Drug Medi-Cal Organized Delivery System
Partnership HealthPlan of California
Regional Implementation Plan

Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano Counties- effective July 1, 2020

Lake County effective TBD

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Department of Health Care Services
Drug Medi-Cal Organized Delivery System
Implementation Plan for Regional Model encompassing Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano Counties, with the addition of Lake County.

This document will be used by the Department of Health Care Services (DHCS) to help assess the readiness of Lake County to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) and to determine the county's capacity, access, and network adequacy. The tool draws upon the Implementation Plan (IP) requirements identified in BHIN 21-075. Upon completion of the IP, and Readiness Review processes, DHCS will render an approval or denial of the inclusion of Lake County in the DMC-ODS Regional Model.

Table of Contents

Introduction to the Regional Model

The participants in the development of the Regional Model, which included Lake County, have shared philosophies and goals for the Regional Model that underlie the components of the model and the benefits that it will provide to the counties' Medi-Cal populations. These philosophies include:

- *Integration of Physical, Mental Health, and Substance Use Services is essential to quality care and positive health outcomes.* Early in 2015, the 10 initially interested counties, which included Lake, determined that their individual efforts to provide Drug Medi-Cal (DMC) services would be most effective if integrated with the current physical and mental health systems. This philosophy is reflected in the efforts to develop a model that focuses on limiting the practical and regulatory constraints that separate the various systems and involves, as much as possible, all parts of the Medi-Cal health care delivery system including clinics and hospitals, as well as the mandated components of the DMC-ODS model. While Del Norte, Lake, and Trinity opted out initially from the model, their philosophies and input were instrumental in the understanding and planning for the needs of beneficiaries within our region.
- *Continuum of Care:* The most effective health care system is one that is comprehensive and facilitates the transition of people in care among levels of care based upon their needs. Lake County has strong partners in and around the county. Whether a person is identified in the emergency room or a PCP's office, there are existing relationships and connections to treatment that will be leveraged to increase opportunities through the DMC-ODS services expanded continuum.
- *Regional Collaboration:* The Regional Model came about because of the culture of cooperation and collaboration that exists among the counties and with Partnership HealthPlan of California. The encouragement and strengthening of this collaboration are key to the success of the Regional Model expansion into Lake County.
- *Person in Care Engagement:* The necessity of engaging individuals in their treatment is a key philosophy for the Regional Model, from the initial appointment throughout the treatment episode. Individuals receive services individualized to their needs, with specific treatment plans based on medical necessity and the person's ability to accept change. This same philosophy will be applied in Lake County.
- *Learning Continuum:* Staff in all health care and community support organizations will need to learn to work effectively in multidisciplinary teams, form productive relationships with persons in care, and reflect critically upon and change their own organizational practices based on new knowledge. The Regional Model provides continual trainings and support to our providers and communities, through provider forums, trainings, and advisory groups.

Areas for Future Development

In some parts of this plan there are references to elements that have not yet been fully developed;

- Youth System: Regional Model county representatives and PHC have ongoing work to further develop the elements of the Youth System of Care, including gaining access where access currently does not exist. The Regional Model has

contracted with residential, intensive outpatient, and outpatient services for youth. A robust plan to continue to promote the expansion of access has been developed and includes engagement through available grants, engagement with Federally Qualified Health Centers (FQHCs), and expansion of Medication Assisted Treatment (MAT) services to include youth. The services will be available for youth in Lake County upon their inclusion within the Regional Model.

- Recovery residences/sober living environments: Although the Regional Model does not include recovery residences, we recognize that these may be key to many individuals' recovery. They have a special significance in a regional model where outpatient services are available in each community but residential services are regional. Once sufficient DMC-ODS utilization data has been collected, a recommendation may be made to stakeholders to consider expanding the service continuum to include recovery residences/sober living environments. However, PHC will work with Lake County and its partners to identify recovery residences and provide referrals.

It is important to reiterate that while Lake County opted to not participate in the launch of the model in July 2020, they were heavily involved in the planning sessions and stakeholder meetings. Ultimately it was decided that between uncertainties in fiscal alignment, the timing of implementation, and recent transitions within the Lake County Behavioral Health's leadership, that participation would be considered at a later time.

PART I PLAN QUESTIONS

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply.) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.
    - X County Behavioral Health Agency
    - X County Substance Use Disorder Agency
    - X Providers of drug/alcohol treatment services in the community
    - X Representatives of drug/alcohol treatment associations in the community
    - X Physical Health Care Providers
    - X Medi-Cal Managed Care Plans
    - X Federally Qualified Health Centers (FQHCs)
    - X Clients/Client Advocate Groups
    - X County Executive Office
    - X County Public Health
    - X County Social Services
    - X Foster Care Agencies
    - X Law Enforcement
    - X Court
    - X Probation Department
    - X Education
    - X Recovery support service providers (including recovery residences)

X Health Information technology stakeholders
X Other (specify)

In summary, the following entities participated:
IDEA Consulting, County Board of Supervisors, Lake County Probation Dept., Lake County Child Welfare Services, community based treatment providers, Adventist Health Hospital, Mendocino Community Health Clinic FQHC, American Indian/Alaskan Native (AIAN) community representatives from local Federally recognized Tribes, Sutter Hospital, County Public Health, County Social Services, Lake County Office of Education, Kingsview Information Technology, Kingsview Fiscal Consultant, Partnership HealthPlan, Non-profit treatment providers including Sober Living Residences, Withdraw Management, Intensive Outpatient, Outpatient, Perinatal Residential, Opioid Treatment Providers, Narcotic Treatment Providers, Tribal Narcotic Treatment Providers, Medicated Assisted Treatment Providers, Community Based Self-Help Entities like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), Faith Based Recovery Supports Celebrate Recovery, Lake County Mental Health Behavioral Health Board, Consumers of Peer Support Services, Behavioral Health (BH) Staff.

2. How was community input collected?
   X Community meetings
   □ County advisory groups
   □ Focus groups
   X Other method(s) (explain briefly)

   Outside County DMC-ODS and Regional ODS Providers-
   - El Dorado County-02/08/2021
   - Solano County- 02/10/2021
   - Siskiyou County -03/22/2021
   - Nevada on 03/17/2021
   - Mendocino County- 04/25/2022

   All departments, County, and Contracted Providers
   - 02/23/2022- Stakeholder Presentation & Meeting
   - 03/7/2022- Stakeholder Presentation & Meeting
   - 03/22/2022- Stakeholder Presentation & Meeting

   BH Board Presentation-
   - 02/24/2022

   LCBHS Department Meetings-
   - Beginning Tuesday 01/19/2021 and ending 04/26/2022, Lake County Behavioral Health Services (LCBHS) held bi-weekly internal department meetings between management, fiscal, and managed care.
   - Currently, LCBHS is meeting bi-weekly to review policies, compliance, contract, clinical, fiscal, and managed care elements. In addition, CalAIM and ODS meetings will increase to support opting into ODS.

Meetings with Managed Care Plan-

- Starting in January 2021, meetings with Partnership HealthPlan began quarterly, meetings have increased in frequency, and currently occur bi-weekly.

Board of Supervisors Presentation-

- 04/26/2022

Separate Meetings with SUD providers include-

- Redwood Community Services 03/31/2022
- Hilltop Recovery Services 03/30/2022

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.
   - X Monthly (at least)
   - □ Bi-monthly
   - □ Quarterly
   - □ Other:

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the implementation been the catalyst for these new meetings?
   - □ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to implementation discussions.
   - X There were previously some meetings, but they have increased in frequency or intensity as a result of implementation.
   - □ There were no regular meetings previously. Implementation planning has been the catalyst for new planning meetings.
   - □ There were no regular meetings previously, but they will occur during implementation.
   - □ There were no regular meetings previously, and none are anticipated.

   Meetings between the SUD, MH, and MHP teams were held on the following dates: 6/1/2022, 6/6/2022, 6/29/2022, 7/5/2022, and 7/27/2022.

5. What services will be available to DMC-ODS clients upon year one implementation under this county plan?

   REQUIRED
   - X Withdrawal Management (minimum one level)
   - X Residential Services (minimum one level upon implementation; 3.5 within two years of implementation; 3.1, 3.3, and 3.5 within three years)
   - X Intensive Outpatient
   - X Outpatient
   - X Opioid (Narcotic) Treatment Programs

X Recovery Services
X Care Coordination
X Clinician Consultation

How will these required services be provided?

□ All County operated
X Some County and some contracted
□ All contracted.

OPTIONAL

□ MAT at Alternative Sites (drug product costs)
□ Partial Hospitalization
X Peer Support Specialist
□ ASAM Level 3.7
□ ASAM Level 4.0
□ Recovery Residences (not a Medi-Cal benefit)
□ Other (specify)

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?
   X Yes (required) (855) 765-9703 (multi-lingual, interpreting services available) TTY (800) 735-2929 or 711
   □ No. Plan to establish by:

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.
   X Yes (required)
   □ No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.
   X Yes (required)
   □ No

9. Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:
   - Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment
   - Existence of a 24/7 telephone access line with prevalent non-English language(s)
   - Access to DMC-ODS services with translation services in the prevalent non-English language(s)

- Number, percentage of denied and time period of authorization requests approved or denied

X Yes (required)
□ No

PART II PLAN DESCRIPTION (Narrative)

1. **Collaborative Process.** Describe the collaborative process used to plan DMC- ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

The Regional Model entities have a long history of collaboration with each other and with other providers to develop solutions for systemic problems, this includes Lake County. Most of the Regional Model entities and their various treatment partners collaborated over time to create a system of care that brought together a disparate and fragmented treatment arrangement. Perhaps one of the best examples of this collaboration is the development of the Regional Model itself. In 2015, extensive outreach, consultation, and cooperation among counties with an initial interest in joining a regional model, built the foundation for a collaborative treatment approach. These counties included Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, Lake, and Trinity County. This foundation was built with input from treatment providers, community groups, and Partnership HealthPlan. Although Lake and Trinity did not initially join the Regional Model DMC-ODS, Lake participated in this extensive outreach, consultation, and cooperation from the beginning.

The current counties in the Regional Model share a variety of characteristics and needs including high rates of poverty and substance use; poor health outcomes; rural geography; and challenges in access to care. The county governments are all part of the County Medical Services Program (CMSP) and the Consortium-IV eligibility systems network.

Over a two-year implementation period of the initial model, county and PHC staff, including Lake County, and Trinity County, met at least monthly to develop the parameters of the Regional Model. Within each county, representatives from prevention, residential, outpatient, and detoxification providers, departmental staff, the courts, and probation meet regularly in a variety of settings, on matters that facilitate the development of an integrated continuum of substance use care for adults. The Regional Model participants sought to create a comprehensive continuum of care based upon established benchmarks for the length of stay and intensity of services. Persons move within the continuum of services, from more or less intensive services based on recovery needs. American Society of Addiction Medicine (ASAM) criteria are used to make placement and treatment decisions, based on an individual's functioning within

the six ASAM dimensions. In addition, the system includes other key components, such as a telephone-based screening and placement function, with a toll-free number and a robust utilization management and care coordination process.

Once the vision was vetted and finalized by the leadership of PHC and the participating counties, a workgroup made up of Lake County and PHC staff worked to establish the details of the multiple-county individual flow and program structure. During this process, each county worked to inform their interested community and treatment partners, with concerns and suggestions being incorporated as the Model was developed. Outreach to representatives of community providers, key stakeholder groups, criminal justice, health care, mental health, and other agencies was conducted, in order to help structure the overall Regional Model concept. All of these stakeholders and interests were involved in the implementation and improvement of the treatment and recovery services system which ultimately led to Lake County's inability to proceed with implementation in 2020.

Stakeholder engagement led to the decision for the Regional Model to include key components such as a centralized telephone-based portal (call center) to provide initial screenings and assist in ensuring access to the appropriate level of care; a full continuum of care that facilitates the movement of persons to the most appropriate level of care; a comprehensive quality improvement process that focuses on outcomes and the effectiveness of treatment; a knowledge-driven system that relies on evidence-based practices and models; and a focus on persons in care satisfaction. These components of the proposed Regional Model, and their underlying philosophies, are reflected throughout this document, which will be expanded to serve Lake County persons in care.

The list of individuals and groups that provided input, beginning in November 2021, regarding Lake County joining the Regional Model consisted of the following: IDEA Consulting, County Board of Supervisors, Lake County Probation Dept., Lake County Child Welfare Services, community-based treatment providers, Adventist Health Hospital, Mendocino Community Health Clinic FQHC, AIAN community representatives from local Federally recognized Tribes, Sutter Hospital, County Public Health, County Social Services, Lake County Office of Education, Kingsview Information Technology, Kingsview Fiscal Consultant, Partnership HealthPlan, Non-profit treatment providers including Sober Living Residences, Withdraw Management, Intensive Outpatient, Outpatient, Perinatal Residential, Opioid Treatment Providers, Narcotic Treatment Providers, Tribal Narcotic Treatment Providers, Medicated Assisted Treatment Providers, Community Based Self-Help Entities like AA and NA, Faith Based Recovery Supports Celebrate Recovery, Lake County Mental Health Behavioral Health Board, Consumers of Peer Support Services, County BH Staff.

During the implementation process to include Lake County in the Regional Model, there was a wide variety of opportunities for involvement by the various stakeholder and community representatives. These included ongoing and regularly scheduled meetings between Regional Model staff and SUD providers; discussion at Mental Health and

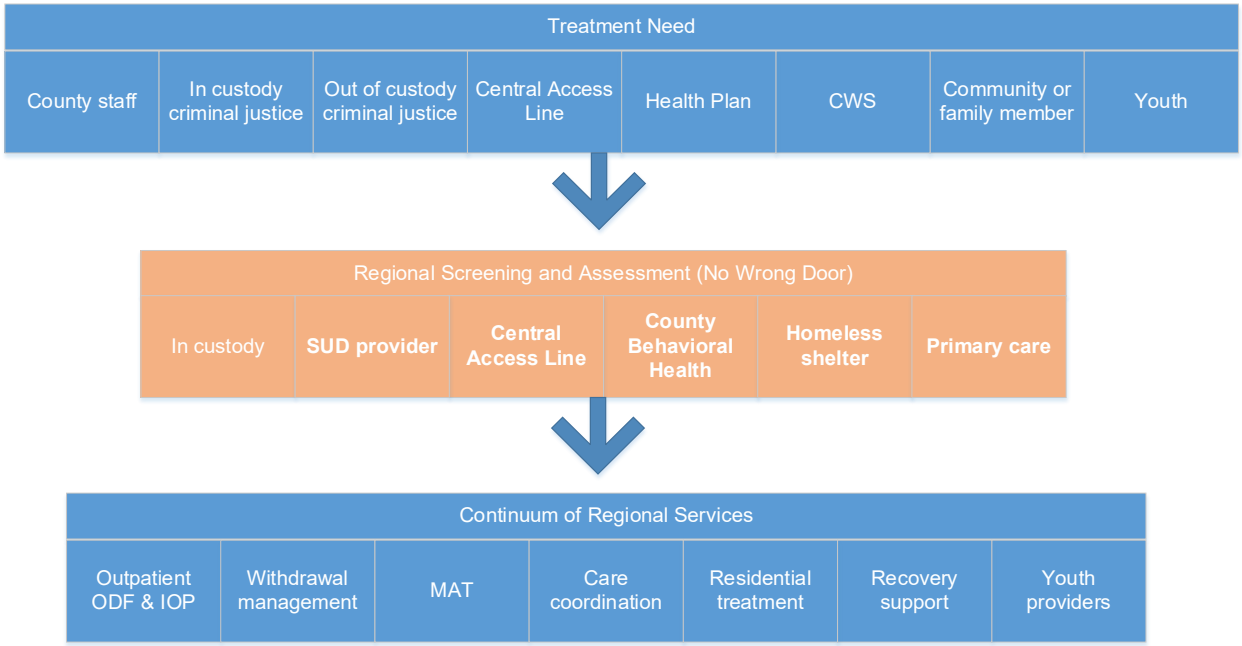
Substance Abuse advisory board meetings; updates and presentations at a variety of elected and appointed bodies with public input and participation; ongoing collaborative meetings among the counties and PHC; continued outreach to specific stakeholders including education, criminal justice, and physical health and mental health providers. These encounters were utilized to bring Lake County into the model. Specific encounters are listed above in Part 1, Question 2.

As previously noted, while Lake County opted not to participate in the launch of the Regional Model in 2020, there was an opportunity to leverage the county's previous engagement based on its involvement during the initial planning sessions. Stakeholder input was supplied through the planning of the transition to DMC-ODS in Lake County by ensuring providers and county partners collaborated in discussions, while also engaging with DHCS to determine the best fiscal alignment for the county. Specific stakeholder engagement activities and meeting dates are referenced above in Part 1, Question 2.

2. **Client Flow.** Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also, describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.

The Regional Model provides different points of entry and levels of care, which have been organized as a continuum. Any given episode of treatment may involve multiple levels of care with several transfers from one modality to another or within a single modality. Thus, an individual's pathway through the system may depend on their starting point, the initial level of care placement, and clinical needs during a treatment episode. The person in care remains within the system of care, irrespective of the level, modality, or service received during the entire episode of care.

A brief overview of the continuum of care is shown below.



There are three main avenues into the system: the single Central Access Line, various regional outpatient sites, and at the sites that provide detoxification. Persons in care may also be identified and briefly screened at primary care sites. Following an initial screening conducted at any of these sites person in care are placed in an ASAM-informed appropriate level of care. Individuals start in the least intensive level of care likely to meet their treatment needs. Individuals exiting residential treatment are transitioned to intensive outpatient, outpatient, and recovery services with assistance and follow-up from PHC Care Coordination. The ASAM criteria interviews are conducted by Licensed Practitioners of the Healing Arts (LPHAs) or by certified/registered alcohol and drug counselors with review and approval by an LPHA. Staff performing the ASAM criteria interviews must at a minimum have completed ASAM training Modules 1 (Multidimensional Assessment) and 2 (From Assessment to Service Planning) and provide evidence of successful completion prior to claiming for reimbursement for assessment services.

Central Access Line staff use an ASAM level of care placement tool as the initial screening tool. Face-to-face assessments at the provider sites involve a bio-psychosocial assessment to determine if the person meets medical necessity criteria based on the current Diagnostic Statistical Manual (DSM), the ASAM criteria is applied to make the appropriate level of care recommendation(s).

Providers are encouraged to provide same-day appointments wherever possible and to document all referrals and the outcomes of referrals to other levels of care or to other providers. In general, providers are required to start treatment for eligible individuals within ten business days, and three days for withdrawal management and Narcotic Treatment Program/ Opioid Treatment Program (NTP/OTP), per timely access guidelines. In the unlikely event that admission to treatment takes longer than ten

business days due to capacity issues, providers are required to link the beneficiary with another provider offering the appropriate ASAM level of care in an expeditious manner.

Note that if the entity screening or assessing the beneficiary determines that the medical necessity criteria has not been met and that the beneficiary is not entitled to services under the Regional Model, a written Notice of Action will be issued in accordance with 42 CFR 438.404.

Frequency of Assessments:
Beneficiaries can be re-assessed as often as clinically necessary with the understanding that an ASAM assessment is generally valid for 180 days. A new assessment will not be required unless the beneficiary's condition changes. Beneficiaries who return to the system following a break in treatment (discharge) will require a reassessment before they can be placed in care.

Treatment plans and/or problem lists should be reevaluated every 30 to 90 days unless there are significant changes warranting more frequent reassessments. Changes that could warrant a reassessment and possibly a transfer to a higher or lower level of care include, but are not limited to, the following:

- Achieving treatment plan goals;
- Inability to achieve treatment plan goals despite amendments to the treatment plan;
- Identification of intensified or new problems that cannot adequately be addressed in the current level of care;
- Lack of beneficiary capacity to resolve problems;
- At the request of the beneficiary.

Timelines for Movements Between Levels of Care:
The treatment system provides individualized treatment, tailored to an individual's needs based on ASAM criteria and Stages of Change. There are no fixed lengths of stay for any program, although there are guidelines for the length of stay for most modalities:

Service	Adult Review	Youth Review
Withdrawal	3-5 days	3-5 days
Intensive Outpatient	30-60 days	42 days
Outpatient	60-90 days	90 days
Residential	25-35 days with authorization	30 days
Recovery Support	12 months	12 months
Housing	90 days	90 days

The ranges for the length of stay serve as guidelines, or for when the stay should be reviewed for the need for an extension. Different standards are used for youth. In the adult system, the duration of stay for detoxification services varies between three (3) and five (5) days; residential treatment approximately 25-35 days; outpatient services between 60-90 days, and intensive outpatient 30-60 days. Note that these timeframes

may be longer for some individuals, especially those with co-occurring conditions. In the youth system, residential treatments average about 30 days, intensive outpatient about 40-60 days, and regular outpatient around 60-90 days.

Authorizations for residential treatment are initiated at the residential treatment site. A Treatment Authorization Request (TAR) and additional supporting documentation are to be submitted within 24 hours of admission. Requests for continuing authorization are to be submitted at least seven (7) calendar days before the expiration of the initial authorization.

Partnership Health Plan's utilization management department reviews the TAR and responds to the requesting agency within 24 hours with an Approved, Pending, or Denied determination. If the TAR is denied, a written Notice of Action will be sent to the beneficiary notifying them of the authorization decision and they will be referred to the appropriate level of care.

Over and underutilization are monitored through reporting, and are intended to identify the following intervention needs:

- Three or more episodes of residential treatment within a 365-day span
- Episodes of withdrawal management without a transition to a lower level of care
- High cost of care

Cases identified as meeting an intervention need are referred to PHC's Care Coordination department. Cases are then assigned to case managers consisting of licensed therapists, social workers, and registered nurses. Potential interventions include outreach to providers or persons in care, requesting medical records, on-site provider visits, case conferences, and consultation with PHC BH Clinical Director.

Cases of high utilization or at risk of unsuccessful transitions are followed through all admissions and discharges, with the inclusion of PHC case managers either participating or consulting in treatment or discharge planning. If a person in care is unable to transition, PHC Care Coordination staff will outreach to the individual to identify the cause. If the case warrants escalation, PHC will schedule case conference(s) and/ or consult with the PHC Behavioral Health Clinical Director.

When overutilization has occurred and results in waste, a Fraud Waste and Abuse report is completed by the identifying entity initiating a further investigation. PHC's Regulatory and Compliance Department will notify DHCS within 10 days of the identification of waste and will investigate through interviews, record retrieval, and data review all reports of waste and abuse. Results of the investigation may result in fines, suspension, and disenrollment in the Regional Plan.

3. **Beneficiary Notification and Access Line.** For the beneficiary toll-free access number, what data will be collected (e.g., measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The

access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Central Access Line:
As described above, a person's in-care first contact with Regional Model services may occur with a phone call to the Central Access Line or an individual provider site, which then conducts a brief screening (defined below) and refers the individual to an initial level of care (detoxification, outpatient, residential and/or MAT). A comprehensive ASAM assessment is subsequently conducted at the treatment site. All provider sites are assessment sites. Residential care placements require prior approval by PHC's utilization management department. This basic referral process is mirrored in the Youth and MAT systems of care with some variations, which are required by the specific needs of the targeted populations. Note that, as with the Regional Model as a whole, the capacity to serve youth strengthens as the Model continues to address access needs. The central access line is available in non-English languages via bilingual staff for threshold languages. Additionally, the language line is available for non-threshold languages, free of charge. Furthermore, the TTY option is available for ADA compliance.

Referrals and Entry into the System; "No Wrong Door" Philosophy:
Referrals for services will be made in three different ways;

1. Appointments will continue to be offered at service programs;
2. Calls to the central Access line will result in referrals; and
3. Referrals to resources provided by various partner agencies, such as through staff at probation and child welfare agencies.

Outpatient Sites:
Persons in care can enter the system through provider service sites that will allow for drop-ins or appointments for assessments; no referral is required. The opportunity to schedule an admission into treatment will help the system welcome and engage with the person seeking services.

Entry Through the Central Access Line:
A brief substance uses and risk screening is administered and an initial level of care placement is made through referrals directly to treatment agencies. The date of the Central Access Line call, the date of referral to care, and the actual date of the first service ("intake show rate") are all recorded and used for performance objectives measurement. Treatment providers are required to attempt to reach out to patients that fail to attend treatments to assess the motivational status and potentially offer another appointment. Additionally, reports are provided to PHC when individuals are not connected to a provider, and PHC Care Coordination staff to continue access efforts conduct follow-up.

Entry Through Partner Agencies:
Individuals seeking services may be referred directly to a provider site for treatment. Direct provider referrals support structured access into the system with improved links between treatment providers, partnering agencies, and persons in care.

Entry Through Care Coordination:
Persons with special needs or in special circumstances, individuals being served in programs such as Enhanced Case Management (ECM) within counties will be identified and reviewed by staff and connected with a geographically accessible provider to assess the appropriate level of care. The Central Access Line or PHC Care Coordination may also be assessed to refer persons with special needs for screening prior to placement.

Same-day Referrals: A counselor or program staff person can register, assess and meet with the person in care for an intake session and begin the treatment process the same day or within 24 hours of their initial call to the Central Access Line.

As noted above, individuals can access services through the Central Access Line or at individual provider sites during business hours. The "no wrong door" philosophy is designed to encourage access, and facilitate person-in-care engagement and involvement. In addition to the access methods described above, each county provides beneficiary access information through their information and referral resources. The Regional Model has a 24-hour toll-free number that will connect to the Central Access Line for immediate screenings and placement in treatment. The Central Access Line phone number is located on PHC's website, county websites, member-facing materials, and beneficiary ID cards.

All-Access Sites:
The Central Access line, individual provider sites, and partner agencies are required to collect and report data on the efficacy of access to services, including the number of individuals initiating contact for services and the times from contact to the first appointment.

At All Intake Sites:
Places where a full assessment is conducted, including individual provider sites – persons are screened and referred to the appropriate level of treatment through "warm handoffs" or the direct involvement of case managers. All individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification, and are advised of the benefits to which they are entitled under the DMC-ODS. Sites use a uniform screening tool and a decision tree based on the ASAM 6-dimensions. Screenings are conducted by an LPHA or by certified/registered alcohol and drug counselors with the review and approval of an LPHA. All screening staff are required to have successfully completed ASAM modules 1 and 2.

All calls to the Central Access Line will be logged and the following data collected:

- Number of calls, including the date, and time.
- Caller's name.
- Call type (i.e., seeking a referral, etc.) and whether emergency, urgent or routine.
- Disposition including ASAM level of care for referrals.

Other data collected includes:

- Total calls received.
- Total calls answered.
- Abandonment rate.
- Average answered hold time (in seconds).
- Average abandoned hold time (in seconds).

4. **Treatment Services.** Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, care coordination, clinician consultation) and optional (MAT at alternative sites, peer support specialist services) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county. Describe how the county plans to cover or ensure referrals and coordination to ASAM Levels 3.7 and 4.0.

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the implementation date. This list will be used for billing purposes for the Short Doyle 2 system.

Early Intervention (ASAM Level 0.5): Primary care, hospital emergency rooms, providers in community settings and other professionals perform Screening, Brief Intervention, and Referral to Treatment (SBIRT) activities for alcohol and substance use among adults, as currently required by DHCS. Persons at risk of developing alcohol or substance use disorders or those with an existing alcohol or substance use disorder are identified and offered: screening for adults, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage to services. Primary Care Providers (PCPs) screen for other substance use conditions using the Staying Healthy Assessment or Alcohol Use Disorders Identification Test (AUDIT-C), and offer referrals as appropriate. These services are available in Lake County and within each county participating in the Regional Model.

Outpatient Services (ASAM Level 1.0):

Outpatient services consist of up to nine (9) hours per week of medically necessary services for adults and less than six (6) hours per week of services for adolescents. Providers offer ASAM Level 1 services including: assessment, impairment/problem identification and intervention planning; individual and group counseling; family therapy;

patient education; medication services; collateral services; crisis intervention services; discharge planning; and care coordination. Services may be provided in person, by telephone, or by telehealth in any appropriate setting in the community.

The Regional Model has at least one DMC certified outpatient program in each county. Lake County will offer outpatient treatment under its county-operated services and may include contracted providers. Where possible and as indicated by need, the Regional Model continues to implement an array of approaches, including those focused on adolescents and adults with co-occurring conditions, are needing gender-specific services, and/or Spanish-language translations and support.

Intensive Outpatient Services (ASAM Level 2.1):

Intensive outpatient services (IOPs) consist of a minimum of nine (9) hours and a maximum of nineteen (19) hours per week for adult perinatal and non-perinatal persons. Adolescents are provided a minimum of six (6) and a maximum of nineteen (19) hours per week of services. ASAM Level 2.1 services include assessment; impairment/problem identification and intervention planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and care coordination. Services may be provided in person, by telephone, or by telehealth in any appropriate setting in the community.

The Regional Model has at least one certified DMC intensive outpatient program in each county. Lake County will offer IOP under its county-operated services and may include contracted providers. Where possible and as indicated by need, the Regional Model continues to implement an array of approaches, including those focused on adolescents and adults with co-occurring conditions, are needing gender-specific services, and/or Spanish-language translations and support.

Lake County beneficiaries will have access to the following ASAM levels of care within the County: 0.5 Early Intervention Services, 1.0 Outpatient Services, 2.1 Intensive Outpatient Services, and 3.1 Clinically Managed Low-Intensity Residential Services.

Withdrawal Management Services (ASAM Levels WM-1, WM-2, and WM-3.2):

Withdrawal Management/Detoxification services are provided as medically necessary to persons in care and Include assessment, observation, medication services, discharge planning, and coordination. Persons receiving residential withdrawal management (WM 3.2) shall reside at the facility for monitoring during the detoxification process.

The Regional Model offers withdrawal management at five sites throughout Northern California: Fairfield, Ukiah, Redding, Eureka, and Vallejo.

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, licensed prescriber; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all-day withdrawal management and support and supervision; at night has a supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; licensed prescriber; or OTP.
Residential withdrawal management	3.2-WM	Moderate withdrawal: Clinically managed Residential WD management: 24-hour support	DHCS Certified Residential Facility with Detox Certification

Residential Treatment Services (ASAM Levels 3.1, 3.3, and 3.5):

Residential treatment is a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adults, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level 3.5: Clinically-Managed High-Intensity Residential.

Beneficiaries approved for residential treatment receive approval through a prior authorization process based on the results of the ASAM assessment. The length of stay for residential services is based on medical necessity, with a targeted average length of stay of 30. Perinatal beneficiaries may receive longer lengths of stay based on medical necessity and up to 60 days postpartum.

Residential treatment services include assessment, impairment/problem identification, and intervention planning, individual and group counseling, education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and care coordination. All providers are required to accept and support persons in care who are concurrently receiving medication-assisted treatments.

Implementation of the Regional Model has had a significant impact on existing residential services. In the Regional Model, residential services focus on stabilization and transitioning persons to lower levels of care for further treatment and recovery. Prior to joining DMC-ODS, Regional Model counties experienced lengths of stay in residential services in months not weeks. Residential providers under the Regional

Model now offer a full continuum of stabilization and rehabilitation services. Residential services provide “stabilization and discharge,” as well as referrals to outpatient settings for continued rehabilitation and recovery services in the community. Residential length of stays within the Regional Model are averaging 38 days (including cases where extensive medical necessity requirements have been met). This approach to residential services is based on research that indicates long residential stays without connection to community recovery services do not improve long-term abstinent outcomes.

The Regional Model has sixteen residential providers, across seven (7) counties (two outside of the Regional Model). Currently, one adolescent facility is contracted for residential services, in Los Angeles County, with additional contracting opportunities expected in year three of the Model (FY 2022/2023). The Regional Model has also explored out-of-county facilities, including those in neighboring areas of Oregon and Nevada and in Bay Area (Phase I) counties, especially when there is a need to address a special need (i.e., Friendship House for Native American clients).

The Regional Model was able to execute a contract in 2022 with two facilities in Solano and Contra Costa County to allow access to ASAM level 3.3 residential services for those with cognitive impairments. This out-of-county provider will be accessible to Lake County beneficiaries; however, there are no plans to offer these services inside of Lake County. The Regional Model Plans to contract with Merritt Peralta Institute (MPI) an ASAM 3.7 medically monitored intensive inpatient service provider and ASAM 4.0 medically managed intensive inpatient services provider in the fiscal year 2022/2023 pending approval of DMC certification. Lake County beneficiaries will have access to these ASAM levels of care outside of Lake County should MPI be granted ASAM 3.7 and 4.0 certification.

Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1):

The Regional Model includes contracts with licensed narcotic treatment programs to offer services to beneficiaries who meet medical necessity criteria requirements. Services are available to all beneficiaries in Lake County and other Regional Model Counties. Services are provided in accordance with an individualized plan determined by a licensed prescriber. Prescribed medications offered include methadone, buprenorphine, naloxone, disulfiram, and other medications.
Services provided as part of an NTP include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services. Persons in care receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor. When medically necessary, additional services may be provided.

Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Levels 1, 2, 3):

The Regional Model offers medically necessary MAT services through contracted providers. Services include assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.

The Regional Model extends MAT services to beneficiaries with chronic alcohol-related disorders as well as opiate addiction. Medication-assisted therapies include: oral and injectable forms of naltrexone, topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse); uses are noted below.

- Opiate overdose prevention: naloxone (Narcan), is provided currently on the state AOD formulary.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone medications including ReVia (oral) and Vivitrol (injectable), provided currently on the state AOD formulary. Note that methadone is available through the licensed narcotic treatment program.
- Alcohol use disorder: Naltrexone, acamprosate, disulfiram
- Other, off-label MAT agents with limited evidence of effectiveness (such as topiramate and gabapentin) are available at the discretion of any licensed prescriber.

Additionally, on behalf of the Regional Model, Partnership HealthPlan offers coordinating care and the availability of non-methadone MAT through the capacity of the entire health system by x-waivered providers available to apply these treatments for beneficiaries with a substance use disorder. PHC offers training to physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, education on practice guidelines, and information on medication administration. Physicians provide support in the following areas: medication selection, dosing, side effect management, adherence, and drug-to-drug interactions.

Case managers are provided by PHC's Care Coordination Department to coordinate care with treatment and ancillary service providers and to facilitate transitions between levels of care. Beneficiaries may simultaneously participate in medication-assisted treatment and other ASAM levels of care.

The Regional Model has MAT services available in each of the seven (7) counties, and three (3) providers have been identified to provide MAT services within Lake County.

Recovery Services (ASAM Dimension 6, Recovery Environment):

Recovery services are available once a beneficiary has completed the primary course of treatment and during the transition process. Persons in care accessing recovery services are supported to manage their own health and health care, use effective self-

management support strategies, and use community resources to provide ongoing support.

Within the Regional Model, Lake County beneficiaries will have a broad range of recovery-oriented services available to support sustained changes and increase recovery environment supports. County-operated programs and contracted service providers may provide recovery services face-to-face, by telephone, telehealth, or by community services and providers. Services may include recovery monitoring (recovery coaching and monitoring via telephone and internet); substance misuse assistance (outreach, peer-to-peer services, relapse, prevention, and substance abuse education); education and job skills (linkages to life skills, employment services, job training, and education services); family support (linkages to childcare, parent education, child development support services, family/marriage education); support groups (linkages to self-help and support, spiritual and faith-based support); ancillary services (linkages to housing assistance, transportation, case management, or individual services coordination). Any eligible DMC-ODS provider within the network may provide medically necessary recovery services to persons in care.

Care Coordination Services:

Care coordination is provided at Regional Model provider sites. Each provider who is contracted for DMC-ODS services, including Lake County providers, has the opportunity to provide care coordination services, during an episode of care or independent of treatment service. Services are provided by persons specifically designated either as case managers or by provider staff in the course of their delivery of treatment. Care coordination services include, depending on medical necessity and assessment of individual needs:

- Comprehensive and periodic assessments;
- Assistance to transition to a higher or lower level of care;
- Communication, coordination, referral, and related activities,
- Monitoring of service delivery to ensure access to care;
- Monitoring of individuals' progress;
- Patient advocacy and/or linkages to physical or mental health care, transportation, and primary care services.

Care coordination services may be provided by an LPHA or certified/certified-eligible counselor. Services may be provided face-to-face, by telephone, or by telehealth and may be provided anywhere in the community.

Clinician Consultation:

Experts in addiction treatment are available to assist physicians and nurse practitioners and to provide expert advice on complex cases and in the design of the treatment plan in such areas as medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Experts in addiction treatment

include addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists.

The Regional Model includes the availability of addiction specialty consultations for providers within the substance use system as well as for primary care and BH providers. Consultations are available for the use of Vivitrol, Buprenorphine, other medications, and pain management to provide support to the entire health system to treat beneficiaries with substance use disorders. The standards for such complementary medical services in ASAM level 1, 2, and 3 settings are defined in BH Information Notice 21-075.

Peer Support Services: A Peer Support Specialist is an individual in recovery with a current State approved Medi-Cal Peer Support Specialist Certification Program certification offering services as defined below:

- Educational Skill Building Groups means providing a supportive environment in which persons in care and their families learn coping mechanisms and problem-solving skills in order to help achieve desired outcomes. These groups promote skill building in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services for the person receiving care.
- Engagement services means activities and coaching led by Peer Support Specialists to encourage and support beneficiaries to participate in BH treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, and development of natural supports, self-awareness, and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

PHC currently contracts for all required levels of care in the Regional Model. Lake County beneficiaries will have access to the complete continuum of care provided in Lake County and/or counties participating in the DMC-ODS Regional Model of care. PHC coordinates care with surrounding counties not participating in the Regional Model through quarterly collaboration meetings and displays county contact information for SUD departments for persons wishing to access services. When policy and/or access becomes an issue, or at the county's request, PHC will contract with providers in opt-out counties. PHC has no barrier preventing them from these contracts.

5. ***Coordination with Mental Health*.** How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

Coordination of services is the basic premise and philosophy of the Regional Model. The organizing entities for the Model are, collectively, responsible for the range of mental health services available to Medi-Cal beneficiaries. The seven (7) current county agencies, and now Lake County, all have jurisdiction over their county's mental health system for those needing moderate to severe mental health services, and Partnership HealthPlan is responsible for the provision of mild to moderate mental health services within the Regional Model. Lake County currently employs staff that are trained in providing both substance use and mental health services to co-occurring persons. Lake County is committed to advancing specialized training on co-occurring disorders and interventions such as strength-based approaches to ensure county and contracted providers are able to effectively serve those with co-occurring substance use and mental health disorders.

Starting in 2014 with the implementation of the mild to moderate mental health benefit, the counties and PHC, through its contract with Beacon Health Options, have worked to facilitate communication, referrals, and an effective continuum of mental health services. The implementation of the Regional Model has strengthened this system, providing a strong voice in the discussion of persons BH needs. By utilizing Beacon for Access Line services, individuals have the opportunity to be screened for mental health and substance use disorder services on the same call.

Collaboration in care coordination activities across levels of care is a goal for all providers upon admission and planning for discharge. Receiving programs are encouraged to participate in person (when available) at discharge planning meetings to build a relationship with the person in care and solidify necessary stabilization goals in the discharge plan. As a best practice, providers begin documenting care coordination during the request for services and at admission. These efforts are maintained throughout the care coordination process. As a best practice, all efforts to engage and link persons to care are included in the documentation. Prior to being discharged the person in care will have their first appointment scheduled at the receiving facility.

Collaboration activities are monitored through PHC's utilization and care coordination activities. During the process of determining a beneficiary's continued authorization, staff review preliminary discharge plans to ensure collaboration with a lower level of care providers. Upon discharge, an alert is sent from PHC's Utilization Management team to the Care Coordination department initiating outreach to the person in care to confirm services were actually rendered, an appointment is scheduled with the receiving provider, and that there are no barriers in keeping that appointment.

When co-occurring needs are identified providers/facilities providers have the following options:

- Engage in mental health services if included in the scope of services provided at the facility.
- Connect the person in care with Bright Heart Health to provide mental health services via the telehealth kiosk provided.
- Contact Beacon Health Options to connect to a mental health provider.
- Engage the county (of residence) for mental health services.

Each provider will be responsible for ensuring that appropriate release of information documents have been signed by the person in care for sharing of pertinent information across systems of care. This is monitored through the annual site and medical record reviews conducted by both county and PHC staff consisting of licensed therapists, social workers, and registered nurses. All care coordination services are provided so as to be consistent with confidentiality requirements identified in 42 CFR, Part 2, in California law, and in the Health Insurance Portability and Accountability Act (HIPAA).

Additionally, all mild/moderate mental health providers are expected to use the SABIRT or Staying Health Assessment to ensure early identification of a person's substance use needs. Similarly, all Regional Model providers are required to access and facilitate a person's mental health needs under the SMHS benefit, which will carry over to Lake County.

Lake County's current infrastructure in offering mental health and SUD services are separate, however, when services are rendered to beneficiaries who are identified as needing co-occurring services, systems exist practicing cooperation and collaboration in the BH system and within wider provider Care Coordination Meetings. Lake County currently participates in a care coordination team, care coordination occurs bi-weekly, those in attendance at the bi-weekly care coordination meeting are, local Healthcare providers, SUD providers, and Mental Health providers including crisis, discharge, and access teams. Participating in the Regional Model will only enhance these activities and the collaboration that occurs between all participating entities. By expanding access to SUD services, Lake hopes to provide better wrap-around services to the persons in care and to the individuals who are in need of both substance use and mental health services.

The care coordination team actively provides care coordination in a variety of levels of care, between providers to monitor comorbid health conditions and to assist in care transitions, in addition to providing recovery resources and referrals to teams and other specialty care providers. Within the team functions additional coordination of care exists linking beneficiaries to community-based services, criminal justice systems, cultural resources, and other valuable needed services. A continuing goal is that when additional providers are identified and included in beneficiary care, those providers/contractors will be invited as partners to the care coordination team meetings.

Minimum care coordination requirements include closed-loop referrals; ensuring contact is made, and/or follow up appointments scheduled in the interim of obtaining the appropriate release of information.

Within LCBHS co-occurring beneficiaries receive care coordination and provider cooperation in both SUD and MH providers in a shared setting, allowing for appropriate warm handoffs, integrated staffing, regular case management, and collaborative meetings that address persons care, referral, access, and discharge planning. Co-occurring concerns are/will be clearly outlined in problem lists and progress notes and are continually monitored by clinicians who provide direct services to beneficiaries under the BH umbrella of services.

Monitoring of co-occurring beneficiary cases occurs annually, quarterly, and with all discharge planning, through internal audits, file reviews, compliance, and sampling. Each discharge is reviewed through the utilization review that occurs with residential treatment.

6. **Coordination with Physical Health.** Describe how the counties will coordinate physical health services within the DMC-ODS program. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

The basic philosophy and strength of the Regional Model is its ability to provide a person in care with an integrated and comprehensive healthcare service system. The network includes the primary care system for all of the individuals in the Regional Model. All Partnership HealthPlan members, and thus all individuals served by the Regional Model, have identified primary care sites and are linked to primary care upon their initial entry into the system. In addition, primary care sites are expected to conduct SABIRT screenings as well as mental health screenings to ensure that individuals have the appropriate access into the system.
The Regional Model sponsors trainings and other opportunities to better train primary care providers on the substance use system as well as the performance of MAT services. Similarly, substance use providers are encouraged to participate in trainings focusing on the effective use of primary care resources.
As required by state regulation, and implicit in the ASAM assessment process, individuals entering ASAM level 1 and above treatment programs are encouraged to have a comprehensive history and physical exam just before or soon after starting treatment. Wherever possible, this will be performed within the person's medical home by the primary care provider. This requirement is verified by a yearly review of medical records during the site review process.

7. **Coordination Assistance.** The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- Comprehensive substance use, physical, and mental health screening;

- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers, and all providers;
- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems

Comprehensive Substance Use, Physical and Mental Health Screening:
All Lake County providers, including those in the current PHC system, will receive continuing training and support by PHC on the use of screening tools, including the ASAM tools, the CAGE and AUDIT used in SBIRT, and the PHQ-2 and PHQ-9 (mental health tools required by HEDIS). Challenges in ensuring the effective use of these tools include the many demands on providers' time and resources; and limitations on clinic Space Making It Hard to Co-Locate SUD Staff or Other Resources.

Beneficiary engagement and Participation In an Integrated Care Program: Effective outreach to Lake County beneficiaries is always a challenge and there is a continuing need to educate the community, providers, and potential beneficiaries on the resources available in the system. Lake County will be able to build upon the networks and practices established in order to encourage effective use of the mild to moderate mental health service system within the Regional Model. The success of these efforts can be seen in the relatively high penetration rates for the mild to moderate benefit, ranging from 5% to 11% across the region, and most specifically 7% in Lake County.

Shared Development of Care Plans By the Beneficiary, Caregivers, and all Providers:
This is perhaps the largest challenge facing the system, including in Lake County, with the complex laws governing the exchange of information, individual providers' interpretations, and the need for the broad acceptance of common tools and understandings. Implementation of the Sac Valley HIE, planned in 2023, will assist in the identification of engagement with other service providers to ensure appropriate sharing of care plans, where ROIs are included.

Collaborative Treatment planning With Managed Care:
There are no significant barriers here.

Care Coordination and Effective Communication Among Providers:
This is a challenge in any complex system and effective communication is key to the Regional Model's success. The Regional Model relies upon the tools already identified and used by PHC as well as the counties in ensuring that the entire community is aware of the services available and how to access them.

Navigation support for Patients and Caregivers:
PHC Care Coordination provides support to persons and caregivers when navigating the system. Requests for support may be made by contacting 1-800-809-1350. Cases

will be opened and will focus on the immediate need while ensuring medical and mental health services are also offered. The individual is followed until all support needs have been met.

Facilitation and Tracking of Referrals Between Systems:
This is monitored through various sourced systems such as Access Call Center data, CalOMS data, provider screening, authorizations, and claims data. Where deficiencies are identified, remediation plans are made through provider and person-in-care outreach. Where deficiencies are found within the provider network, corrective action is applied.

8. **Availability of Services.** Pursuant to 42 CFR 438.206, the pilot County must ensure the availability and accessibility of adequate number and types of providers of medically necessary services. At a minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:

- The anticipated number of Medi-Cal clients.
- The expected utilization of services by service type.
- The numbers and types of providers required to furnish the contracted Medi-Cal services.
- A demonstration of how the current network of providers compares to the expected utilization by service type.
- Hours of operation of providers.
- Language capability for the county threshold languages.
- Specified access standards and timeliness requirements, including the number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
- The geographic location of providers and Medi-Cal beneficiaries, considering the distance, travel time, transportation, and access for beneficiaries with disabilities.
- How will the county address service gaps, including access to MAT services?
- As an appendix document, please include a list of network providers indicating, if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (e.g., adolescent, adult, perinatal).

Anticipated Number of Medi-Cal Beneficiaries:
As of July 1, 2022, there are 265,000 Partnership HealthPlan Medi-Cal members in the 7 counties in the Regional Model, and an additional 34,500 Lake County beneficiaries will be added. We estimate that ten percent of the overall population will have substance use issues. Of these, only a subset will voluntarily accept a referral to treatment in any given year. Relying on existing claims data from the first two (2) years

of the Model, approximately 5%-6% of beneficiaries will seek treatment. Year one (1) Lake County beneficiaries seeking treatment = 1725 to 2070.

The Expected Utilization of Services:
The projected utilization of services was based on a variety of sources:

- Review of current DMC systems in the participating counties.
- Review of the use of SUD services in states with Medicaid expansion with more robust SUD programs.
- Kentucky, rate in 2015: 1.5%/year; rate as of mid-2016: approximately 5%/year.
- Oregon rate estimated by Care Oregon in early 2017: less than 5%
- Experience through the Regional Model, fiscal years 2020-2021, 2021-2022.

The numbers and types of providers required to furnish the contracted Medi-Cal services: this was part of the utilization calculation noted above. It is expected that based on the expected year 1 utilization at least one additional service provider per modality will be necessary. Recruiting efforts have begun with outreach to 40 targeted providers across the Regional Model, and are expected to be completed by January 2023.

Hours of Operation of Providers:
In general, providers will operate from 8:30 a.m. through 5 p.m. on business days, with after-hour coverage provided by the Central Access Line. Should an emergent service be required, the Central Access Line will coordinate emergent support. Additionally, PHC offers an after-hours advice/ triage line that can be reached by calling 1-800-863-4155. PHC ensures that Medi-Cal beneficiaries are offered the same treatment times and capacity as non-Medi-Cal beneficiaries through contractual requirements.

Language Capability for the County Threshold Languages:
Spanish. Throughout the Regional Model, providers are required to provide interpretation and translation services to all beneficiaries, regardless of county. The Regional Model Quality Program ensures providers comply with language access requirements. When assistance is needed, providers or members may contact PHC Member Services at 1-800-863-4155 to request services through PHC's Language Line contract at no cost. Additionally, all forms and appropriate materials are translated into the threshold languages and made available to Regional Model providers. Every effort is made to have materials translated in an accurate and timely manner.

Timeliness of the First Face-To-Face Visit, Timeliness of Services for Urgent Services, Including Withdrawal Management and Opioid Treatment Program are Required Within 3 Days and 10 Days for Non-Urgent Urgent Services:
Follow-up appointments will be in accordance with the person in care's specified level of care. Providers, who lack capacity, yet accept new persons and are not able to offer sufficient appointments may be subject to corrective action. This is measured through ongoing utilization review through claims data to ensure continuity and continuance in care.

The Geographic Location of Providers and Medi-Cal Beneficiaries, Considering Distance, Travel Time, Transportation, and Access for Beneficiaries with Disabilities:
Medi-Cal beneficiaries are offered services throughout the Regional Model while being encouraged to remain in the county whenever possible. Experience to date indicates 5% of services within the model are received outside of the beneficiaries' county of responsibility. Where transportation is a barrier, PHC will arrange for transportation to and from the treatment facility in accordance with APL 17-010 and 22-008, regardless of distance. Travel time is considered when identifying the most appropriate mode of transportation (flight versus vehicle). Should it be identified during the screening or placement process that a beneficiary has a disability that may require additional coordination, PHC's Care Coordination staff is engaged to ensure all needs are met.

How Will the County Address Service Gaps, Including Access to MAT Services:
There are three (3) MAT providers in Lake County, Dr. Stephen Bradley, and 2 Adventist providers Dr. Melody Law and Dr. Bob Gardner. 572 pharmacy claims have been identified as MAT drugs while there are 2169 members with significant utilization tied to a SUD diagnosis. In an effort to bridge the gap, PHC will engage with Bright Heart Health to provide MAT services through telehealth services.

9. **Access to Services.** In accordance with 42 CFR 438.206, describe how the County will assure the following:

Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of the need for services.

All providers offering NTP and withdrawal management services are required to begin treatment with a person in care within three (3) days of initial screening. All other treatment providers must ensure beneficiaries are served with ten (10) days of screening. Timely access standards are monitored from screening to the first billable service. A report is pulled each month to verify whether standards have been met or not. When standards have not been met, PHC reaches out to the provider to give technical assistance in the needed issue. If technical assistance is not enough and the issue persists, a Corrective Action Plan (CAP) will be issued for violation of their contract. Detail of the provider's timely access is provided to all regional model counties during Quality meetings that occur no less than once a quarter.

Require Subcontracted Providers to Have Hours of Operation During Which Services are Provided to Medi-Cal Beneficiaries That are No Less Than the Hours of Operation During Which the Provider Offers Services to Non-Medi- Cal Patients:
All providers must offer the same hours of operation per contractual requirements indicated in the agreement between PHC and the provider. Hours may not vary or be less for Medi-Cal beneficiaries. All providers report their operational hours to PHC when entering into their agreement. If hours are subpar, a notice of obligation will be provided. If the provider is unable to meet the standard hours, the contract will be rescinded.

Make Services Available to Beneficiaries 24 Hours A Day, 7 Days A Week, When Medically Necessary:
Screenings and assistance in accessing services are available 24 hours a day, 7 days a week by contacting the Central Access Line.

Establish Mechanisms to Ensure That Network Providers Comply With the Timely Access Requirements: Timely access is monitored no less than monthly via sourced data from the level of care data, submitted by the providers and the call center, and claims. A report is pulled each month to verify whether standards have been met or not. When standards have not been met, PHC reaches out to the provider to give technical assistance in the needed issue. If technical assistance is not enough and the issue persists, a CAP will be issued for violation of their contract.

Monitor Network Providers Regularly to Determine Compliance with Timely Access Requirements:
Metrics are reported at monthly provider on-site meetings, trended for quarterly county and provider meetings, and reported to DHCS annually.

Take Corrective Action If There Is a Failure to Comply With Timely Access Requirements:
Providers found to be out of compliance will receive corrective action plans. Repeated noncompliance may result in suspension or termination of the provider agreement.

10. **Training Provided.** What training will be offered to providers chosen to participate in the DMC-ODS program? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Lake County will implement the following required trainings:

- Annual compliance and DMC-ODS training (all staff)
- Annual ASAM training (clinical staff)
- Annual Evidence-Based Practices (2) (clinical staff)
- On-boarding CalOMS (administrative staff)
- On-boarding Claims & Billing (administrative staff)
- On-boarding DATAR (administrative staff)
- Annual Cultural and Linguistics training (all staff)
- Annual Human Trafficking training (all staff)

Each provider shall ensure that position appropriate trainings are included in the staff member's onboarding plan and documented in the personnel file.

Should significant policy changes be made or findings from an audit that warrant program changes, an ad hoc training session will be held.

11. **Technical Assistance.** What technical assistance will the county need from DHCS?

There is no current need for technical assistance.

12. **Quality Assurance.** Describe the County's Quality Management (QM) and Quality Improvement (QI) programs. This includes a description of the Quality Improvement Committee (QIC) (or integration of DMC-ODS responsibilities into the existing MHP (QIC).

The Monitoring of Accessibility of Services Outlined in the Quality Improvement Plan will at a Minimum Include:

- Timeliness of first initial contact to face-to-face appointment.
- Frequency of follow-up appointments in accordance with individualized treatment plans.
- Timeliness of services of the first dose of NTP services.
- Access to after-hours care.
- Responsiveness of the beneficiary access line.
- Strategies to reduce avoidable hospitalizations.
- Coordination of physical and mental health services with services at the provider level.
- Assessment of the beneficiaries' experiences, including complaints, grievances, and appeals.
- Telephone access line and services in the prevalent non-English languages.

The Regional Model Quality Improvement Plan Includes the Following Activities:

- Monitoring for a person in care satisfaction; adherence to access and language standards and other aspects of contract compliance.
- Monitoring individual treatment plans to ensure that persons in care are receiving the proper level of care in the context of integrated services, with appropriate follow up appointments.
- Monitoring outcomes of treatment.
- Site review activities, including facility site reviews and medical record reviews.
- Updating policies and procedures to improve clinical practice and ensure excellent audit reports.
- Improve training participation, documentation, and quality of care.
- Implementing, assessing, and reporting on performance improvement measures.
- A robust, NCQA compliant process for credentialing, re-credentialing, and peer review of all licensed providers and non-licensed alcohol and drug counselors.

The Quality Improvement Plan will Monitor the Following Performance Measures:

- Number of days to the first service at the appropriate level of care after referral:
- Continuity of ongoing services.
- Timeliness of first dose for NTP services.

- ED diversion programs to ensure services are received within the most appropriate setting, therefore reducing emergent and acute utilization.
- Person satisfaction through TPS administration with opportunities for improvement identified for providers with less than adequate scoring.
- 24/7 telephone access with non-English language capacity.
- Access to translation services in threshold language.
- Number, percentage, and time period of prior authorization requests (for residential treatment) approved or denied.
- Review of Utilization Management activities, ensuring that interventions are appropriate to the assessed ASAM level of care.

Quality Improvement Committee:
Regional Plan QI activities are incorporated into the larger QI activities of Partnership HealthPlan, including a multi-committee oversight structure that includes credentialing, peer review; policy and program consultation; and regular reporting. The Quality, Utilization, and, Access Committee (QUAC) has established a subcommittee structure to ensure that Regional Plan activities are sufficiently monitored and reviewed. Through this structure, PHC ensures sufficient attention to critical incidents and person-in-care complaints; monitoring of audit results and information; obtaining input from standing or ad hoc subcommittees; and review of the most effective provision of DMC-ODS services in the context of an integrated healthcare system.

Grievances and Appeals:
A beneficiary may file a grievance or appeal by calling PHC Member Services (800) 863-4155 or via the website at www.partnershiphp.org. This information will be made available to beneficiaries by the beneficiary handbook, as well as information provided and posted at provider sites.

Every effort is made to resolve grievances within 90 days, with rare occurrences requiring no more than 120 days.

All appeal resolutions require determination via a Notice of Adverse Benefit Determination (NOABD) and a “Your Rights” attachment of which is submitted to the provider and beneficiary.

All documentation is stored in PHC’s system “Everest”. The following elements are reportable:

- The date and time of receipt of the grievance or appeal;
- The name of the beneficiary filing the grievance or appeal;
- The name of the representative recording the grievance or appeal;
- A description of the complaint or problem;
- A description of the action taken by the Plan or provider to investigate and resolve the grievance or appeal;
- The proposed resolution by the Plan or provider;
- The name of the Plan provider or staff responsible for resolving the grievance or appeal;

- The date of notification to the beneficiary of the resolution.

All beneficiaries with pre-existing provider relationships who make a continuity of care request to PHC are given the opportunity to continue treatment for up to 12 months with an out-of-network provider. PHC will provide continuity of care with an out-of-network provider when the following criteria are met:

- PHC is able to determine that the member has an ongoing relationship with the provider. Self-attestation is not sufficient to provide proof of an established relationship with a provider.
- The provider is willing to accept the higher of PHC's contract rates or current year county DMC-ODS interim rates as published on the DHCS website
- The provider meets PHC's applicable professional standards and has no disqualifying quality of care issues
- The provider is a Medi-Cal enrolled provider and is DMC certified
- The provider supplies PHC with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan

PHC informs members of their continuity of care protections through the member welcome packet and the PHC website. All information provided is made available in threshold languages and alternative formats upon request.

PHC is not required to provide continuity of care for services that are not covered under DMC-ODS.

Continuity of care requests are supported through PHC's Care Coordination and Utilization Management departments and are reportable through the following data elements:

- The date of the request.
- The beneficiary's name.
- The name of the beneficiary's pre-existing provider.
- The address/location of the provider's office.
- Whether the provider has agreed to the terms and conditions.
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

State Fair Hearings are offered to beneficiaries, with a requirement of filing within 120 days of receipt of a (NOABD). All State Fair Hearings are responded to within 90 days of receipt. Beneficiaries can request a State Fair Hearing directly from the California Department of Social Services by writing to: State Hearings Division California Department of Social Services 744 P Street, Mail Station 9-17-37 Sacramento, California 95814, or by calling 1-800-952-8349 or for TDD 1-800-952-8349.

Requests for expedited appeals will be accepted through the same submission process as previously indicated, with an indication of "expedited appeal request" being included by the submitter either through verbal or written form. PHC will review the request for expedited decision and if approved will notify the beneficiary and provider within 72

hours, except in rare, extenuating circumstances which may constitute an extension to 14 calendar days. Should the request for expeditious review be denied, the beneficiary and provider will be notified and the appeal will transition into the standard appeal timeframe.

13. **Evidence Based Practices.** How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

The Regional Model has chosen the following evidence-based practices for particular support: Motivational Interviewing (MI); Living in Balance; Seeking Safety. Lake County has incorporated MI and the Transtheoretical Stages of Change Model within the County operated programs and services. The Regional Model provides periodic trainings on each of these practices and facilitates a provider-sharing network to encourage skills and practice sharing among providers.

All providers are required to use evidence-based practices and are expected to show fidelity to the models as listed via their contract between PHC and the provider. This is monitored via periodic chart reviews and annual monitoring. Noncompliance will result in potential corrective action plans as well as denial of claims for services and repeated noncompliance may result in suspension or termination of the provider agreement.

14. **Regional Model.** If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

Lake County will be added to the existing regional model structure described throughout this document. For additional information regarding the Regional Model, please visit PHC Wellness and Recovery (www.partnershiphp.org).

15. **Memorandum of Understanding**. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 “Care Coordination” of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

The current MOU between Lake County and PHC has expired as we await the new guidance for the BH MOU template from DHCS. It is understood that all efforts shall be made to ensure the new MOU template is signed within 90 days of receipt from DHCS.

Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers, and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures or exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

16. **Telehealth Services.** Describe how the telehealth and telephone delivery of services will be structured for providers and how will the county ensure confidentiality.

Over the past few years, PHC, in conjunction with its subcontractor, Beacon Health Options, has developed a robust telehealth network. This network is inclusive of addiction specialists and offers kiosks to DMC treatment sites to allow for assessment support and co-occurring services.

Existing technology and vendors are also used to provide addiction specialist consultation services to primary care and other providers in the system. Providers shall ensure secure networks are utilized when available, and when unavailable staff will wipe their device clean of any PHI.

17. **Contracting.** Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

The Regional Model contracts only with DMC certified providers based upon program needs and in a manner to ensure the ongoing fiscal and programmatic integrity of the Regional Model. All contracts include provisions outlining timely access to care requirements and performance standards, taking into account the urgency of the need for services; requiring hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation in which the provider offers services to non-Medi-Cal beneficiaries; and providing directly or through referral access to services 24 hours a day, 7 days a week, when medically necessary. Contracts also require all DMC providers to have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop regarding wait times for services.

All contracts are evergreen, with the opportunity to amend as needed. Terms are mutually agreeable and the contract may be termed by either party with no less than 60-day written notice. No less than annually, contracts are reviewed to ensure all necessary policy inclusions and fee schedule updates have been addressed. Additionally, contracts are reviewed annually during the completion of the Substance Abuse Block Grant (SABG) risk assessment. During this review utilization and quality is considered when determining whether the contractual relationship should continue.

Continuity of care policies applies when a beneficiary is receiving services from a provider that is not contracted with PHC at the time of implementation. PHC will enter into a single case agreement to ensure services are not interrupted once the beneficiary makes a continuity of care request. All requests for contracts are responded to within 30 days. Additionally, PHC will make every effort to contract with each willing provider. Should a provider and PHC not come to terms during contract negotiations, the provider may file an appeal by contacting PHC's Provider Relations department at 1-800-863-4130.

18. **Residential Authorization.** Describe the county's authorization process for residential services. Continued stay authorization requests for residential services must be addressed within 24 hours.

The Regional Model requires prior authorization for all residential treatment, which is submitted by the residential provider. All requests for authorization will be completed within five business days. Authorization for residential services is based on ASAM assessment criteria and medical necessity. Continued stay authorizations for residential services are addressed within 24 hours.

County Approval

The County Behavioral Health Director must review and approve the Implementation Plan. The signature below verifies this approval.

_____ _____

Lake County Behavioral Health Director Date