


County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-73
	Next Review Date: April 2024
POLICY:	Date Reviewed/Revised: April 21, 2021
<u>DRUG/MEDI-CAL SERVICE PROVISION</u>	By:  Jel Africa, PsyD Director, Behavioral Health and Recovery Services
SUPERCEDES: MHSUS-ADP-18	

POLICY: DRUG/MEDI-CAL SERVICE PROVISION

I. PURPOSE:

The purpose of this policy is to ensure that Drug/Medi-Cal (DMC) services and activities meet the DMC requirements pertaining to certifications/licenses, County and State notification of changes, access to services, documentation and claiming. Other BHRS policies contain additional information pertaining to other aspects of the DMC-ODS.

II. REFERENCES:

- Drug/Medi-Cal Organized Delivery System (DMC-ODS) State-County Intergovernmental Agreement (IA)
- DMC-ODS Standard Terms and Conditions
- Title 22 and Title 9 CCR
- 42 CFR, Part 438
- Drug Medi-Cal Certification Standards for Substance Abuse Clinics (July 1, 2004)
- Drug Medi-Cal Provider Billing Manual
- Alcohol and Other Drug Program Certification Standards (May 1, 2017)
- DHCS Funding Hierarchy – Payment of First and Last Resort
- BHRS Clinical and Administrative Practice Guidelines
- County Professional Services Agreement

III. POLICY:

The County and contractors providing DMC services must adhere to all related laws, regulations and standards including, but not limited to, those outlined in the DMC-ODS Standard Terms and Conditions, applicable sections of 42 CF 438, Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1, the Drug/Medi-Cal Provider Billing Manual, the Drug/Medi-Cal Certification Standards, the Alcohol and Other Drug Program Certification Standards and Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

IV. AUTHORITY/RESPONSIBILITY:

- Contract Managers
- Alcohol and Drug Administrator
- BHRS Director

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BHRS Quality Management

V. PROCEDURE:

Certifications and Licensure

1. Unless otherwise approved in writing by the County Alcohol and Drug Administrator, all programs that claim DMC funding must possess current DMC certification and/or licensure and contractors shall submit verification of status to Contract Manager prior to executing a contract agreement.
2. Residential programs: All licensed AOD facilities must obtain at least one DHCS Level of Care (LOC) Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification. The facility must submit a DHCS LOC Designation Application (DHCS 4022) and all required supporting documentation to DHCS. Contractors shall submit verification of an approved LOC Designation to Contract Manager prior to executing a contract agreement.
3. Refer to Policy BHRS-ADP-19 Selective Provider Contracting, Policy BHRS-28 Credentialing and Re-Credentialing and Policy BHRS-27 Excluded and Ineligible Providers for additional information on organizational provider and rendering staff requirements.

Status Changes and Notifications

1. Existing DMC Provider Changes: Any proposed reductions in covered services or changes in location shall be communicated in writing to BHRS and DHCS Provider Enrollment 60 days prior to the proposed effective date. Within 35 days of notification of intent to reduce or relocate services, the Provider shall submit a DMC application to Provider Enrollment. No reduction of covered services or relocations can be implemented until approval is issued by DHCS.
2. Providers with Pending DMC Applications: Any additions or changes in information submitted in a DMC application package shall be reported to BHRS. Within 35 days of notification, the Provider shall submit a new DMC Certification application to DHCS Provider Enrollment reflecting the change.
3. Providers Surrendering Certification or Contract Terminated: Any DMC program that surrenders their DMC certification or closes their facility shall notify the County Alcohol & Drug Administrator in writing within two (2) business days and BHRS shall notify DHCS within two (2) business days of notification or discovery. BHRS shall send notification to DHCSMPF@dhcs.ca.gov and ODSSubmissions@dhcs.ca.gov. In addition to the aforementioned notifications, if BHRS terminates the contract with a

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DMC provider, BHRS will also submit notification of the termination and the basis for termination within two (2) business days by secure and encrypted email to SUDCountyReports@dhcs.ca.gov.

4. **Provider Suspension/Revocation/Modification:** Any DMC program whose license, registration, certification or approval to operate a SUD program or provide a covered services is revoked, suspended, modified, or not renewed by entities other than DHCS shall notify the County Alcohol & Drug Administrator within two (2) business days. BHRS shall notify DHCS Provider Enrollment by email at DHCSDMCrcert@dhcs.ca.gov within two business days of learning of the change.

Access to Services:

1. DMC providers must have procedures in place to check beneficiary eligibility on a monthly basis prior to rendering services in order to ensure coverage.
2. BHRS will contract with DMC certified providers in good standing to maintain continuous availability and accessibility of covered services and facilities, service sites and personnel. Services shall not be limited due to budgetary constraints.
3. BHRS and contracted providers shall have a documented system to monitor and evaluate accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.
4. Upon a beneficiary request for services, medically necessary services shall be initiated with reasonable promptness. Requirements for timely access to services are included in contract agreements and are referenced in Policy BHRS-46 Timely Access to Services. If services are denied, the provider shall inform the beneficiary in accordance with Policy BHRS-22 Notice of Adverse Benefit Determination (NOABD) to Medi-Cal Beneficiaries and Policy BHRS-19 Consumer Grievances and Appeal Resolution.

Documentation:

1. The County requires the establishment of a Utilization Review Committee (URC) and requires URC protocols, which must include regularly scheduled reviews of client files, be submitted prior to executing a contract agreement.
2. BHRS Quality Management will review beneficiary files on a monthly basis using a standardized template and as outlined in Policy BHRS-SUS-24 Monitoring.
3. BHRS Contract Management staff will review a sample of DMC-ODS Provider personnel files for compliance with pertinent documentation and training during the annual mid-year Site Visit.
4. DMC program staff are required to participate in DMC-ODS documentation training annually. BHRS will forward to DMC programs information on DHCS-provided training and will offer annual DMC-ODS training, as requested.
5. Client records shall be maintained in accordance with timeframes noted in the Professional Services Contract and per Marin County policy.

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Services and Claims:

1. County-operated and contracted programs that bill for services identified in the State-County DMC-ODS IA shall submit claims in accordance with the DHCS DMC Provider Billing Manual.
2. Claims for DMC reimbursement shall include DMC-ODS services covered under the Special Terms and Conditions of the State-County DMC-ODS IA, and any State Plan services covered under CCR Title 22, Section 51341.1(c-d) and administrative charges that are allowed under WIC, Sections 14132.44 and 14132.47.
3. For OTP/NTP, the Provider shall ensure that a beneficiary that resides in a county that does not participate in DMC-ODS does not experience a disruption of OTP/NTP services. Contracted OTP/NTP provider(s) shall provide any medically necessary NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. The OTP/NTP contractor(s) that provide services to an out-of-county beneficiary shall submit the claims for those services to the county in which the beneficiary resides (according to MEDS).
4. Entities that bill for services shall certify the public expenditure was made prior to submitting the electronic claim. Contracted providers shall submit to BHRS and BHRS shall submit to DHCS the Drug/Medi-Cal Certification Form [DHCS Form 100224A] for each claim file submitted for reimbursement of federal Medicaid funds. The form should reflect either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated, or 2) the claimed amount identified on the 837P claim file, which could account for both approved and denied claims. Claims will not be uploaded to DHCS until a completed and accurate DHCS Form 100224A form has been submitted to BHRS.
5. BHRS will submit all DMC claims electronically in a HIPAA-compliant format (837P). All adjudicated claim information shall be retrieved by BHRS via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).
6. As applicable, prepare and maintain on file for BHRS and DHCS review: Good Cause Certifications (MC 6065A and MC 6065B).
7. Unless otherwise noted on the DHCS Funding Hierarchy-Payment of First and Last Resort, claimed services for Drug/Medi-Cal beneficiaries are reimbursed with Drug/Medi-Cal funding as the payment of first resort.
8. Billed services require complete, accurate and timely documentation compliant with the DMC-ODS STCs, Title 22, Title 9 and Drug/Medi-Cal Certification Standards in order to receive payment.
9. Billing must accompany correct coding, diagnosis and identification numbers.
10. Payments for services that later are deemed ineligible for payment will be recouped from provider by the County at End of Year - Cost Report, during monthly invoice processing or via the procedures outlined in the DHCS Post Service Post Payment (PSPP) review process.
11. Refer to Policy BHRS-51 Voluntary Reporting of Overpayments and Disclosure of Material Deficiencies for guidance and procedures related to reporting and repayment

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of overpayments received from Federal health care programs and other funding sources.

Fraud, Waste and Abuse

1. County-operated and contracted providers shall implement and maintain procedures designed to detect, prevent and report fraud, waste, and abuse of Federal or state health care funding (42 C.F.R §438.608 (a)(7). County-operated and contracted providers must report fraud and abuse information to the County pursuant to 42CFR §455.1(a)(1).
2. The County and contracted providers shall have in place a compliance program designed to detect and prevent fraud, waste and abuse. Applicable minimum program components are noted in the DMC-ODS IA and Professional Services Contract Exhibit I.

Contractor compliance with this policy shall be achieved through the following:

1. Distribution of the Contractor Manual and Practice Guidelines annually at contract renewal which includes links to the DHCS resource materials including, but not limited to, DMC-ODS Standard Terms and Conditions, Title 22 Section 51341.1, Drug Medi-Cal Certification Standards and the Drug Medi-Cal Provider Billing Manual.
2. The approval of contract as to form and legal affect by county counsel.
3. Signature of Contractor on contract agreeing to all conditions set forth in the contract will constitute a binding agreement with County and Contractor.
4. The annual completion of the Provider Self Audit (including Drug Medi-Cal Regulation Compliance) by Contractor, and subsequent review by BHRS Contract Manager, including Contractor’s signed attestation of adherence to all laws and regulations to ensure compliance.
5. At annual Site Visit, Contract Manager shall review Contractor policies and procedures regarding Drug/Medi-Cal service provision and claiming and ensure that they adhere to regulation. Contract Manager will also review logs to ensure timely access to services and will review training logs and/or personnel files to ensure that Drug/Medi-Cal staff attend a DMC-ODS training annually.
6. BHRS Quality Management will review client files monthly to verify service provision and documentation adheres to regulation, policies and procedures.
7. HHS Fiscal staff will perform annual fiscal monitoring to assure covered services are being appropriately rendered.
8. BHRS will submit to DHCS copies of programmatic and fiscal monitoring reports within two weeks of completion by sending via encrypted and secure email to SUDCountyReports@dhcs.ca.gov.
9. BHRS staff will perform a monthly DMC provider check to ensure continued active participation in the DMC program and to monitor for a triggering recertification event (e.g. change in ownership, change in scope of services, remodeling, change in location). BHRS staff will document the monthly status check and will notify pertinent

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departments within DHCS within two (2) business days of any relevant notification or discovery.

10. Contractor will be required to complete and submit a Corrective Action Plan (CAP) to the requesting entity for any areas identified as non-compliant by DHCS or BHRS. The CAP shall address the specific actions to correct the deficiency or non-compliance, identify who will be responsible for the action, and provide a timeline for completing the action. The Contract Manager will monitor adherence to the CAP.

County-operated program compliance with this policy shall be achieved through the following

1. Approval of State-County DMC-ODS IA by Board of Supervisors or authorized designee agreeing to all conditions set forth in the contract.
2. Attestation to compliance with DMC requirements at the annual DHCS Monitoring review.
3. Annual completion of Self Audit, including County Alcohol & Drug Administrator's signed attestation of adherence to all laws and regulations.
4. At annual Site Visit, BHRS Quality Management shall review policies and procedures regarding DMC. Quality Management will also review logs to ensure timely access to services and will review training logs and/or personnel files to ensure that DMC staff attend a DMC-ODS training annually.
5. BHRS Quality Management will review client files monthly to verify service provision and documentation adheres to regulation, policies and procedures.
6. HHS Fiscal staff will perform cost reporting to assure covered services are being appropriately rendered.