to the document and save the document. ||| Staff NPI not found or document not yet saved. Document must be saved first ("In Progress" status) to pull Staff NPI. ||| If changing the Care Partner Name or Program, you must save the document and refresh the page in order to get the updated NPI in this help text

Section 1: Overview of Sharing Your Personal Information

SmartCare: Viewing Consent Preferences

- Preferences appear in the Client Information → Custom Fields tab.
- Displays data type-specific preferences, signature date, and expiration.
- Automatically updates when a new ASCMI is completed.


client infor
Client Information (Client)
Client Information (My Office)
Client Information (My Office)
Client Information (Client)


Client Information
General
Aliases
Demographics
Financial
Release of Information Log
Contacts
Family
External Referral
External Identifications
Custom Fields
School Information
School Name:
ASCMI
Source: SmartCare Signed By: Client: [redacted]
Date: 2026-04-16 Expires: 2027-04-16
Communication Preference: No
SUD Sharing: Yes
Housing Sharing: Yes
MH Sharing: Yes
I/DD Sharing: Yes
HIV Test Results Sharing: Yes
Genetic Test Results Sharing: Yes

SmartCare: ASCMI Completion Report

- Identifies clients with enrollments and returns the most recent ASCMI in SmartCare.
- Prioritization:Signed by client/guardianSigned by provider (pending client signature)In-progress ASCMI
- Blank entries indicate no ASCMI found for an enrolled client.
- Respects CDAG rules—ASCMI will not display if protected under Part 2 and not authorized for sharing.
- Provides author, signature dates, signer type (client/guardian), and relationship.

Resources

- ASCMI Overview & Forms – CalMHSA
- ASCMI Webinar & Training Materials – CalMHSA
- Completing ASCMI (Electronic & Paper) – CalMHSA
- ASCMI Completion Report Guide – CalMHSA
- BHS Info Notice: Transition to ASCMI (March 23, 2026)
- DHCS ASCMI Initiative (DHCS)
  - ASCMI Forms, Language Translations
  - ASCMI FAQs for Care Partners, Front-Facing Client FAQs
- Data Sharing Authorization Guidance – DHCS
- HIPAA & 42 CFR Part 2 Resources

Thank You!

Questions?

QIMatters.HHSA@sdcounty.ca.gov

DHCS ASAM Criteria 4th Edition Implementation

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Glenda Baez, Psy.D., LMFT
Quality Assurance Supervisor
HPO – Quality Assurance-SUD

ASAM Criteria 4th Edition

In December 2023, the American Society of Addiction Medicine (ASAM) released the ASAM Criteria 4th edition. In alignment with the goals of CalAIM and the evolving standards of care, the California Department of Health Care Services (DHCS) is anticipated to adopt the 4th edition of the ASAM Criteria for use within DMC-ODS in 2027.

California's Transition to ASAM Criteria 4th Edition

Goal: Align DHCS policy with evidence-based standards to best serve members with substance use disorder (SUD), in accordance with state law.

- DHCS is developing **updates to SUD treatment standards and Medi-Cal policy to align with the ASAM Criteria 4th Edition,** as required by state law.[1]
- Alignment with ASAM Criteria 4th Edition brings state standards **up-to-date with the most effective, evidence-based and person-centered SUD treatment guidelines.**

[1] W.I.C. §14184.402(e)(1); H.S.C. § 11834.015(a)

California's Transition to ASAM Criteria 4th Edition

DHCS aims to establish the core requirements needed to implement ASAM Criteria 4th Edition, balancing evidence-based policy with the practical realities of delivering care across California

- DHCS is looking at Policy Development through how changes will impact Counties and Providers and barriers that will need to be considered
- DHCS is working to understand impacts on costs for providing certain DMC-ODS services

» DHCS is in process of considering whether implementation will include a 'ramp-up' period for all or certain LOCs.

Key Updates to ASAM Levels of Care (LOCs) and Alignment with DHCS Policy

DHCS

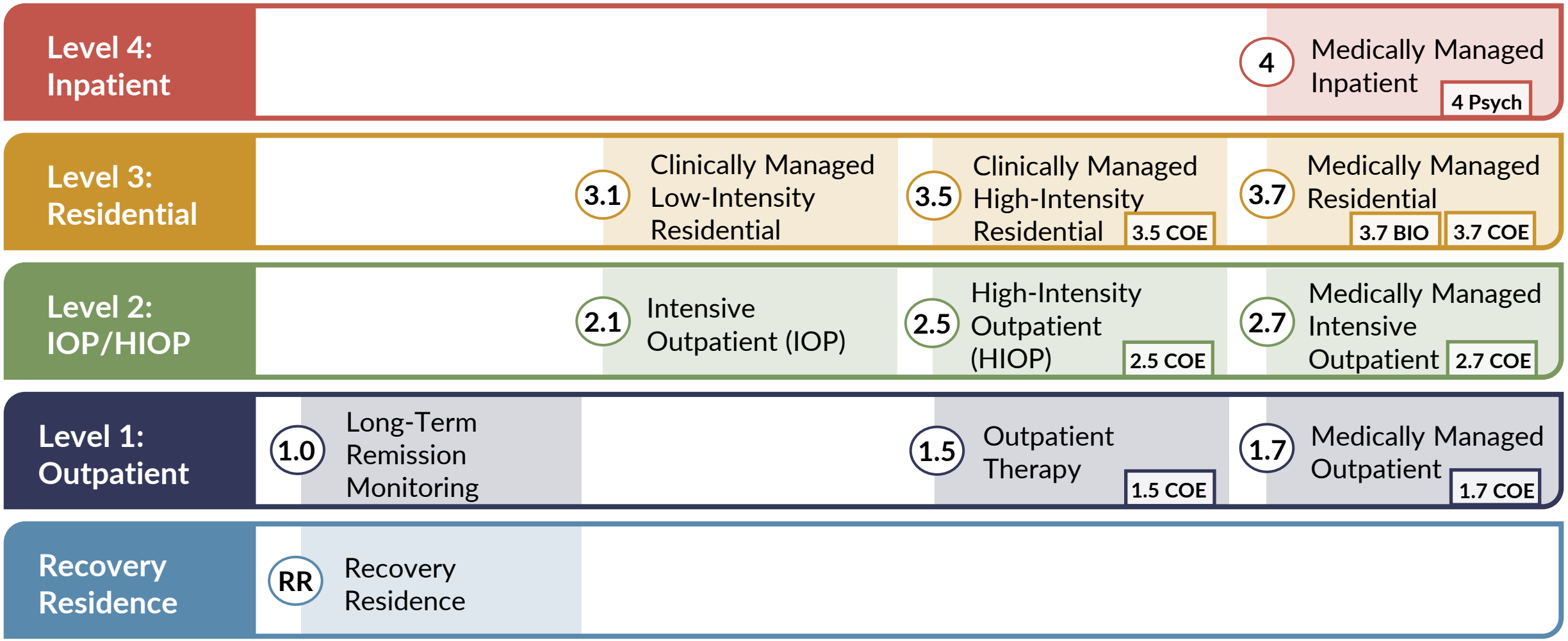
ASAM Criteria 4th Edition LOCs

- ASAM Criteria 4th edition maintains four broad levels of services:
  - **Level 1:** Outpatient Treatment Services
  - **Level 2:** Intensive Outpatient/High-Intensity Outpatient Treatment
  - **Level 3:** Residential Treatment Programs
  - **Level 4:** Inpatient Treatment
- LOCs are either **clinically managed** or **medically managed**

	Clinically Managed	Medically Managed
Definition	Treatment services are primarily overseen and delivered by clinical staff.	Programs with a greater focus on medical management for intoxication, withdrawal management and/or stabilizing biomedical and psychiatric comorbidities in addition to psychosocial services.
ASAM 4th Ed. LOCs	**1.0, 1.5, 2.1, 2.5, 3.1, 3.5**	**1.7, 2.7, 3.7, 4.0**

ASAM Criteria 4th Edition Goal: Better support the integration of physical and mental health care to promote a chronic care model of addiction treatment across all LOCs.

The ASAM 4th Edition Criteria Continuum of Care for Adult Addiction Treatment



Note: ASAM Criteria 4th Edition includes programs with enhanced biomedical capabilities (i.e., BIO) to manage patients with medical comorbidities and enhanced capabilities to treat patients with co-occurring mental health conditions (i.e., co-occurring enhanced [COE]).

ASAM 4th Ed. Alignment with Current DMC-ODS Policy

ASAM 3rd Ed. Current DMC-ODS LOC	ASAM 4th Ed. LOC Equivalent	Alignment with Current DHCS Policy
Level 0.5: Early Intervention Services	*LOC removed*	-
Level 1.0: Outpatient Treatment Services	Level 1.5: Outpatient Therapy Services	Mostly Aligned
Level 1-WM	Level 1.7: Medically Managed OP Treatment	Mostly Aligned
Level 2.1: Intensive Outpatient	Level 2.1: Intensive Outpatient Treatment	Mostly Aligned
Level 2.5: Partial Hospitalization	Level 2.5: High-Intensity Outpatient Treatment Services	Mostly Aligned
Level 2-WM	Level 2.7: Medically Managed Intensive Outpatient Treatment	Somewhat Aligned
Level 3.1: Clinically Managed Low-Intensity Residential	Level 3.1: Clinically Managed Low-intensity Residential Treatment	Somewhat Aligned
Level 3.2-WM: Clinically Managed Residential WM	*LOC removed/integrated into Level 3.5*	-
Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services	*LOC removed*	-
Level 3.5: Clinically Managed High-Intensity Residential	Level 3.5: Clinically Managed High-intensity Residential Treatment	Somewhat Aligned
Level 3.7: Medically Monitored Intensive Inpatient Services / Level 3.7-WM	Level 3.7: Medically Managed Residential Treatment	New to Most Providers
Level 4.0: Medically Managed Intensive Inpatient / Level 4.0-WM	Level 4.0: Medically Managed Inpatient Treatment	Mostly Aligned

ASAM Criteria 4th Edition Changes (1/2)

Key Changes
» **Integration of WM services across the continuum of care** to maximize individualized care and to encourage the delivery of requisite treatment in any clinically feasible setting.
» **New LOC added:** Level 1.0 Long-Term Remission Monitoring
» **Reconfigured LOCs:** • **Level 0.5 (Eliminated)** Early Intervention Services • **Level 3.2-WM (Eliminated)** Clinically Managed Residential Withdrawal Management • **Level 3.3 (Eliminated)** Clinically Managed Population-Specific High-Intensity Residential • **Level 3.7 and Level 3.7-WM:** Combined into ASAM Criteria 4th Edition Level 3.7 • **Level 4.0 and Level 4.0-WM:** Medically Managed Intensive Inpatient/Inpatient Withdrawal Management combined and reconceptualized with standards for General Hospitals and Addiction Specialty Units

ASAM Criteria 4th Edition Changes (2/2)

Key Changes

- **Updated Service Levels:**
  - **Level 1-WM** is now **Level 1.7**: Medically Managed Outpatient Treatment
  - **Level 2-WM** is now **Level 2.7**: Medically Managed Intensive Outpatient Treatment
  - **Level 2.5** is renamed High-Intensity Outpatient Treatment Services
- **Service Requirement Changes for Residential LOCs:**
  - **Level 3.1:** Clinically Managed Low-Intensity Residential Treatment
    - Minimum clinical service hours increased from 5 to 9-19 hours per week; includes structured services each day of the week.
  - **Level 3.5:** Clinically Managed High-Intensity Residential Treatment
    - Minimum clinical service hours increased from 5 to 20 hours per week to align with Level 2.5.
  - **Level 3.7:** Medically Managed Residential Treatment
    - Combines Level 3.7 and 3.7-WM into one **residential** LOC.

ASAM Implementation Timeline

Q1-Q3 2026:
ASAM Criteria Fourth Edition policy development and stakeholder engagement

Q3 2026:
Public comment/public notice periods for DHCS licensing and LOC designation, DMC-ODS BHINs and ASAM SPA.

Q1 2027:
ASAM guidance published and SPA submitted to CMS by **January 1, 2027**.

Q1- Q2 2027:
DHCS system updates. ASAM Criteria Fourth Edition policy changes go live **July 1, 2027.**

Program Integrity

Tammy Pham, **LCSW**
Quality Assurance Specialist
HPO- Quality Assurance-SUD

Internal Compliance Program

- Recommended that programs have an internal program integrity/compliance program commensurate with the size and scope of their agency.
- Contractors with more than $250,000 in annual agreements with the County must have a compliance program that meets the following 42 CFR guidelines:
  - Development of a code of conduct and compliance standards.
  - Assignment of a compliance officer who oversees/monitors compliance program.
  - A communication plan which allows workforce members to express complaints/concerns without fear of retribution.

Internal Compliance Program

(Continued)

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

Internal Compliance Program

Cont'd.

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

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

Reporting Fraud, Waste, & Abuse (FWA)

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

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

Individual and Service Level (ISL)

Eileen Quinn-O'Malley, LMFT
Chief, Agency Operations
EHR Project Team

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Individual and Service Level (ISL)

ISL activities/encounters capture all individual level behavioral health services provided directly to clients by the County Behavioral Health Plan Provider network that are not reimbursable by Department of Health Care Services (DHCS) through the Medi-Cal benefit package

- DHCS sees only a fraction of the investments counties make to serve their communities
- ISL reporting provides insight into behavioral health service delivery across the care continuum
- There is a value, as a health plan, to knowing the full cost of care for each person served
- ISL will capture the gap between what is claimed in Medi-Cal and other county investments

Note: ISL encounters will not be tied to service reimbursement

Level of Care – BHS Services

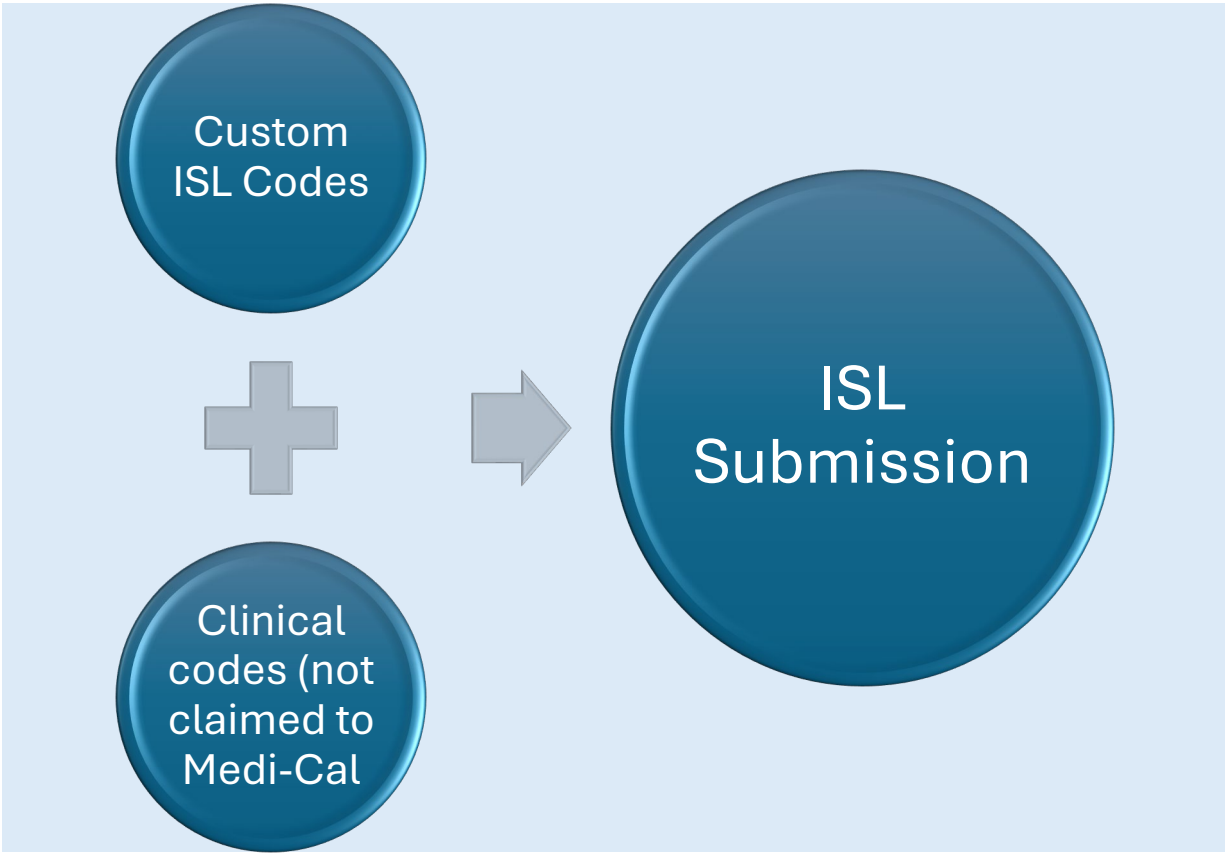
BHT Care Continuum

DHCS developed the Behavioral Health (BH) Care Continuum for BHPs to capture BH services across funding sources – there are discrete frameworks for MH and SUD.

Identifying ISL Codes?

What Services are Included in ISL Submissions?

- ✓ Individual-level services and expenditures that are not claims to Medi-Cal
- ✓ Recorded using either:
  - Custom ISL codes, or Clinical (CPT/HCPCS) codes



BHS Preparation for ISL

Create groupings aligned with SmartCare programs

Create ISL code groups aligned with SC program groupings

Confirm SmartCare programs mapping to ISL codes

Plan for SmartCare build for ISL codes

TBD provider training on ISL codes

Thank you!

Eileen.quinn-omalley@sdcounty.ca.gov

SmartCare Resources

CalMHSA: https://2023.calmhsa.org/ to find:

- Procedure Code Definitions (Service code crosswalk)
- Clinical Documentation Guide 2025
- …and so much more!

Resources

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

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

Thank you for all that you do!

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Q & A
FROM LIVE FORUM

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Q&A From Live Forum

Q: Does SmartCare training need to be completed before an ARF can be submitted for access to the system?

A: *Yes, users must complete the required SmartCare trainings before submitting the ARF. The trainings will be completed via CalMHSA's Learning Management System (LMS). Only after training has been completed should the required ARF be submitted to the MIS help desk and BHS Credentialing. Once training completion is confirmed, the MIS help desk will issue the user's SmartCare credentials*

Q: If an individual is hired in September and Credentialing takes 2 months, they would not be able to provide services for 2 months?

A: *We recommend starting the credentialing process at the same time as the hiring process. Optum can typically credential someone in 30 days IF all required documents and information is submitted timely. Delays occur because there is back and forth or follow-up needed from providers.*

Q: Who can we reach out to so, our organization can credential our own staff?

A*: BHS determines if an organization can self-credential; it will be part of their contract if they can. If they currently cannot, the organization can reach out to their COR to see if it's an option to amend their contract to do so.*

Q&A From Live Forum Cont'd…

Q: For the ARF, how will we add that date when credentialing takes sometimes up to 3 months to give us a completion date?

A: *We recommend starting the credentialing process at the same time as the hiring process. Optum can typically credential someone in 30 days IF all required documents and information is submitted timely. Delays occur because there is back and forth or follow-up needed from providers.*

Q: Medically Frail definition: Is withdrawal management (3.2) considered residential care, or only RTP SUD (3.5 and 3.1)?

A: *ASAM LOC 3.2 WM (Clinically Managed Residential Withdrawal Management), is delivered in a 24-hour residential setting with structured daily observation, medication management, and supervision by credentialed clinical personnel. ASAM LOC 3.1 and 3.5 (Residential Treatment Programs-RTP) are also 24-hour residential services but with a primary focus on rehabilitation and recovery.*

Q: The Deaf community does not use or have access to almost any TTY or TTD capable equipment. Continuing to present this technology as an accessible means of communication for the Deaf community is inaccurate.

A*: The slide deck has been updated, and this information has been removed.*

Q&A From Live Forum Cont'd…

Q: Regarding Eleos. AI cannot record/report on sign language, so this is not accessible for all programs. Also, Privacy concerns about AI supersede its functionality and cannot replace the intuition and specialized training of a counselor.

A: *The text summary can be used by a clinician or paraprofessional after the session.* Eleos is HIPAA compliant and uses advanced encryption and certified security practices. Their website outlines these protections, and these topics will likely be covered in the upcoming trainings.

Q: What if the client denies to sign the ASCMI?.

A*: This is addressed in the DHCS FAQs and knowledge articles on CalMHSA's site. Completing and signing the form is optional and not required for treatment; however, it should be reviewed with the client, and best practice is to complete and select "declined" for their preferences and obtain signature if possible. For SUD/part 2 providers - if a client won't sign ASCMI and you need to submit billing, you must collect a separate payment-specific authorization.*

Q: Will there be a report to show if a client already has an ASCMI?

A*: Yes, that is addressed in the slides and additional information can be found on the CalMHSA Knowledge Base page:*

CalMHSA 121 – ASCMI Completion Report - 2023 CalMHSA

Q&A From Live Forum Cont'd…

Q: Will an ASL translation of the ASCMI be available to explain this to low-language, language deprived Deaf clients?

A: *DHCS has links to language translations, however we are not sure if there is an ASL specific translation. Please review the DHCS resources/links and/or reach out to DHCS directly.*

Q: Will SD be getting a 4.0 level of care facility?

A: The most recent update we have received is new contracts are planned to start in July 2027 or later after ASAM 4th edition has been implemented.