Annual DMC-ODS and SUBG Compliance Training
FY 2024-25

Training Overview

Agenda:

- DMC-ODS Overview and Training
- SUBG Overview and Training

Notes/Reminders:

- Training slides will be shared with participants
- Participants that stay for the duration of the training will be provided with certificates of completion
- The training will be recorded and available to providers

DMC-ODS Overview

- In April 2017, Marin County opted into a five-year demonstration waiver to operate the Drug/Medi-Cal program as an organized delivery system. The intent of the DMC-ODS pilot was to demonstrate how organized substance use disorder care improves successful outcomes while decreasing other system health care costs.
- DMC-ODS will improve access to and quality of care for Marin Medi-Cal members by:
    - Enhancing the **Continuum of Substance Use Disorder (SUD)Services** and expanding access to—and Federal Medicaid reimbursement for—services
    - Using the **American Society of Addiction Medicine (ASAM) Criteria** to ensure that members are in the most appropriate level of care
    - Coordinating with **mental health and primary care** to ensure integrated care
    - Requiring providers to deliver care **utilizing Evidence Based Practices (EBPs)**
    - Acts as a **managed care plan for SUD treatment** services
- DMC-ODS was renewed through 2026 as part of CalAIM
- Refer to BHIN 24-001 for DMC-ODS Requirements from 2022 – 2026. *Note: Refer to the most recent BHIN for DMC-ODS Requirements.*

Marin DMC-ODS Covered Services

- ASAM 0.5: Early Intervention for Youth (Under 21 Years)
- ASAM 1.0: Outpatient Treatment
- ASAM 2.1: Intensive Outpatient Treatment
- ASAM 3.1, 3.3, 3.5: Residential Treatment (Must have an ASAM or DHCS Level of Care Designation)
- ASAM 3.2-WM: Withdrawal Management (Residential WM must have an ASAM or DHCS Level of Care Designation)
- Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP)
- Medications for Addiction Treatment (MAT)
- Peer Support Services
- Recovery Services
- Care Coordination (formerly referred to as Case Management)
- Clinician Consultation (formerly referred to as Physician Consultation)
- Contingency Management / Recovery Incentives
- Coordinate with other services, such as Inpatient Residential and WM

- *Refer to DHCS IN 24-001 for updated definitions on the levels of care*
- ***Note: This will change once ASAM 4th Edition is implemented*

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DMC-ODS: Provider Specifications

- Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.
- 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**.
- LPHAs, including the Medical Director, shall receive a minimum of **five hours of continuing education related to addiction medicine each year.**
- Any counselor providing clinical services (assessment, treatment or recovery planning, individual or group counseling) in a DHCS licensed or certified program is required to be certified as defined in CCR Title 9, Division 4, Chapter 8.
- A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meets all other applicable California state requirements. Services are provided under the direction of a Behavioral Health Professional

Medical Director Requirements

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

**Required elements for the Code of Conduct and Medical Director Roles and Responsibilities are in the Marin DMC-ODS Practice Guidelines*

DMC-ODS: Required Trainings

- Providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care"
- Cultural Humility Training (At least four hours annually)
  - One LGBTQ+ Training (Annual)
  - One Cultural Humility Training (Annual)
  - Working with Interpreters Training (bi-annually – every other year)
- 42 CFR Part 2, HIPAA, Law & Ethics, Information Privacy and Security (Annual)
- SmartCare and CalOMS (Prior to use of SmartCare)
- LPHAs: Five hours/CEUs in addiction medicine (Annual)
- DMC-ODS Compliance (Annual)
- Signed Oath of Confidentiality (Annual)
- Other trainings as required by regulation (e.g., CPR and First Aid, Naloxone, specific training/orientation for Withdrawal Management providers)

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Timely Access to Services

- DMC-ODS Plans shall have a 24/7 Member Access Line (Marin BHRS Access Line: 1-888-818-1115)
- Members determined to be in crisis shall be immediately linked to appropriate support and management
- Members screened as having an urgent need shall be linked to care within 48 hours
- For OTP, providers shall ensure a face-to-face appointment within three (3) business days of the initial request for services
- For all other DMC-ODS services, providers shall ensure an appointment within ten (10) business days of the initial request for services
- **Reminder**: Record Timely Access in SmartCare (Search “Timeliness”)

Beneficiary* Informing Materials

- Post and include in documents that are vital/critical to obtaining services (e.g. outreach and marketing materials, written notices to individuals):
  - A DHCS-approved **Nondiscrimination Notice** (at least 12-point font) that informs members, potential members, and the public about nondiscrimination, protected characteristics, and accessibility requirements.
  - Complaint process and **grievance procedures and forms** – *Note: The grievance forms and self-addressed stamped envelopes should be where a member can access them without having to ask staff*
  - **Language Assistance Taglines** – Informing of availability of no-cost language assistance services (at least 12-point font and in English and State's top 18 non-English languages)
  - Other information including the appeal process for involuntary discharge, and program rules and expectations (including reasons for potential discharge)

**DHCS is in the process of updating the term beneficiary to member so terminology may vary during the transition process.*

Member Informing Materials

- Provide the following to members/potential members, either in paper or in electronic format, at the time they are first required to enroll in the program.
  - **Provider Directory and Formulary**: Make available in electronic form and, upon request, in paper form. Link to DMC-ODS Provider Directory
  - **Beneficiary/Member Handbook**: Includes features of managed care, enrollment information, service area, covered benefits, how to access the Provider Directory and formulary, access to covered benefits and services, after-hours care, restrictions o freedom of choice, rights and responsibilities, coordination of care, access to language assistance, reporting suspected fraud, waste or abuse, and grievance and appeal processes. Link to DMC-ODS Beneficiary Handbook
    - Note: As of 1/1/2025, there will be an integrated MHP/DMC-ODS Member Handbook
  - Other program documents, such as Consent to Services, Share of Cost (if applicable), information noting DMC is payment in full (if applicable)

Member Informing Materials – Beneficiary/Member Handbook

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

Grievance and Appeal Requirements

- DMC-ODS Providers shall post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone.
- The County produces required member informing materials in English and Spanish. Materials are available at www.MarinBHRS.org
- Contractor shall request materials from the County, as needed.
- Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.
- Link to Grievance Brochures: https://www.marinbhrs.org/clients-caregivers/grievance-brochure

Notice of Adverse Benefit Determination (NOABD) Requirements

A NOABD is a formal communication of any action and consistent with 42 CFR 438.404 and 438.10. Contractor shall have written procedures to ensure compliance with the following:

- Contractor shall request consent from members for the County to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a member refuse to consent, then the Contractor is responsible for issuing any applicable NOABD to the member.
- If a NOABD is applicable, Contractor shall complete letter, attach applicable documents (e.g. Your Rights, Non-Discrimination, Taglines), and provide to member within applicable timeframes. Per BHRS Policy Memo 2023-03:
    - DMC-ODS Providers that have opted to use the full clinical functionality of SmartCare shall use the available NOABD functionality in SmartCare
    - DMC-ODS Providers that have not opted to use the full clinical functionality of SmartCare shall follow the existing procedures specific to issuing NOABDs, placing a copy in the member's file, and submitting the NOABD log via encrypted email to Marin BHRS by the 10th of each month

Link to NOABD Templates, Log and Instructions

NOABD Requirements (continued)

- Marin has no discretion and must follow federal/state requirements for timing of notices, which are outlined in DHCS MHSUDS IN: 18-010E. Per the following exceptions to the requirement to provide 10-day advance notice (see 42 CFR 431.213 and 42 CFR 483.15(c)(4)(ii)), "Notice must be made as soon as practicable before transfer or discharge when:
    - The safety of individuals in the facility would be endangered [due to the clinical or behavioral status of the resident];
    - The health of individuals in the facility would be endangered;
    - The resident's health improves sufficiently to allow a more immediate transfer or discharge [and the resident no longer needs the services provided by the facility];
    - An immediate transfer or discharge is required by the resident's urgent medical need [and is necessary for the resident's welfare, and the resident's needs cannot be met by the facility]; or
    - A resident has not resided in the facility for 30 days."

CalAIM and DMC-ODS Policy Clarifications and Updates

Expanding Access to Medications for Addiction Treatment (MAT)

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

Access to DMC-ODS Services

Initial Assessment Process

- Excluding Residential treatment and NTPs, effective January 1, 2024, to ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member’s clinical needs and generally accepted standards of practice.
  - The initial assessment using the ASAM embedded in SmartCare shall be completed in a timely manner following the first visit with an LPHA or registered/certified counselor.
  - Covered, clinically appropriate and medically necessary services may be provided during the initial assessment period.

Level of Care Determination (IN 24-001)

Note: If DHCS issues an updated BHIN that supersedes 24-001 during FY 24-25, the updated BHIN guides DMC-ODS requirements.

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

- For members 21 and over, a full assessment using the ASAM Criteria shall be completed
- A full ASAM Criteria assessment is not required to deliver early intervention services for members under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).
- A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
- A full ASAM assessment using the embedded ASAM in SmartCare shall be repeated when a member's condition changes.
- These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

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

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Medical Necessity

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

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

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

Care Planning Requirements
Excerpted from DHCS Slide Deck

- Prospectively completed, standalone treatment plans (DMC, DMC-ODS) are no longer required.
- Care planning is meant to be an ongoing and interactive component of care delivery, rather than a one-time event.
- There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities.
- These requirements are noted in Enclosure 1a of BHIN 23-068 (may not be exhaustive list).
- For programs, services, and facility types that still require care plans and/or specific care planning activities, BHIN 23-068 establishes one standard for documentation of care planning.

Where a care plan or care planning activities are required:

» Providers must adhere to requirements in state/federal law;

» Required care plan elements must be documented within the member record (location is flexible); and

» The provider must be able to produce and communicate the content of the care plan.

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Payment Reform Reminders (Effective July 1, 2023)

- The provider licensure type and the service type will determine which HCPCS & CPT code is billed.
    - Reimbursement rates are based on the certification/licensure performing the service

- Outpatient is the most impacted by the switch from HCPCS to CPT codes.

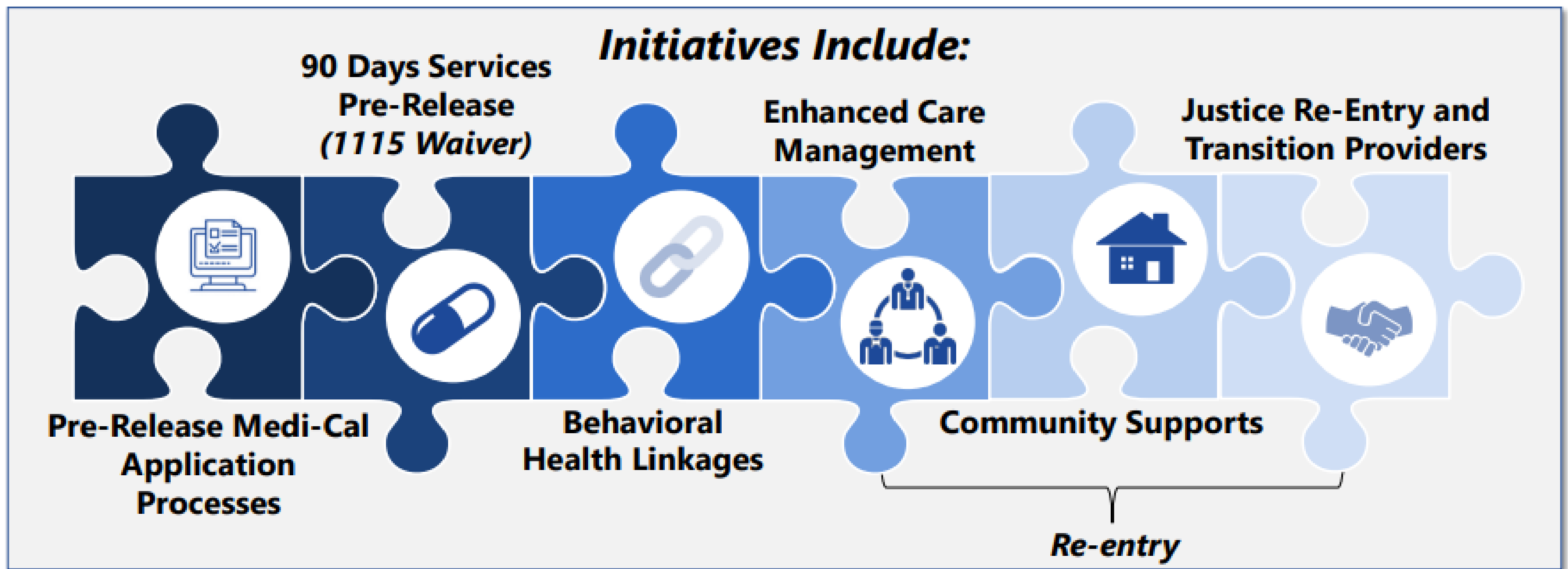
- Outpatient CPT code reimbursement will be based on face-to-face time only and will be inclusive of both documentation and travel time.
    - Note: Even though the rate is inclusive, the new EHR will continue to capture the documentation and travel time for each outpatient service.

- A comprehensive list of HCPCS/CPT codes by licensure type is included in contracts

- Payments will be based on approved claims, up to the contract maximum.

What is CalAIM Justice Involved?

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



Excerpted from DHCS & HHS Slide Decks

CalAIM Justice Involved

Pre-Release Services

- Marin County Jail and Juvenile Hall expected to provide Medi-Cal physical and behavioral health services 90 days before release
  - Implementation must be between October 1, 2024 and March 31, 2026. Marin go live is projected for 2026 – specific date TBD.

Behavioral Health Links

- County BH agencies are required to receive warm hand-offs from correctional facilities of DMC-ODS eligible individuals by **October 1, 2024**
- Per DHCS BHIN 24-001, DMC-ODS plans will be required, within 14 days prior to release (if known), and in coordination with the pre-release care manager, to ensure processes are in place for a BH Link between the correctional behavioral health provider, a DMC-ODS provider, and the member.

Resources:

- BHIN 23-059 Medi-Cal Justice-involved Re-Entry Initiative: State Guidance
- DHCS CalAIM Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved

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MOUs with Managed Care Plans *(MCPs: Kaiser & Partnership HealthPlan)*

Services Provided or Arranged by DMC-ODS and MCPs

- MCPs must provide or arrange for the provision of the following covered services:
  - Non-specialty mental health services (APL 22-006 and superseding guidance)
  - Substance use services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT), Medications for Addiction Treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
  - Emergency services necessary to stabilize the member.
  - *References: APL 22-006, BHIN 21-073, BHRS and MCP MOU; Copy of MOUs and Quarterly Meeting notes at www.MarinBHRS.org*

- DMC-ODS must provide or arrange for the provision of the following covered services:
  - Outpatient, intensive outpatient, residential, withdrawal management, recovery services, care coordination, and clinician consultation services
  - Services access via 1-888-818-1118 (24/7) or directly via Provider
  - *References: BHIN 24-001; Copy of MOUs at www.MarinBHRS.org*

Accessing and Coordinating Services with MCPs

Primary Care, Enhanced Care Management (ECM), Community Supports (CS) and Other Services

Kaiser Permanente

- Member Services: 1-855-839-7613 (TTY 711), 24 hours a day, 7 days per week (closed major holidays) | www.kp.org/finddoctors
- Kaiser Member Handbook

Partnership HealthPlan of California

- Member Services: 1-800-863-4155 (TTY 1-800-735-2929), Monday – Friday (8am – 5pm) | Advice Nurse at 1-866-778-8873, 24 hours a day, 7 days a week | www.partnershiphp.org
- Partnership Member Handbook
- For ECM or CS:
  - Fill out the ECM Referral [Adult | Youth] or CS Referral form and send back to the appropriate helpdesk via **secure** email: **ECM:** ECM@partnershiphp.org or fax 530-351-9040 | **CS:** CommunitySupports@partnershiphp.org

SmartCare Reminders and Resources

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SmartCare Updates & Tips

- **Reminder: DMC Timely Access to Services**
  - Links to Instructions:
    - **For Non-OTP:** https://2023.calmhsa.org/how-to-complete-the-dmc-outpatient-timeliness-record/
    - **For OTP:** https://2023.calmhsa.org/how-to-complete-the-dmc-opioid-timeliness-record/
- This is required for State Reporting and important for assessing access to care and for continuous quality improvement
- There will be a "flag" set-up in SmartCare to prompt staff to complete this form when a client is enrolled

- **New Users and Staff Updates** (e.g. role change, updated certification/ licensure dates, etc.)
  - Link to: Staff User Access Form (can be found at www.marinbhrs.org/providers)

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SmartCare Tips & Reminders

- **Service Entry and Billing Submission**
  - Ensure all services in SmartCare have been moved from Scheduled and Show status each month with submission of billing**.**
  - All services should be in Complete, Cancel, No Show or Error ***status.***
  - Use the Services (My Office) List page and filter the All Services Status dropdown by Scheduled and Show to review outstanding services.
  - Services with Warnings or Errors will remain in Show status until the errors are resolved.

Services (3551)

All Services | Scheduled | Include Do Not Complete | All Programs | Financial Assignment... | Apply Filter

All Locations | All Procedure Codes | All Clinicians | All Service Entry Staff | All Service Areas

Service Id | Entered From | Entered To | DOS From 07/01/2023 | DOS To 06/30/2024

Include Services created from Claims | Only include Services with Add On Codes | Only show Non-Billable Services | Show Only Active Clients

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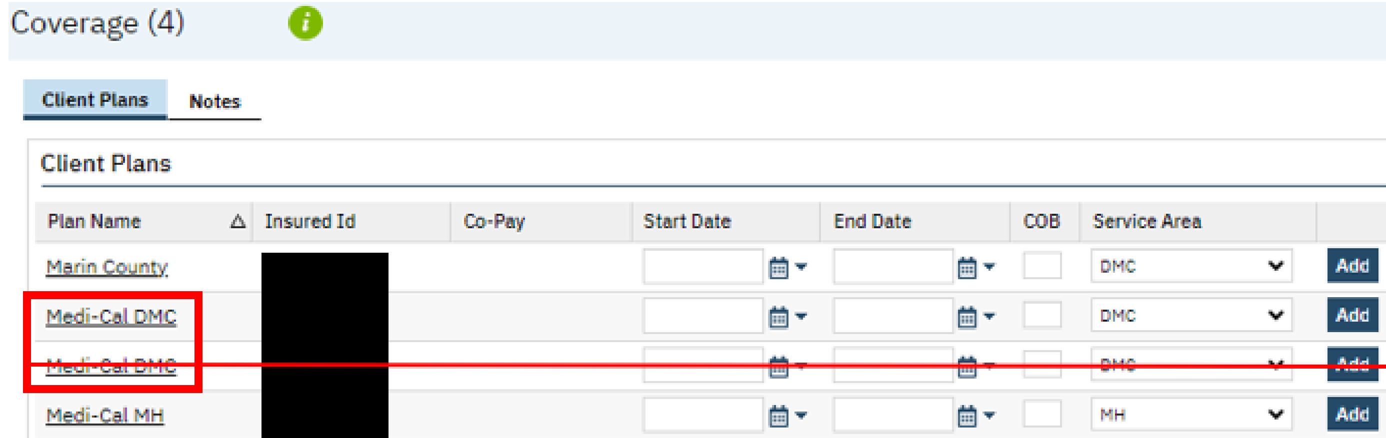
SmartCare Tips & Reminders

- **Payer Plan Entry and Maintenance**
  - All services must have an active payer plan on the date-of-service.
    - Non Medi-Cal services also require an additional payer plan that is appropriate for the service.
  - All payer plans must have an ID number.
    - For Marin County, SB678, AB109, ADC, etc. add the client's account number.
  - All payer plans should have a "Start Date" of the first of the month that services were rendered.

SmartCare Tips & Reminders

- **Payer Plan Entry and Maintenance (cont.)**
  - Enter payer plans only once in the coverage screen
    - If the payer is already present in the "Client Plans" (top) box, use the "start/end dates" and "Service Area" fields to "Add" the payer to the "Plan Time Spans" (bottom) box.



Preventing Fraud, Waste and Abuse

Preventing Fraud, Waste and Abuse

- ***Fraud*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. This is a criminal offense, resulting in imprisonment and/or fines.
  Examples: misrepresenting duration of the session, billing for services that weren't rendered).

- ***Waste*** refers to practices that, directly or indirectly, result in unnecessary costs to the Medi-Cal program, such as overusing services.
  Examples: prescribing excessive services or ordering excessive testing.

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

Preventing Fraud, Waste and Abuse

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

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

Reporting Fraud, Waste and Abuse

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

- DHCS Medi-Cal Fraud:
  - Telephone: (800) 822-6222
  - Email: Fraud@dhcs.ca.gov
  - Mail: Medi-Cal Fraud Compliant – Intake Unit, Audits and Investigations
    PO BOX 997413, MS 2500, Sacramento, CA 95899-7413

- Marin County HHS Compliance Hotline (Anonymous): 415-473-6984 or HHSCompliance@marincounty.gov

- **Overpayments**: Providers shall report to the County Alcohol & Drug Administrator all identified overpayments and reason for the overpayment, including overpayments due to potential fraud, **immediately upon discovery and no later than 5 calendar days** when it has identified payments in excess. All overpayments shall be **returned to the County within 60 calendar days** after the date on which the overpayment was identified, or the date any corresponding cost report is due, if applicable.

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Resources

- Marin BHRS Website: www.MarinBHRS.org
  - Contractor Resources – Policies & Procedures, SmartCare and Reporting Resources, Practice Guidelines, Contracting Documents
  - Member Resources – Provider Directory, Member Handbook, FAQs, Other Informing Materials

- CalMHSA Documentation Re-Design Resources
  - Documentation Trainings: https://www.calmhsa.org/doc-trainings
  - Documentation Guides: https://www.calmhsa.org/documentation-guides/

- DHCS INs: https://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx

- Contingency Management Resources: https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx

- DHCS CalAIM Resources: https://www.dhcs.ca.gov/calaim

Additional Substance Use Prevention and Treatment Block Grant (SUBG) Requirements

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DMC-ODS AND SUBG: Additional Provisions

- **Hatch Act**: All providers must comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
- **No Unlawful Use or Unlawful Use Messages Regarding Drugs**: No aspect of a treatment program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol.
- **Cultural and Linguistic Proficiency**: Each provider receiving funds from DMC-ODS shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.
- **Trafficking Victims Protection Act**: Providers shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702.
- **CalOMS Tx**: All data shall be entered within seven (7) days of the service, for all clients regardless of funding source. Please note that for agencies using SmartCare as their electronic health record for progress notes, effective July 1, 2022, these shall be entered within three (3) business days of the service (or within 24 hours if a crisis service).
- **DATAR**: Enter by the 10th of the month.

Overview of SUBG

- Administered by SAMHSA, the Substance Use Prevention and Treatment Block Grant (aka SAPT Block Grant or, more commonly, SUBG) provides federal funds to prevent and treat substance abuse. DHCS acts as a pass-through agency to provide SUBG funds to local governments to provide SUD services directly or by contracting with local providers.
- The SUBG Program's objective is to help plan, implement, and evaluate activities that prevent and treat SUDs. Grantees use the SUBG program for prevention, treatment, recovery support, and other services to supplement Medicaid.
- The SUBG program targets the following populations and service areas:
  - Pregnant women and women with dependent children
  - Intravenous drug users
  - Tuberculosis services
  - Early intervention services for HIV/AIDS
  - Primary prevention services

Overview of SUBG – Funding Requirements

- Prior to expending SUBG Block Grant funding, every reasonable effort should be made to, including the establishment of systems for eligibility determination, billing, and collection: (1) Collect reimbursement of the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and (2) Secure from patient or clients payments for services in accordance with their ability to pay.
- In accordance with Title 45 Code of Federal Regulations, Part 96, Section 96.137, SAPT Block Grant funding is the "payment of last resort" for services for Pregnant and Parenting Women, Tuberculosis, and HIV.
- SUBG may not be used to pay for a service that is reimbursable by Medi-Cal.

Overview of SUBG – Funding Requirements

- SUBG may not be used on the following activities:
  - Provide inpatient services.
  - Make cash payments to intended recipients of health services.
  - Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment
  - Satisfy any requirement for the expenditure of SUBG as a condition for the receipt of federal funds.
  - Provide financial assistance to any entity other than a public or nonprofit private entity.
  - Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level II of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm.
  - Purchase treatment services in penal or correctional institutions in California.
  - Supplant state funding of programs to prevent and treat substance use/related activities.
  - Carry out any program prohibited by 42 USC 300x–21 and 42 USC 300ee–5

SUBG Provisions

- **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances:** No SUBG funds may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).
- **Marijuana Restriction**: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.
- **Restriction on Distribution of Sterile Needles:** No SUBG funds shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program.
- **Tuberculosis Treatment** - Providers shall:
  - Routinely make available TB services to each individual receiving treatment.
  - Reduce barriers to patients' accepting TB treatment.
  - Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and TA.
- **Byrd Anti-Lobbying Amendment**: No SUBG funds shall be used to pay any person or organization for influencing or attempting to influence an officer/employee of any agency or member of Congress in connection with obtaining any Federal contract, grant, or other award. Any lobbying with non-Federal funds should be disclosed to DHCS.

SUBG Provisions

- When conducting compliance reviews, Marin County will also look for compliance with the following standards, which are incorporated into SUBG-funded contracts (depending on the population served):
  - Culturally and Linguistically Appropriate Services (CLAS) Standards
  - Minimum Quality Drug Treatment Standards (ALL SUBG recipients)
  - Adolescent Best Practices Guide (replaced Youth Treatment Guidelines)
  - Perinatal Practice Guidelines (Perinatal providers only)
- Providers are responsible for familiarizing themselves with these regulations and maintaining policies and procedures consistent with them.
- **Resources**:
  - Policies, Guidelines, Templates: www.MarinBHRS.org
  - DHCS SUBG Policy Manual: https://www.dhcs.ca.gov/Documents/CSD_YV/SABG/SABG-Policy-Manual-V2-3-25-21.pdf

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THANK YOU!