PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE INTERNAL QUALITY IMPROVEMENT COMMITTEE
MEETING AGENDA

Date: September 21, 2021 **Time: 10:00-11:30 AM** **Location: WebEx**

Substance Use Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. The SUIQI meeting frequency will be determined at a later date, closer to the implementation of the benefit. Activities and progress are reported to the IQIC. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential over-use, under-use, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Clinical Director, Behavioral Health, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Departments.

Invited Participants - PHC					
La Rae Banks	Grievances & Appeals	Liz Gibboney	Chief Executive Officer	Dolores Plascencia	Configuration
Katherine Barresi	Care Coordination	Angela Guevarra	Care Coordination - SR	Matt Ramsey	Care Coordination
Sonja Bjork	Chief Operating Officer	Jessica Hackwell	Health Services	Erika Robinson	Quality
Mark Bontrager	Administration	Ruth Hood	Health Services	Diana Rose	Quality
Rebecca Boyd Anderson	Care Coordination	Peggy Hoover	Health Services	Chloe Schafer	Administration
Heather Brandeburg	Provider Relations	Mary Kerlin	Provider Relations	Kevin Spencer	Member Services
Dani Carpenter	Provider Relations	Margaret Kisliuk	Administration	Nancy Steffen	Quality - NR
Elena Carter	Grievances & Appeals	Jackie Krznarich	Quality	Nicole Talley	Administration
Doreen Crume	Health Services	Laurel McCarthy	Care Coordination	Amy Turnipseed	Administration
Tahereh Daliri Sherafat	Member Services/Provider Relations – NR	Melissa McCartney	Care Coordination - NR	Wendi West	Director - NR
Jeff Devido	Clinical Director, BH	Wendy Millis	Administration		
Alison French	Beacon	Robert Moore	Chief Medical Officer		
Rachel French	Quality	Dani Ogren	Finance		
Karen Garnick	Quality	Rachel Peterson	Quality		
Invited Participants- Counties					
Elvira Schwarz	Humboldt	Barbara Longo	Lassen	Katie Cassidy	Shasta
Emi Botzler-Rogers	Humboldt	Tiffany Armstrong	Lassen	Paige Greene	Shasta
Kaleigh Emry	Humboldt	Jenine Miller	Mendocino	Sarah Collard	Siskiyou
Michelle Thomas	Humboldt	Rendy Smith	Mendocino	Toby Reusze	Siskiyou
Nancy Starck	Humboldt	William Riley	Mendocino	Emery Cowan	Solano
Paul Bugnaki	Humboldt	Michael Traverso	Modoc	Sandra Sinz	Solano
Raena West	Humboldt	Stacy Sphar	Modoc		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE INTERNAL QUALITY IMPROVEMENT COMMITTEE
MEETING AGENDA

		Lead	Time
I.	**Approval of Minutes** • **July 20, 2021**	Wendy Millis	10:00
II.	**New Business**		10:05
	- Behavioral Health Medical Director brief - Wellness and Recovery Program Updates o Short Doyle updates	Dr. DeVido Wendy Mills Nicole Talley Margaret Kisliuk	
III.	**Discussion – Review of Data**		10:20
	- Referrals to Treatment Beacon Referrals Actual vs Indicated LOC by County - Paid Claims By Member County/LOC Demographics Info - CalOMS Participation in treatment		
IV.	**Presentation – Transportation Benefit**	Aaron Maxwell	10:30
V.	**Presentation – Grievance and Appeal Quarterly Update**	Kory Watkins	10:50
VI.	**Discussion – New/updated policies and BHINs**	Nicole Talley	11:00
	- MCCP2028 – Residential Substance Use Disorder Programs - New Behavioral Health Information Notices		
VII.	**Adjournment – next meeting November 16 10:00-11:30 AM**	Wendy Millis	11:25

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Elena Carter	Grievances & Appeals	Jackie Krznarich	Quality	Lauri Stevenson	Quality - NR
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Jeff Devido	Clinical Director, BH	Wendy Millis	Administration	Wendi West	Director - NR
Alison French	Beacon	Robert Moore	Chief Medical Officer	Alicia Kay, RN	Quality
Rachel French	Quality	Dani Ogren	Finance		
Karen Garnick	Quality	Rachel Peterson	Quality		
Invited Participants- Counties					
Elvira Schwarz	Humboldt	Barbara Longo	Lassen	Katie Cassidy	Shasta
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE INTERNAL QUALITY IMPROVEMENT COMMITTEE
MEETING AGENDA

		Lead	Time
I.	**Approval of Minutes –** • **March 1, 2021** • **May 18,2021**	Nicole	10:00
II.	**New Business**	Dr. DeVido Nicole Talley Margaret Kisliuk	10:05
	• Behavioral Health Medical Director brief: Continuing to monitor things at the state level as things open back up. Subocane – trying to get clarifications from the state. Two realms of challenges Clinical side – long acting injectable not being the typical treatment path Non clinical side – how to make it feasible to offer this treatment This information is available in the behavioral health notice (attached to meeting invite) • Wellness and Recovery Program Updates: Margaret: State sent out 54 page document to everyone identifying duties. Margaret is going through this document to break it down into policies and implement into the contractors Year 2 into the program, implementing full care for adolescents. Additionally improving on how to help our network in its entirety. Also starting the reconciliation process as part of our waiver. (reviewing the first year). Our fiscal staff has started on this process. o Short Doyle updates: Nicole: there are some claims that have come through as denials. We are continuing to work with the state to make sure these issues are alleviated. Trying to make sure that both programs, PHCs and Short Doyle are working together. We are expecting that in the month of August, all issues will be resolved. Until then, we will continue to monitor claims extrememly closely in order to catch any issues as quickly as possible • NAT submissions have all been submitted. There were additional things that were not previously requested so we are fully aware that we will have more changes to be made and resubmitted to the state. Additional policies need written.	Dr. DeVido Margaret Kisliuk Nicole Talley	
III.	**Discussion – Review of Data**		10:10
	- Referrals to Treatment: Beacon Referrals: 292 out of____? From Beacon 31% non responsive rate at this time. This is lower, but still needs to reduce Actual vs Indicated LOC by County: still indicating that the referrals from Beacon are still high towards the residential sides. This is prior to the ACM being conducted. Reviewed actual VS indicated LOC report (included in calendar invite) Nancy Starck – how are we doing on reaching the people who may want to access services? Nicole – 1.6% at the penetration rate. 9.5% as the overall need in counties.		

	We are tracking the penetration rate by county. Shasta's penetration rate is around 1.3% This will also be a part of the EQRO final report. - Paid Claims: Since go live, have received over 85k claims. Paid % is 90. Which means 10% the providers are making errors. Over the last 2 months, 16,500 payable percent at 95. 2.7 million in claims paid the past 2 months with 100 corrected claims come in. By Member County/LOC: reviewed document provided (attached to invite) Demographics Info: reviewed document provided (attached to invite) - CalOMS Participation in treatment: Breaks down each county with their providers listed. June 1-30 Less than 5% of our CalOMS claims are experiencing issues. Process with the state has improved significantly.		
IV.	**Presentation – Transportation Benefit**	Aaron Maxwell	10:20
	Aaron not present to present		
V.	**Presentation – Grievance and Appeal Quarterly Update**	Kory Watkins	10:35
	Issue #2 G&A Pulse Report: Reviewing 1st quarter of 2021 Grievance & Appeals (attached to invite) Highlights: 926 cases were investigated. 99.9% investigated timely. 100% timely notice to member. Member demographics are broken down: counties, age range, language, genders Closed case comparison 2020 VS 2021. Covid is still an obvious cause of outliers There is a specific page regarding W&R related claims: 1st quarter 2021 9 W&R cases (1% of total cases) Not any way to see any trends related to W&R at this time. Highlighted W&R case: 2nd level case, the member had filed a previous grievance and were unhappy so they filed a 2nd level grievance. Main concern was decreasing the touch points for the member. 2/9 related to program requirements 7/9 related to interpersonal relationship issues Mark Bontrager: In relation to the interpersonal grievance issues, what are the usual concerns? Kory: Typically it usually is that they feel the provider was rude to them. In the first quarter: PHC spent a lot of time in training on new discrimination policy. We also have new letters. Implemented a new process that when a member withdraws a case, we have a letter that goes out confirming. We have 1 case for the 1st quarter that went over the timeframe allotted. Nicole: When members get blacklisted, what type of level does that fall under? Kory: depending on the situation, it may not fall on the report at all as it may not be a provider issue.		
VI.	**Discussion – New policies and BHINs**	Nicole Talley	10:45

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
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MEETING AGENDA

	- MCCP2016: – Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) - MC305A – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program - MPNET101 – Wellness and Recovery Access Standards and Monitoring New Behavioral Health Information Notices - BHIN 21-018: regards cost reporting - BHIN 21-019: regards determining medical necessity: allows DMC services to be reversible up to 30 days, whether or not a diagnosis has been made. Allows 60 days to complete the ASAM - BHIN 21-020: inclusion of NTP services and recovery services. This allows individuals to receive recovery services in NTP location - BHIN 21-021: residential treatment limitation being lifted. Releasing the 2 episode limitation - BHIN 21-023: network adequacy requirements - BHIN 21-024: expansion on what Dr Devido spoke about regarding long acting treatments earlier in this meeting. Michael: Will you be forwarding these policies to us? Nicole: They are included in this invite ☺		
	Any Questions?		
VII.	**Adjournment – next meeting……10:00-11:30am – was not mentioned**	Nicole Talley	11:00

Wellness and Recovery

Beacon Referrals -- Jul 2021 / Fiscal YTD

Referral Outcomes

	Jul'21	YTD
Other	241	241
TOTAL	241	241

Referrals by Level of Care

Actual LOC	Jul'21	YTD
1.0 Outpatient	12	12
2.1 Intensive Outpatient	47	47
3.1 Residential (Low Intensi..	103	103
3.2 Withdrawal Mgmt (Res.)	68	68
3.5 Residential (High Intensi..	3	3
Other	8	8
TOTAL	241	241

Referrals by County

County of Resp	Jul'21	YTD
Humboldt	34	34
Lassen	3	3
Mendocino	23	23
Modoc	3	3
Shasta	99	99
Siskiyou	15	15
Solano	64	64
TOTAL	241	241

Wellness and Recovery
July 2021 - Level of Care by County

Indicated LOC by County

	Mbr County / Screening Done By													
	HUMBOLDT		LASSEN		MENDOCINO		MODOC		SHASTA		SISKIYOU		SOLANO	
Indicated LOC	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider
1.0 Outpatient	2	14				3	1		2	12			7	1
2.1 Intensive Outpatient	6	3	1		4		2		15	19	4	3	21	
3.1 Residential (Low Intensity)	13	8	1		13	7		1	47	5	6	1	21	3
3.2 Withdrawal Mgmt (Res.)	12	10	1	1	6	7			32	4	5		14	38
3.5 Residential (High Intensity)	1	5							1					
3.7 Withdrawal Mgmt (Inpt.)									2					
NTP/OTP										23		1		3
Other						1							1	
Grand Total	34	40	3	1	23	18	3	1	99	63	15	5	64	45

Actual LOC by County

	Mbr County / Screening Done By													
	HUMBOLDT		LASSEN		MENDOCINO		MODOC		SHASTA		SISKIYOU		SOLANO	
Actual LOC	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider	Beacon	Provider
1.0 Outpatient	2	17				3	1		2	11			7	1
2.1 Intensive Outpatient	6				4		2		13	20	3	3	19	
3.1 Residential (Low Intensity)	14	8	2		13	7		1	47	5	6	1	21	3
3.2 Withdrawal Mgmt (Res.)	11	10	1	1	4	7			33	4	6		13	38
3.5 Residential (High Intensity)	1	5							2					
NTP/OTP										23		1		3
Other					2	1			2				4	
Grand Total	34	40	3	1	23	18	3	1	99	63	15	5	64	45

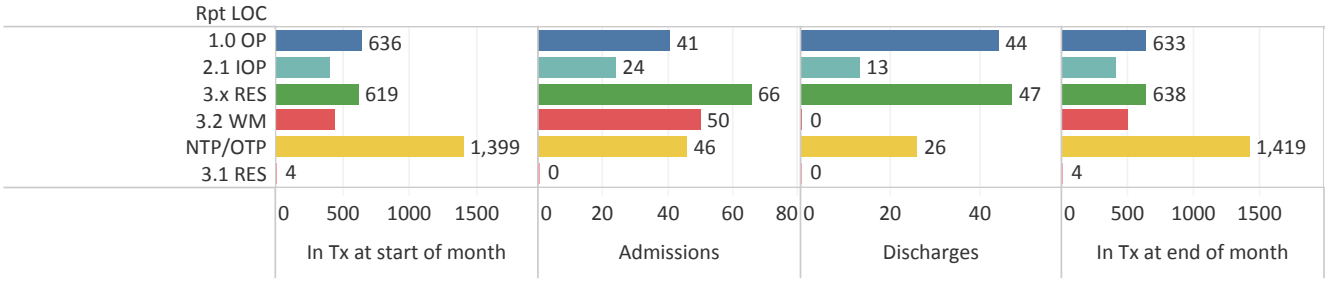
CalOMS Participation in Treatment -- July 2021

by County, Provider, and LOC

Prov County	Provider	Rpt LOC	In Tx at start of mo..	Admissions	Discharges	In Tx at end of mo..
Humboldt	Aegis Treatment Centers - Eureka	NTP/OTP	222	7	10	219
	Crossroads	3.x RES	32	7	4	35
	Humboldt County - Healthy Moms	1.0 OP	6	0	0	6
		2.1 IOP	14	0	4	10
	Humboldt County - Pgms for Recovery	1.0 OP	72	0	6	66
	Humboldt Recovery Center	3.x RES	78	8	2	84
	Waterfront Recovery Services	3.x RES	128	4	11	121
		3.2 WM	287	8	0	295
Lassen	Lassen County	1.0 OP	35	0	0	35
		2.1 IOP	4	0	0	4
Mendocino	Ford Street/URC - OP/IOP	1.0 OP	11	3	2	12
	Ford Street/URC - Res/WM	3.x RES	30	2	0	32
		3.2 WM	19	5	0	24
	Mendocino County - Fort Bragg	1.0 OP	56	5	4	57
	Mendocino County - Ukiah	1.0 OP	74	7	10	71
	Mendocino County - Willits	1.0 OP	13	0	0	13
	RCS - The Arbor	2.1 IOP	3	0	0	3
Modoc	Modoc County	1.0 OP	26	0	0	26
Shasta	Aegis Treatment Centers - Redding	NTP/OTP	492	19	3	508
	Empire - OP	1.0 OP	88	9	4	93
	Empire - Res/WM	3.x RES	131	9	0	140
		3.2 WM	107	9	0	116
	Shasta County - Alcohol and Drug Programs	1.0 OP	4	0	0	4
		2.1 IOP	7	0	0	7
	Shasta County - Women's Recovery ..	2.1 IOP	11	0	0	11
	Visions of the Cross - IOP	1.0 OP	53	6	5	54
		2.1 IOP	212	22	5	229
	Visions of the Cross - Res Men's	3.x RES	57	15	11	61
	Visions of the Cross - Res Women's	3.x RES	116	10	11	115
Siskiyou	Siskiyou County - Mt Shasta	1.0 OP	4	0	0	4
	Siskiyou County - Yreka	1.0 OP	29	0	0	29
		2.1 IOP	8	0	0	8
Solano	Archway Recovery Services - OP/IOP	1.0 OP	21	3	0	24
		2.1 IOP	4	0	0	4
	Archway Recovery Services - Res	3.1 RES	4	0	0	4
	Bi-Bett - Recovery Connection	1.0 OP	14	1	7	8
		2.1 IOP	10	1	4	7
	Bi-Bett - Shamia Recovery Center	3.x RES	24	3	0	27
	Bi-Bett - SSAC	3.2 WM	30	28	0	58
	Genesis House	3.x RES	8	1	0	9
	Healthy Partnerships	1.0 OP	48	0	0	48
		2.1 IOP	91	0	0	91
	MedMark - Fairfield	NTP/OTP	320	11	13	318
	MedMark - Vallejo	NTP/OTP	365	9	0	374
	Ujima Hope Solano	1.0 OP	5	4	0	9
		2.1 IOP	33	1	0	34
(Contra Costa)	Bright Heart Health	1.0 OP	77	3	6	74
	Ujima - The Rectory	3.x RES	2	3	2	3
(Lake)	Hilltop Recovery Services	3.x RES	12	4	6	10
	RCS - Tule House	3.x RES	1	0	0	1
			0 200 400 600	0 10 20 30	0 5 10 15	0 200 400 600

CalOMS Participation in Treatment -- July 2021

by LOC



by County and LOC

Prov County	Rpt LOC	In Tx at start of month	Admissions	Discharges	In Tx at end of month
Humboldt	1.0 OP	78	0	6	72
	2.1 IOP	14	0	4	10
	3.x RES	238	19	17	240
	3.2 WM	287	8	0	295
	NTP/OTP	222	7	10	219
Lassen	1.0 OP	35	0	0	35
	2.1 IOP	4	0	0	4
Mendocino	1.0 OP	154	15	16	153
	2.1 IOP	3	0	0	3
	3.x RES	30	2	0	32
	3.2 WM	19	5	0	24
Modoc	1.0 OP	26	0	0	26
Shasta	1.0 OP	145	15	9	151
	2.1 IOP	230	22	5	247
	3.x RES	304	34	22	316
	3.2 WM	107	9	0	116
	NTP/OTP	492	19	3	508
Siskiyou	1.0 OP	33	0	0	33
	2.1 IOP	8	0	0	8
Solano	1.0 OP	88	8	7	89
	2.1 IOP	138	2	4	136
	3.x RES	32	4	0	36
	3.2 WM	30	28	0	58
	NTP/OTP	685	20	13	692
	3.1 RES	4	0	0	4
(Contra Costa)	1.0 OP	77	3	6	74
	3.x RES	2	3	2	3
(Lake)	3.x RES	13	4	6	11

Wellness and Recovery Overview of Paid Claims by Member County

This dashboard tracks health services by Wellness and Recovery program across the participating counties. Data gathered from paid claims.

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

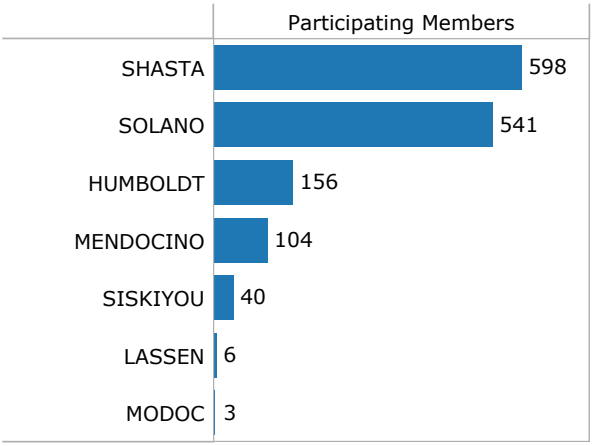
by: Revanth Kasireddy

6/1/21 to 8/1/21	9/13/21	1,444	16,277
Service Date	Max Paid Date	Total participating Members	Total Visits

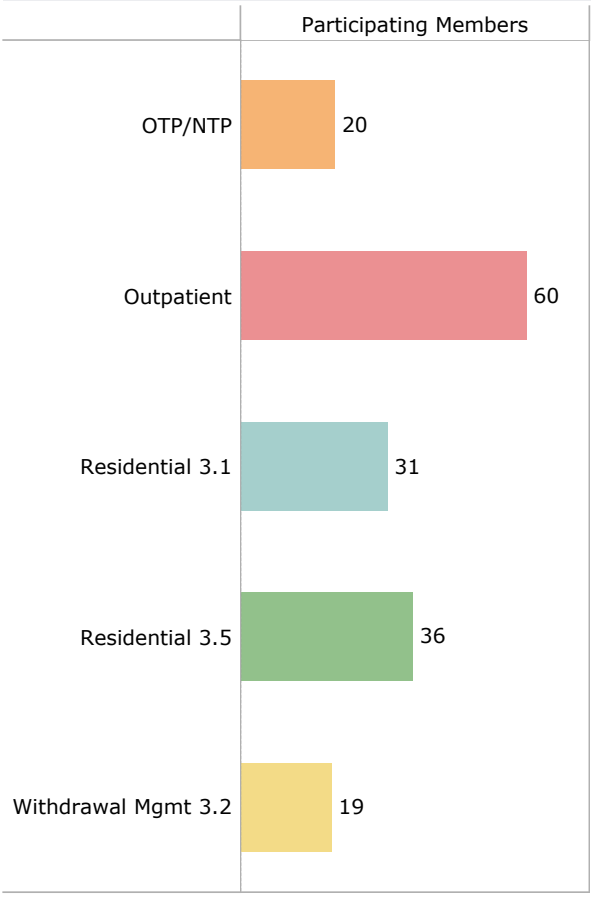
Service date
6/30/2021 to 8..

View by Members/ Total Visits
Participating Members

By County



By Level of Care



By County and By Level of Care

Mbr County	Level of Care	Participati..
HUMBOLDT	Intensive Outpatient	
	None	
	OTP/NTP	20
	Outpatient	60
	Residential 3.1	31
	Residential 3.5	36
	Withdrawal Mgmt 3.2	19
LASSEN	Intensive Outpatient	1
	Outpatient	2
	Residential 3.1	3
	Residential 3.5	
	Withdrawal Mgmt 3.2	3
MENDOCI..	Intensive Outpatient	
	Outpatient	73
	Residential 3.1	28
	Residential 3.5	1
	Withdrawal Mgmt 3.2	9
MODOC	Intensive Outpatient	
	OTP/NTP	
	Outpatient	
	Residential 3.1	3
	Withdrawal Mgmt 3.2	
SHASTA	Intensive Outpatient	47
	OTP/NTP	320
	Outpatient	180
	Residential 3.1	87
	Residential 3.5	4
	Withdrawal Mgmt 3.2	16
SISKIYOU	Intensive Outpatient	4
	OTP/NTP	20
	Outpatient	6
	Residential 3.1	16
	Residential 3.5	
	Withdrawal Mgmt 3.2	1
SOLANO	Intensive Outpatient	9
	None	
	OTP/NTP	404
	Outpatient	63
	Residential 3.1	50
	Residential 3.5	
	Withdrawal Mgmt 3.2	36

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
All

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

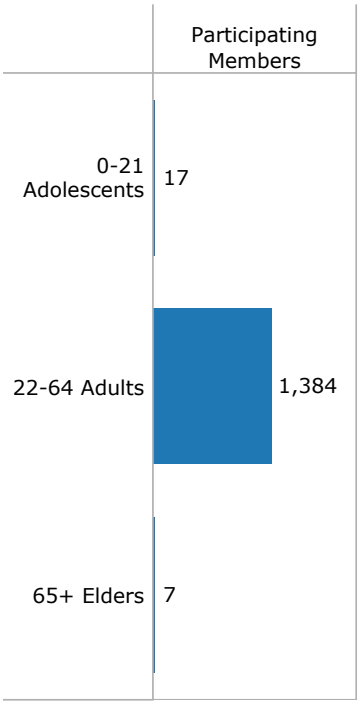
Mbr County
All

By Gender

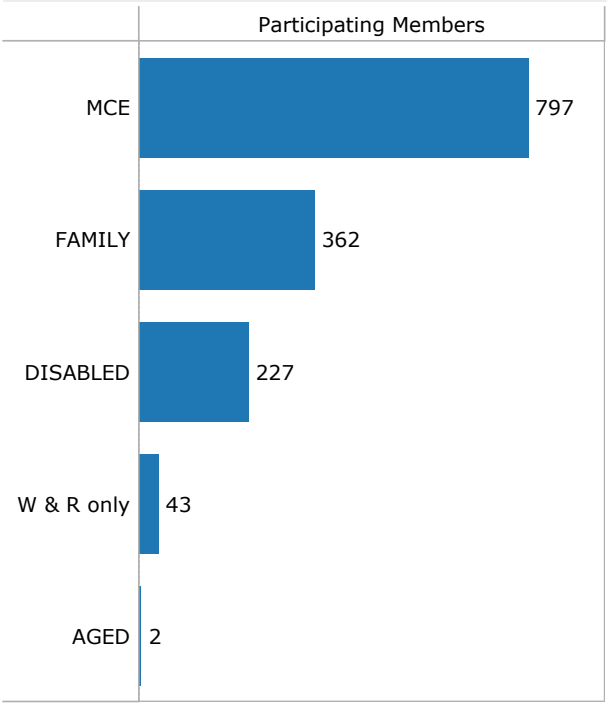
678
48.2%

729
51.8%

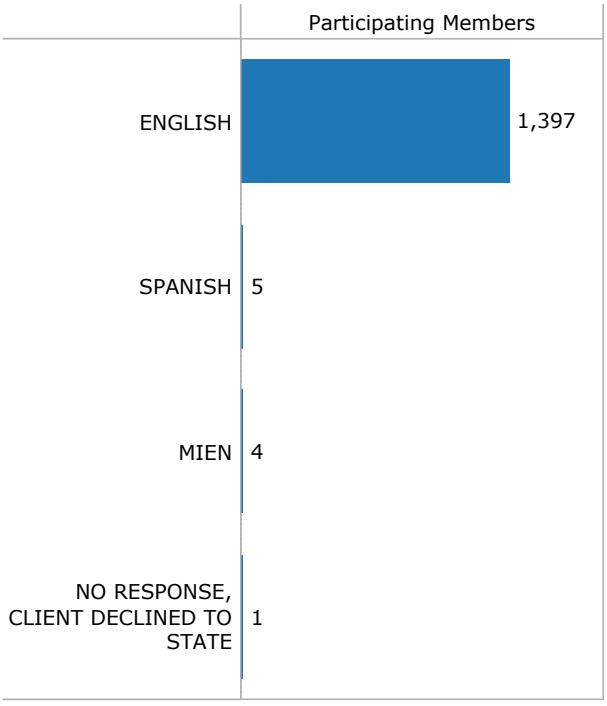
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	144,621	926
HISPANIC	71,676	118
OTHER	23,751	224
ASIAN/PACIFIC ISLANDER	20,009	20
BLACK	25,310	127

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
HUMBOLDT

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

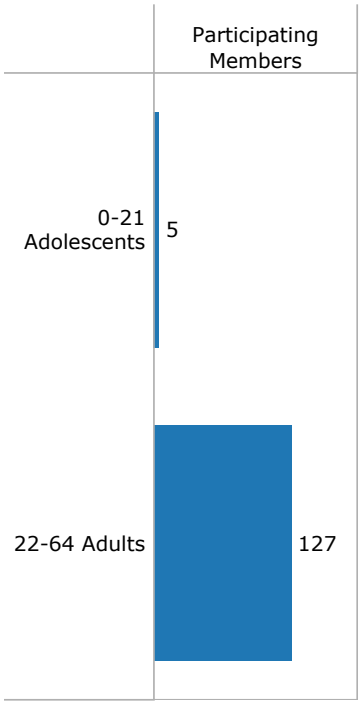
Mbr County
HUMBOLDT

By Gender

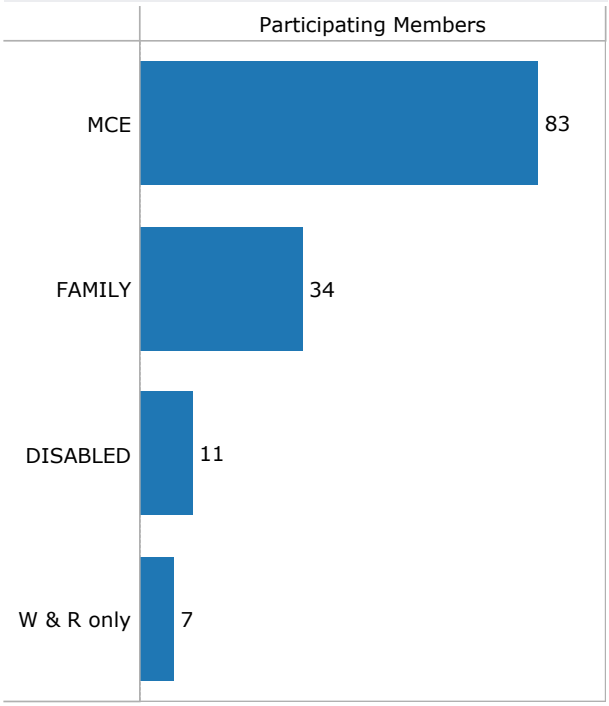

65
49.2%


67
50.8%

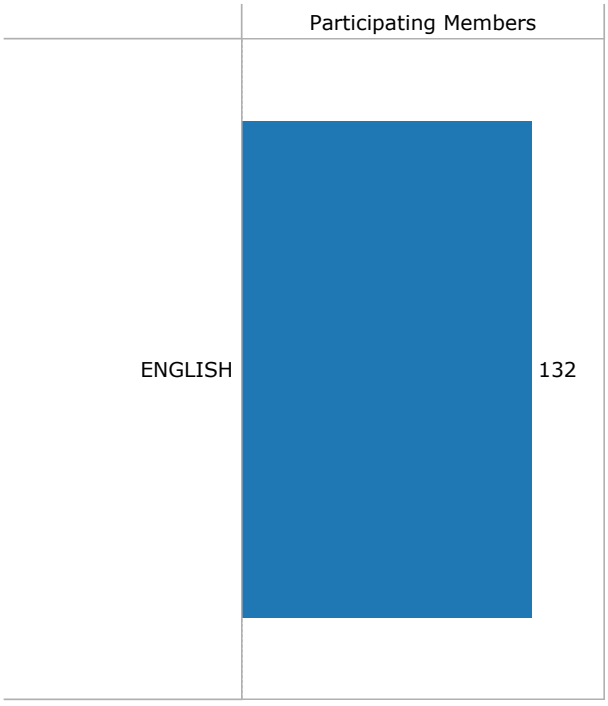
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	33,574	90
HISPANIC	8,069	11
OTHER	879	23
ASIAN/PACIFIC ISLANDER	1,763	1
BLACK	1,046	7

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
LASSEN

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

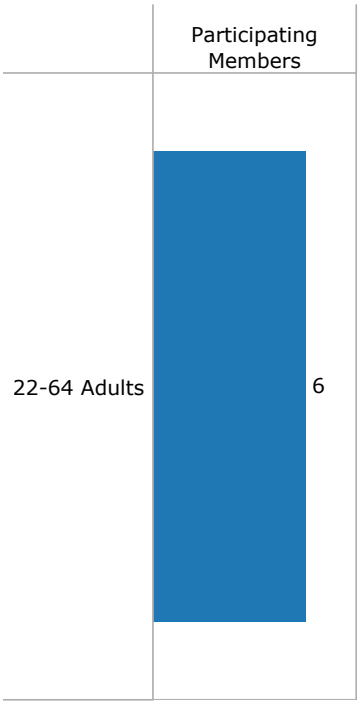
Mbr County
LASSEN

By Gender

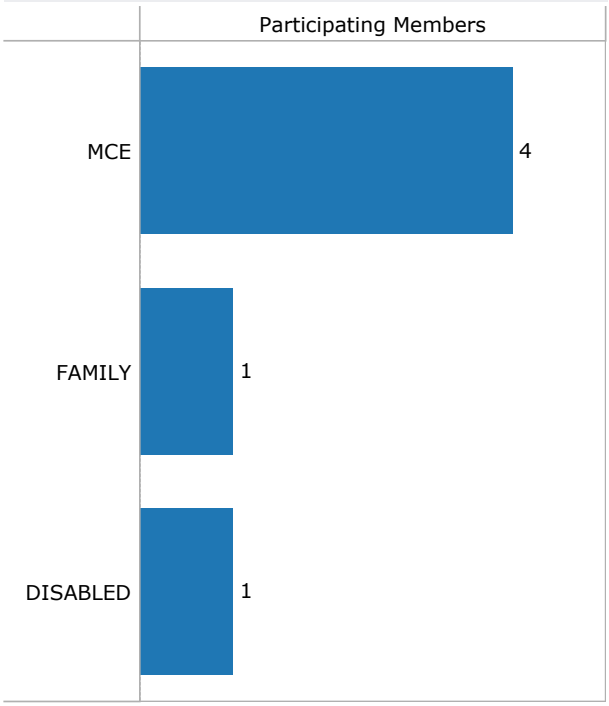
1
16.7%

5
83.3%

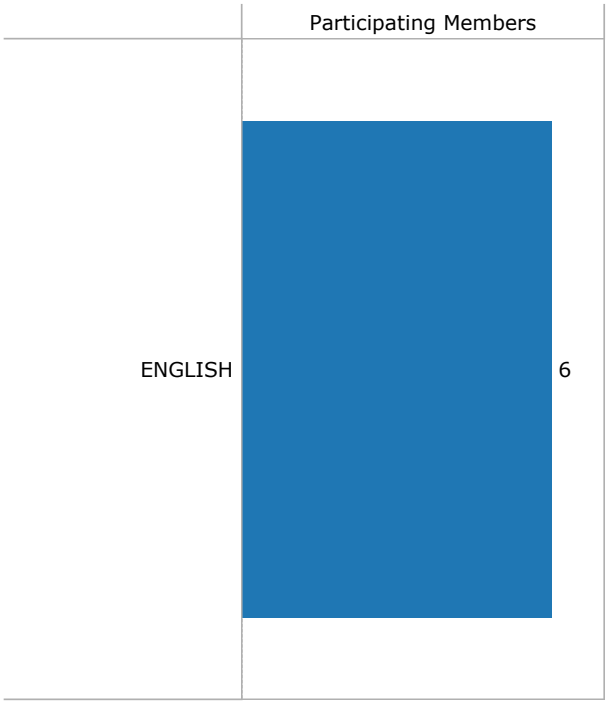
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	5,616	5
OTHER	84	1

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
MENDOCINO

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

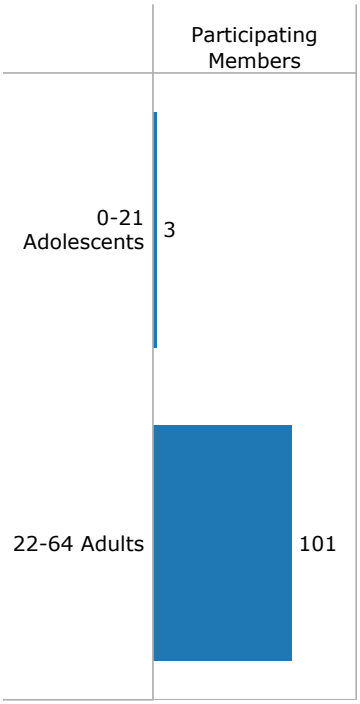
Mbr County
MENDOCINO

By Gender

46
44.2%

58
55.8%

By Age Group



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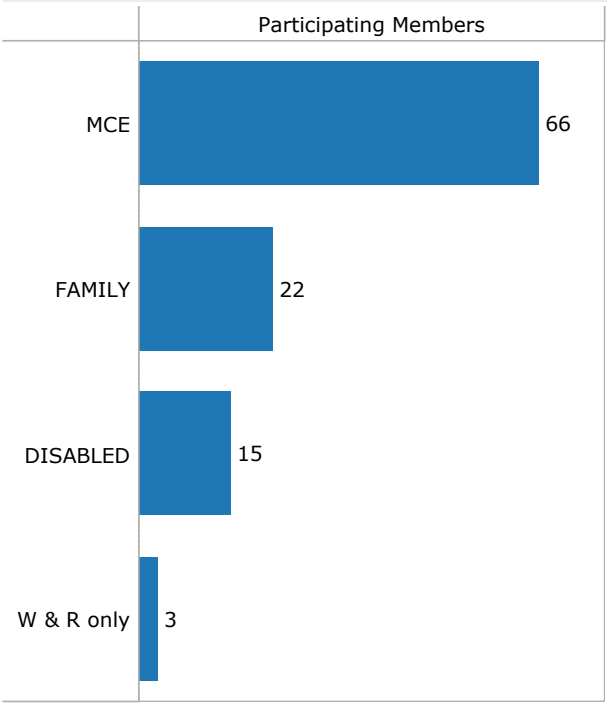
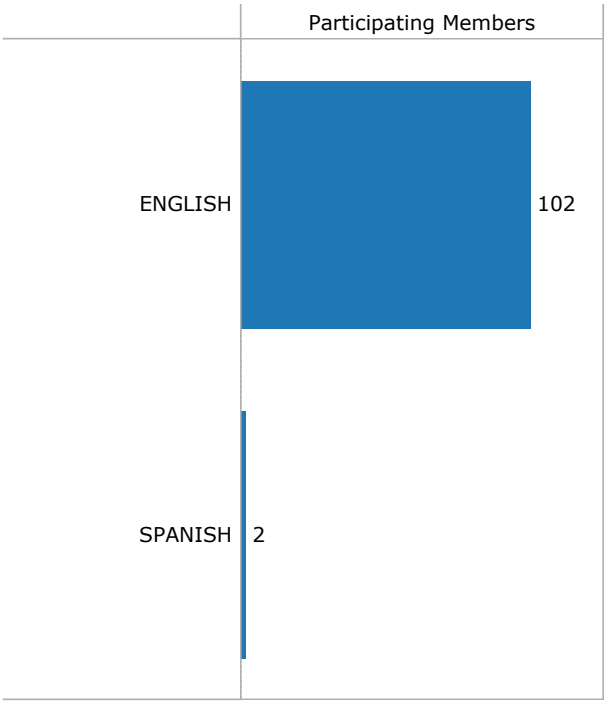


By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	20,165	74
HISPANIC	13,412	17
OTHER	450	11
BLACK	343	2

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
MODOC

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

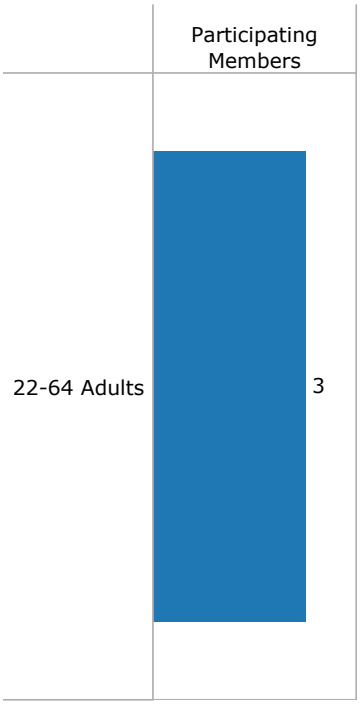
Mbr County
MODOC

By Gender

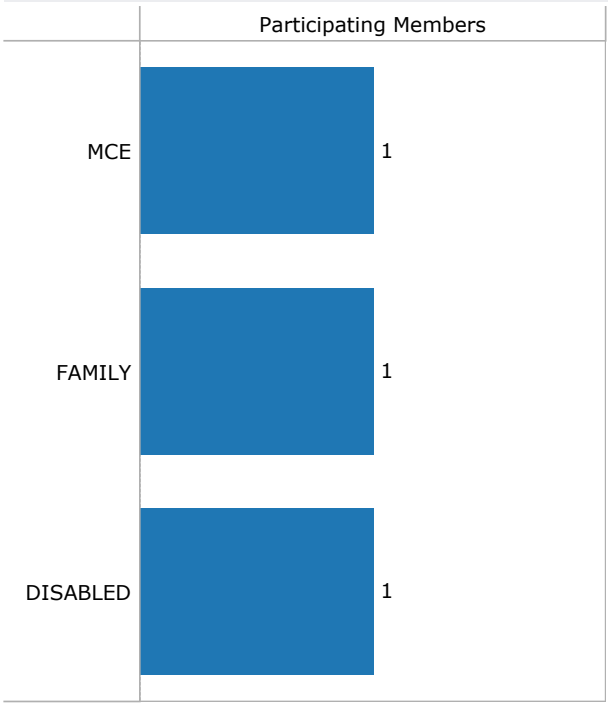

2
66.7%


1
33.3%

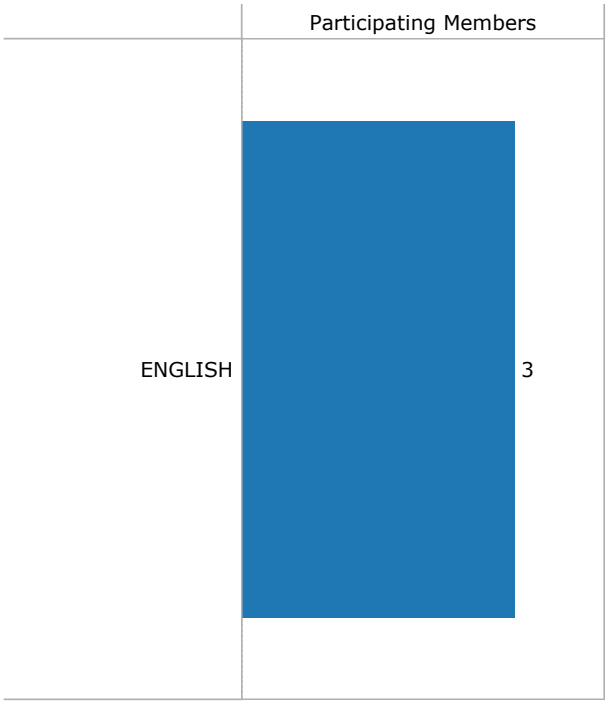
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	2,269	1
OTHER	20	2

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
SHASTA

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

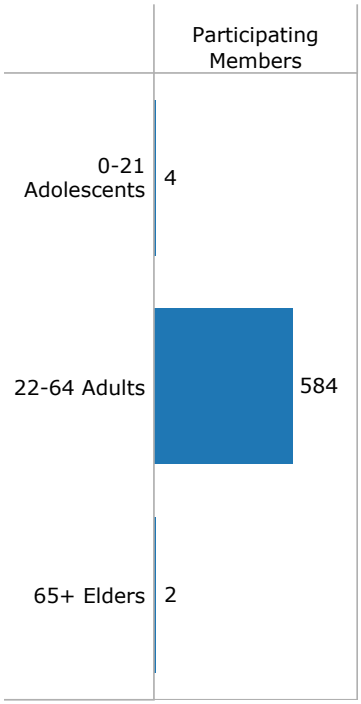
Mbr County
SHASTA

By Gender


262
44.5%


327
55.5%

By Age Group



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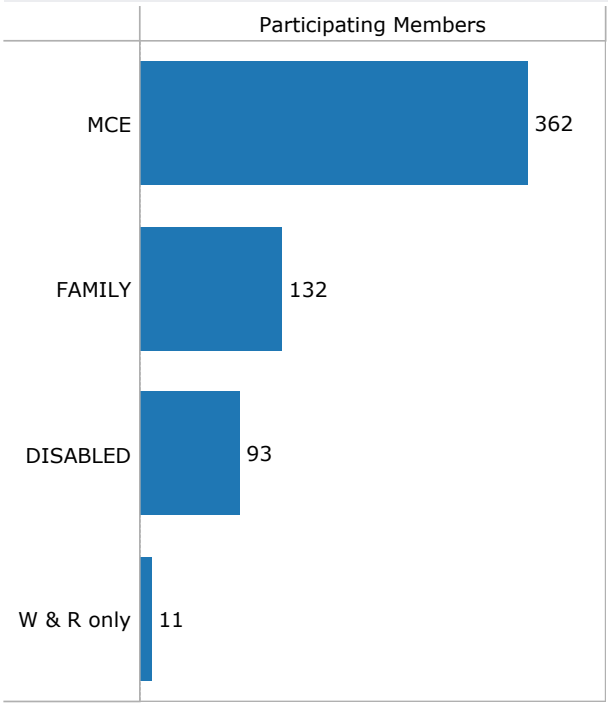
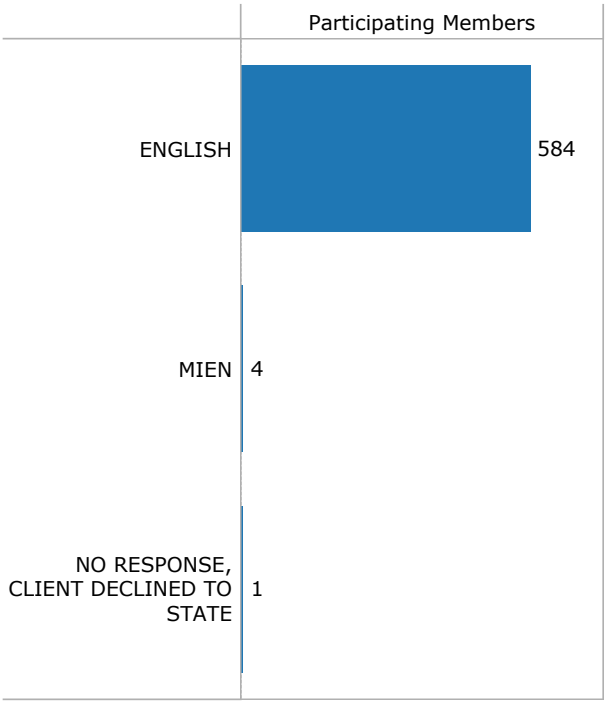


By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	45,585	488
HISPANIC	7,300	28
OTHER	768	54
ASIAN/PACIFIC ISLANDER	2,639	11
BLACK	1,080	9

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
SISKIYOU

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

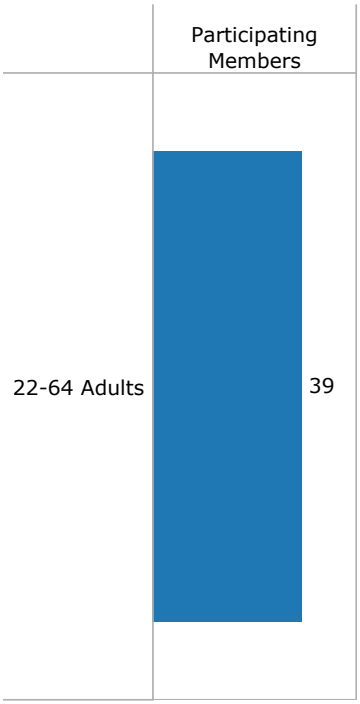
Mbr County
SISKIYOU

By Gender

19
48.7%

20
51.3%

By Age Group



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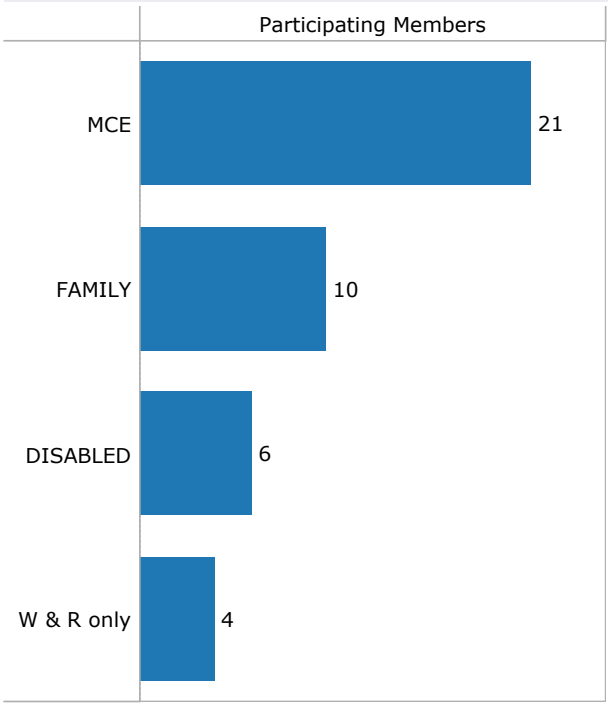
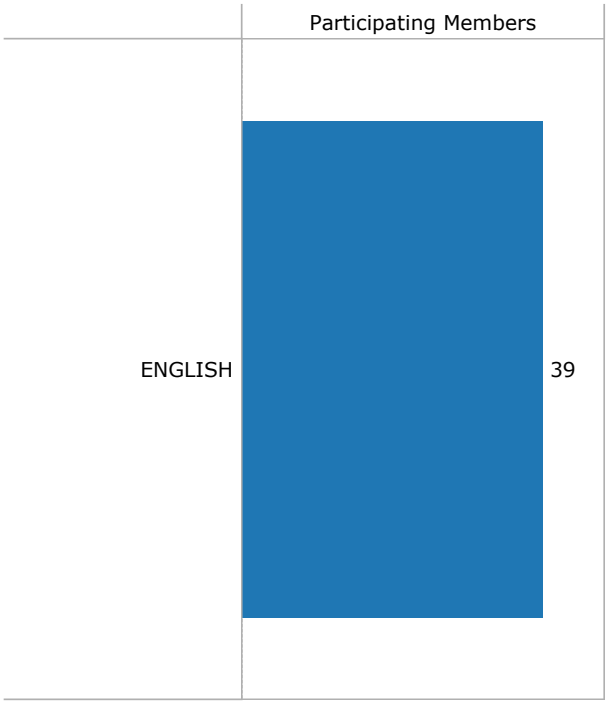


By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	12,367	31
HISPANIC	2,478	2
OTHER	340	6

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
SOLANO

Service date
7/2/2021 to ..

view by Members/ Total Visits
Participating ..

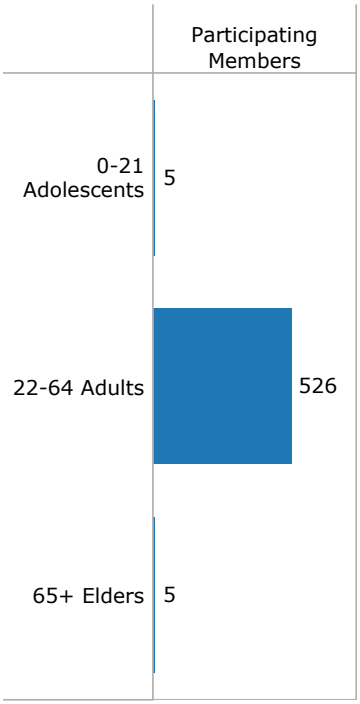
Mbr County
SOLANO

By Gender

284
53.0%

252
47.0%

By Age Group



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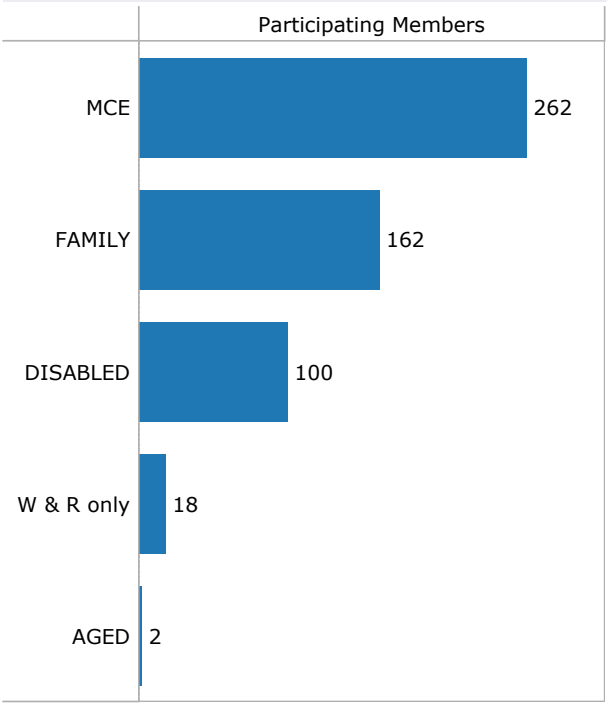
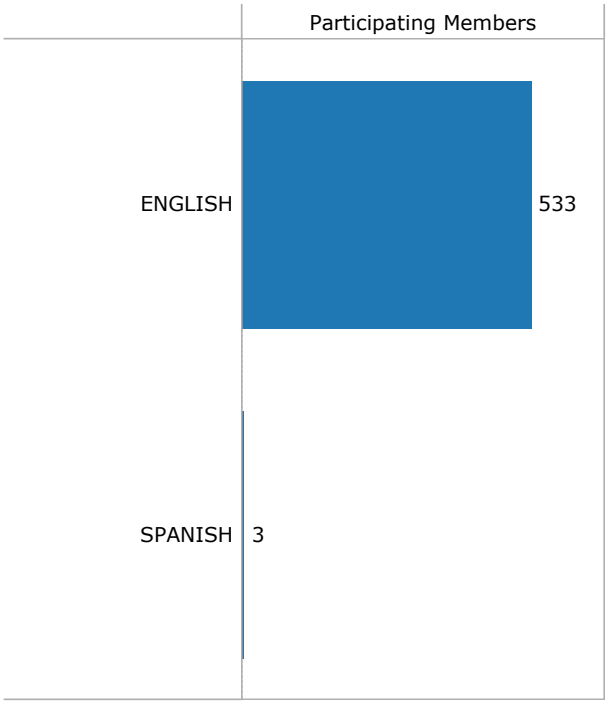


By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	25,045	238
HISPANIC	40,417	61
OTHER	21,210	127
ASIAN/PACIFIC ISLANDER	15,607	8
BLACK	22,841	109

Wellness and Recovery
2020-2021 YTD Referrals

Referral Outcomes

	YTD
Connected to Provider	1,580
Left Message for Provider	1,251
Other	394
Declined Referral	198
TOTAL	3,423

Referrals by Level of Care

Actual LOC	YTD
1.0 Outpatient	399
2.1 Intensive Outpatient	313
3.1 Residential (Low Intensity)	1,691
3.2 Withdrawal Mgmt (Res.)	834
3.5 Residential (High Intensity)	91
NTP/OTP	36
Other	59
TOTAL	3,423

Referrals by County

County of Resp	YTD
Humboldt	580
Lassen	51
Mendocino	454
Modoc	47
Shasta	1,080
Siskiyou	223
Solano	988
TOTAL	3,423

Wellness and Recovery Overview of Paid Claims by Member County

This dashboard tracks health services by Wellness and Recovery program across the participating counties. Data gathered from paid claims.

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

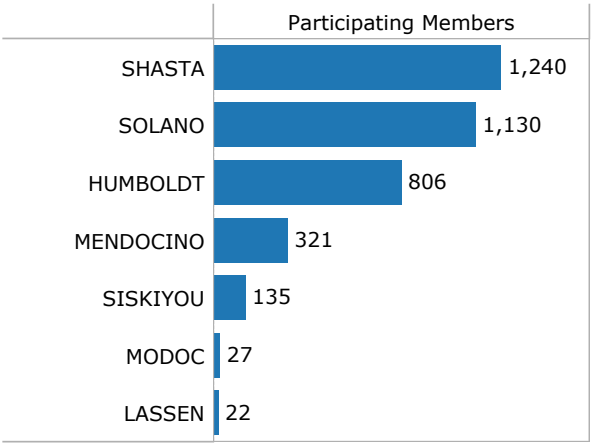
by: Revanth Kasireddy

7/1/20 to 6/1/21	9/13/21	3,653	142,976
Service Date	Max Paid Date	Total participating Members	Total Visits

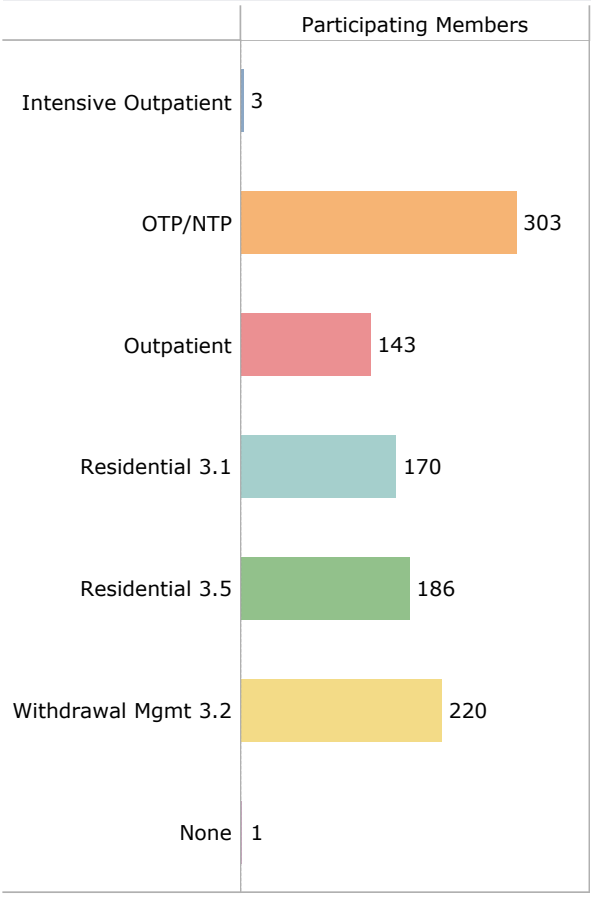
Service date
7/1/2020 to 6/..

View by Members/ Total Visits
Participating Members

By County



By Level of Care



By County and By Level of Care

Mbr County	Level of Care	Participati..
HUMBOLDT	Intensive Outpatient	3
	None	1
	OTP/NTP	303
	Outpatient	143
	Residential 3.1	170
	Residential 3.5	186
	Withdrawal Mgmt 3.2	220
LASSEN	Intensive Outpatient	
	Outpatient	2
	Residential 3.1	19
	Residential 3.5	1
	Withdrawal Mgmt 3.2	6
MENDOCI..	Intensive Outpatient	5
	Outpatient	220
	Residential 3.1	113
	Residential 3.5	16
	Withdrawal Mgmt 3.2	61
MODOC	Intensive Outpatient	3
	OTP/NTP	2
	Outpatient	16
	Residential 3.1	16
	Withdrawal Mgmt 3.2	2
SHASTA	Intensive Outpatient	157
	OTP/NTP	485
	Outpatient	536
	Residential 3.1	334
	Residential 3.5	22
	Withdrawal Mgmt 3.2	71
SISKIYOU	Intensive Outpatient	8
	OTP/NTP	24
	Outpatient	51
	Residential 3.1	58
	Residential 3.5	6
	Withdrawal Mgmt 3.2	16
SOLANO	Intensive Outpatient	80
	None	9
	OTP/NTP	645
	Outpatient	203
	Residential 3.1	225
	Residential 3.5	1
	Withdrawal Mgmt 3.2	176

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 9/21/2021 6:30:39 AM

Health Analytics

by: Revanth Kasireddy

County:
All

Se v ed a e
7/1/2020to..

view by Members/ Total Visits
Participating ..

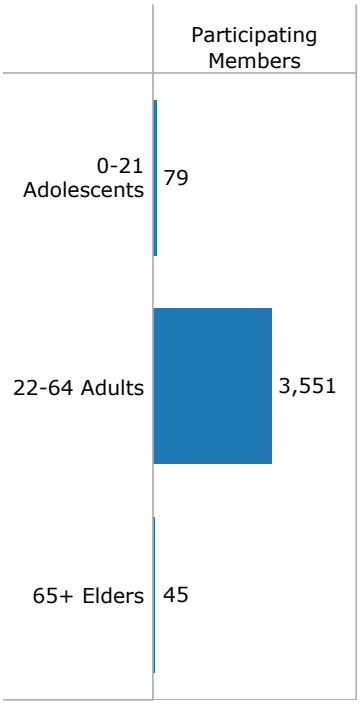
Mbr County
All

By Gender

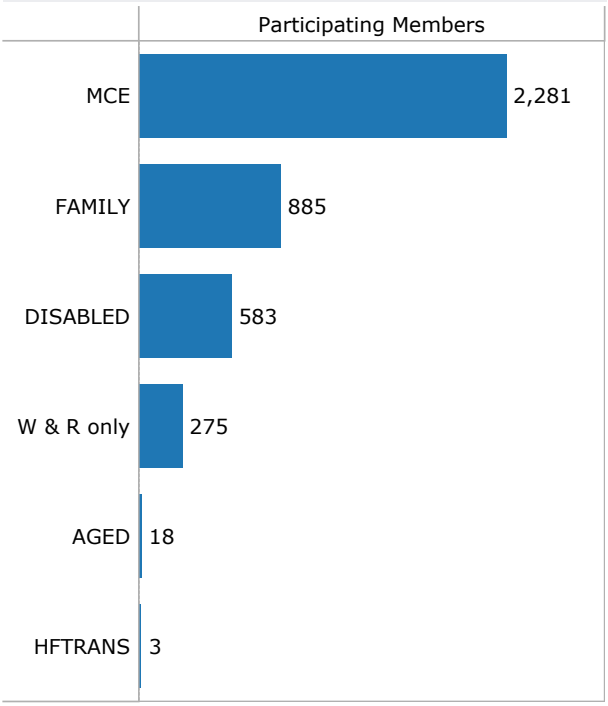
1,704
46.5%

1,963
53.5%

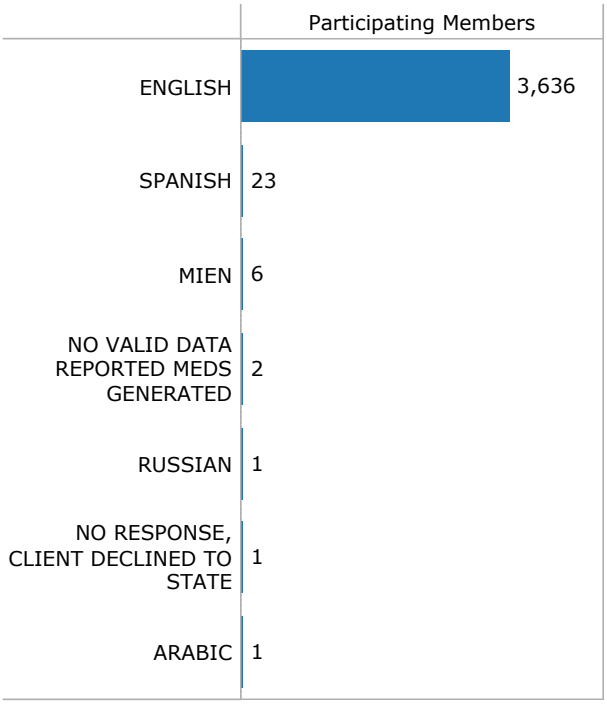
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	144,621	2,497
HISPANIC	73,445	321
OTHER	23,751	640
ASIAN/PACIFIC ISLANDER	21,178	54
BLACK	25,863	300

GRIEVANCE & APPEALS
Pulse Report

Our Mission:

To help our members, and the communities we serve, be healthy

G&A PULSE REPORT

ISSUE 3 | SEPTEMBER 2021

INSIDE THIS ISSUE

Welcome to our third issue of the Grievance and Appeals (G&A) PULSE Report! The purpose of this report is to provide objective updates to all stakeholders regarding trending disruptions that members experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings.

In this issue, we provide a mid-year update of member dissatisfaction as it relates to NCQA categories. The purpose is to gauge how members are experiencing their health plan. This is a preview before the annual report is released in February 2022. See the NQCA sections detailing our findings on pages 9-13.

Partnership HealthPlan of California (PHC) is committed to member satisfaction. When members understand their PHC Medi-Cal benefits, understand how to access services, and the service meets their expectations, we believe members are likely to seek care and maintain their health. We invite all members to share their concerns or challenges. This information will be used to help remove potential barriers. We take great pride in the trust members have in us to resolve their concerns.

*Fluctuations in data can happen. Therefore, statistics included in this report are reported at a 95% confidence level.

2Q21 TRENDS

THE NUMBERS

There were 1,024 cases investigated in 2Q21, a 10% increase over last quarter. All but 8 cases were completed within DHCS/NCQA time frames. Of note, there was about a 30% increase in Appeals. One CCS-related State Hearing was lost. See page 7 for more details.

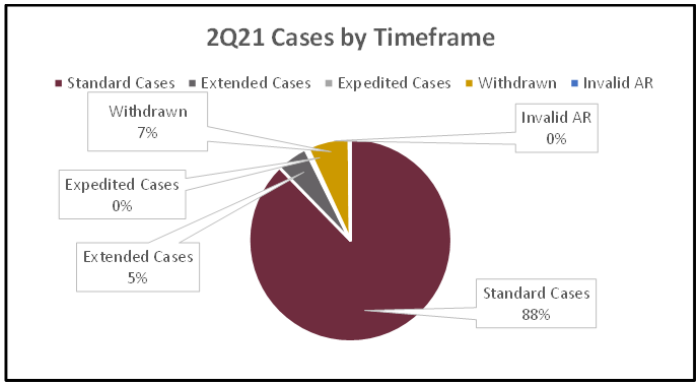
NOTEWORTHY TRENDS

Long Wait Times – We received 59 cases where members reported issues regarding long wait times. This is an increase from 1Q21, in which we received only 30 cases of long wait times. In 2Q21, most of these issues were due to members needing to establish care before receiving a referral to a specialist. Other concerns reported were related to difficulty scheduling appointments or cancellations.

Treatment Plan Disputes – Members reported dissatisfaction with their provider's plan of treatment in 169 cases, accounting for 16.5% of the total cases this quarter. This is the second most reported concern in 2Q21. Updates to G&A's reporting system in the first quarter enabled us to drill the data down further and identify the cause for each reported concern. The most commonly reported category within treatment plan disputes was related to medications. These concerns include disagreements of the medications prescribed by a doctor and doctors not prescribing medications the members feel they require. After investigation, we found the provider was not at fault in 75% of the reported concerns.

Poor Attitude – This quarter we investigated 102 cases involving members reporting poor attitude

from a provider. This is almost a 50% increase from last quarter. Twenty-five percent (25%) of the cases reported in this category correlate with discrimination allegations. When members reported discrimination allegations, most reported perceived rudeness from their doctor. Lastly, a notable number of cases are related to COVID-19. Members reported dissatisfaction with providers' attitude when discussing restrictions due to COVID-19.

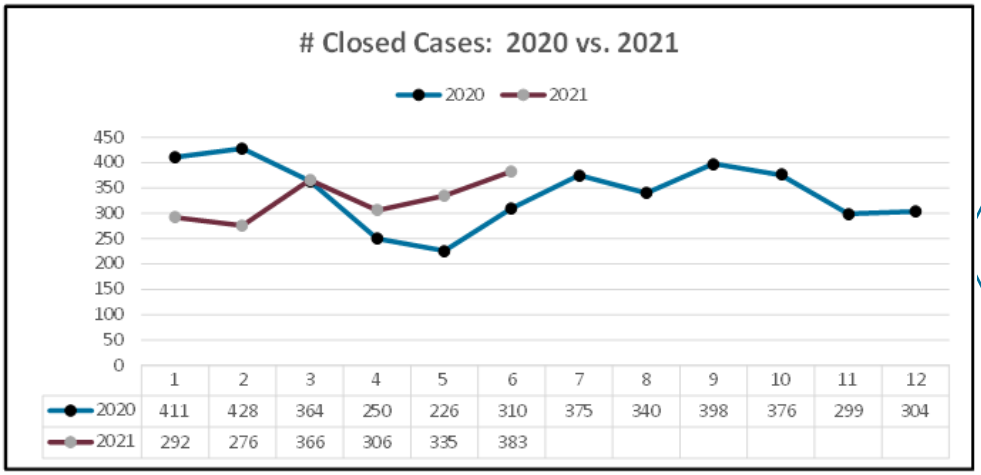


2Q21 TOTAL # INVESTIGATED CASES		
Case Type	# Cases	% Grand TTL
Grievance	631	61.6%
Exempt	178	17.4%
Appeal	171	16.7%
State Hearings	29	2.8%
Grievance-2nd Level	15	1.5%
Grievance-Invalid AR	0	0.0%
Grand Total	1,024	100.0%

KEY STATISTICS

CHARTS OF KEY REPORTING TRENDS

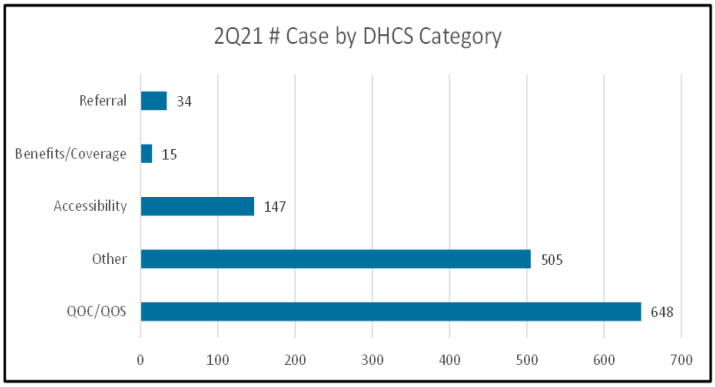
The following charts represent key data metrics used to track and trend Appeals, Grievances, Second Level Grievances, and State Hearings over time.

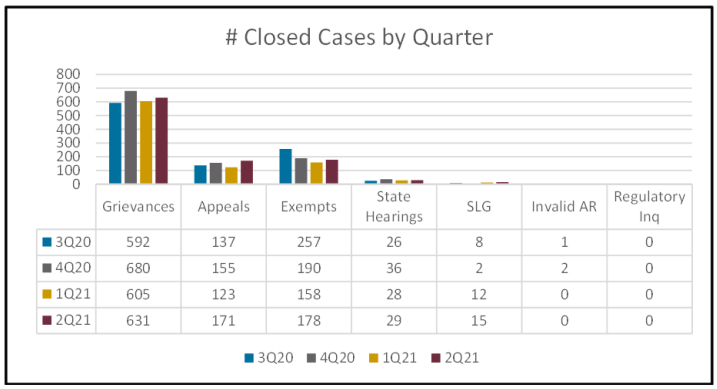


	1	2	3	4	5	6	7	8	9	10	11	12
2020	411	428	364	250	226	310	375	340	398	376	299	304
2021	292	276	366	306	335	383						

"I want to thank Marissa and her team for doing everything they possibly could to resolve my issue."

-PHC member

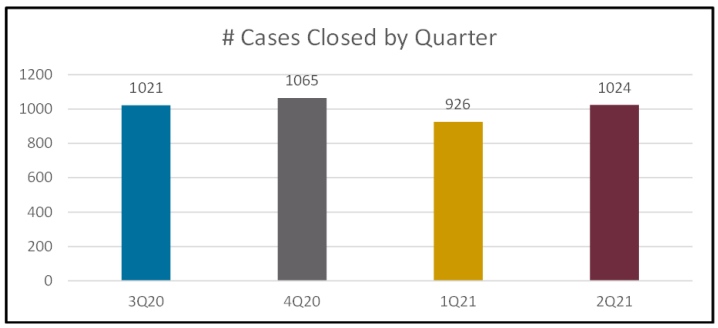


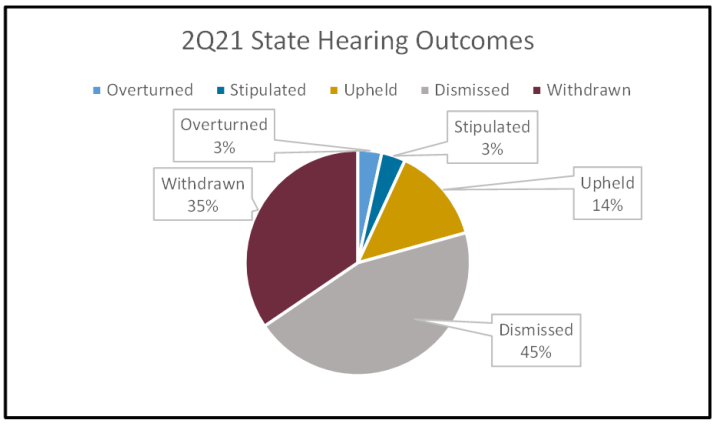


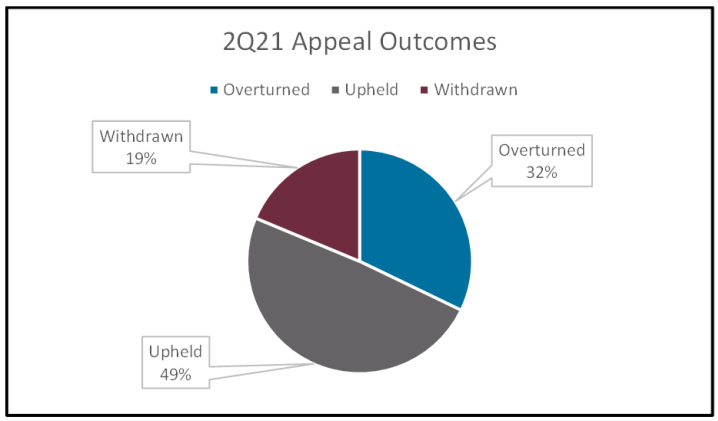
	Grievances	Appeals	Exempts	State Hearings	SLG	Invalid AR	Regulatory Inq
3Q20	592	137	257	26	8	1	0
4Q20	680	155	190	36	2	2	0
1Q21	605	123	158	28	12	0	0
2Q21	631	171	178	29	15	0	0

3Q20 4Q20 1Q21 2Q21

2Q21 Total State Hearings & Appeals	
State Hearings	29
Appeals	171







DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

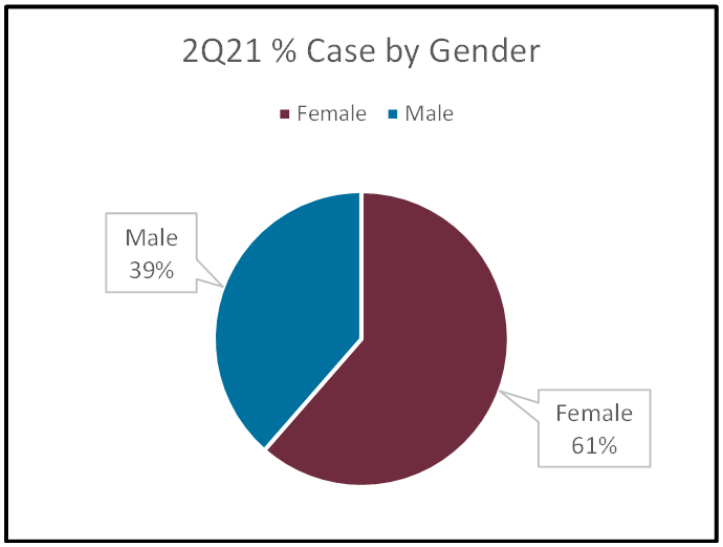
The following charts represent key demographic data of members who filed an Appeal, Grievance, Second Level Grievance, or State Hearing during 2Q21.

2Q21 % CASES BY AGE	
MBR Age	% Cases
Age 0-17	10.55%
Age 18-45	31.05%
Age 46-65	46.19%
Age 66-100	12.21%
Grand Total	100.00%

2Q21 % CASES BY ETHNICITY	
MBR Ethnicity	% Cases
White	58.01%
Other	16.89%
Hispanic	14.84%
Black (African American)	6.84%
Alaskan Native or American Ind	1.17%
Filipino	0.98%
Other Asian	0.59%
Asian Indian	0.39%
Korean	0.20%
Hawaiin	0.10%
Grand Total	100.00%

2Q21 % CASES BY LANGUAGE	
MBR Language	% Cases
English	93.26%
Spanish	5.96%
Unknown	0.29%
Armenian	0.20%
American Sign Language	0.10%
Farsi	0.10%
Russian	0.10%
Grand Total	100.00%

Hispanic members represented 14.84% of the members filing grievances in 2Q21. This is an increase from 9.29% in 1Q21.



2Q21 % CASES BY MBR COUNTY	
MBR County	% Cases
Solano	18.16%
Shasta	14.26%
Humboldt	12.01%
Sonoma	11.43%
Yolo	8.50%
Marin	8.30%
Lake	7.32%
Mendocino	5.66%
Siskiyou	4.20%
Napa	4.20%
Del Norte	2.15%
Modoc	1.66%
Lassen	1.46%
Trinity	0.68%
Grand Total	100.00%

PHC membership rose by 7,370 members in 2Q21

W&R RELATED

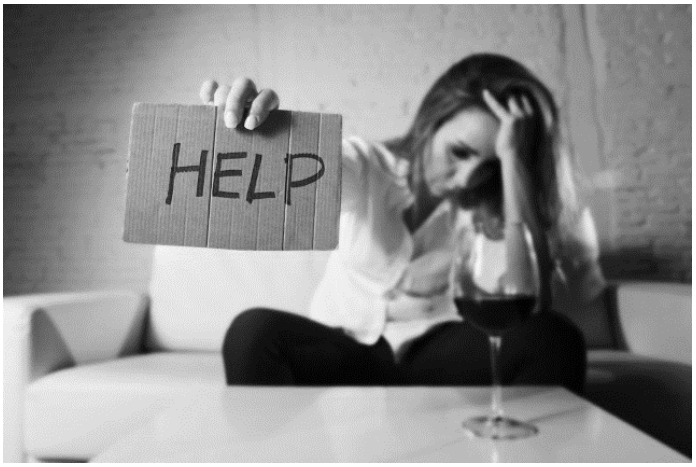
AN OVERVIEW OF THE PROCESS

The Wellness & Recovery (W&R) benefit offers PHC members and non-PHC members substance use treatment services for those struggling with drug and/or alcohol additions. The benefit is available to persons in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties.

TRENDING STATISTICS & ISSUES

There were 16 new W&R cases reported in 2Q21, accounting for 1.5% of all new cases. The most commonly reported concerns were access to care and interpersonal relationship issues. The access to care issues were related to a lack of available substance use disorder services. For interpersonal relationship issues, these concerns included allegations of discrimination and poor provider service.

Regarding discrimination, this is a new trend identified this quarter that has not previously been reported. Four (4) cases included alleged discrimination. The most commonly reported category of discrimination for these cases was disability.



DHCS REPORTING

The Department of Health Care Services (DHCS) requires quarterly reporting of W&R cases. The three tables below provide the number of W&R cases and the case category reported to DHCS by PHC. Access to Care was the highest reported category for 2Q21. Since the implementation of the W&R benefit, PHC has not received any Appeals or State Hearings.

2Q21 W&R Cases	
# Total New Cases	13
# of Received Grievances	13
# of Received Appeals	0
# Total Closed Cases	9
# of Grievance Resolutions	9
# of Appeal Resolutions	0

2Q21 DHCS Appeal Outcomes	
Appeal Resolution Outcomes	
# of Appeals Resolved in Favor of PHC	0
# of Appeals Resolved in Favor of Member	0

2Q21 DHCS Grievance Categories	
Access to Care	5
Quality of Care	1
Program Requirements	0
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	4
Other	3

CCS RELATED

TRENDING STATISTICS

There were 27 total CCS-related cases in 2Q21. This represents 2.6% of the 1,024 cases. The 27 cases consisted of 14 Grievances, 12 Appeals, and one (1) State Hearing.

TRENDING ISSUES

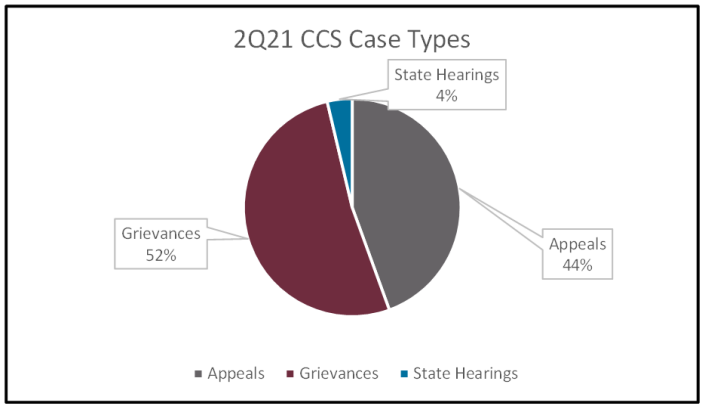
A notable trend identified, accounting for 50% of the Grievances, was regarding Medical Transportation Management (MTM). In these cases, members reported dissatisfaction with MTM's customer service, gas mileage reimbursement (GMR) process, and unsafe drivers. Other issues reported were regarding miscommunication with providers and disagreeing with provider's treatment plans.

Regarding CCS-related Appeals, five (5) of the Appeals were disputing medications. After investigation and review by a PHC Medical Director, four (4) of the cases remained upheld. The remainder of the Appeals were regarding GMR, diabetic supplies, inpatient rehabilitation, and a request to see an out-of-network provider. Of the remaining seven (7) Appeals, four (4) were approved in whole or in part, two (2) were withdrawn by the member because services were already approved, and one (1) was upheld by a PHC Medical Director due to lack of medical necessity.

LOST STATE HEARING

There was one (1) State Hearing overturned by an Administrative Law Judge (ALJ) from the Department of Social Services. The member was diagnosed with several serious conditions including spastic quadriplegic cerebral palsy, autism, seizures, and global developmental delays. The member is non-ambulatory and requires care around the clock. The Member's mother requested a Sleep Safe bed to keep the child safe at night. Although PHC found the

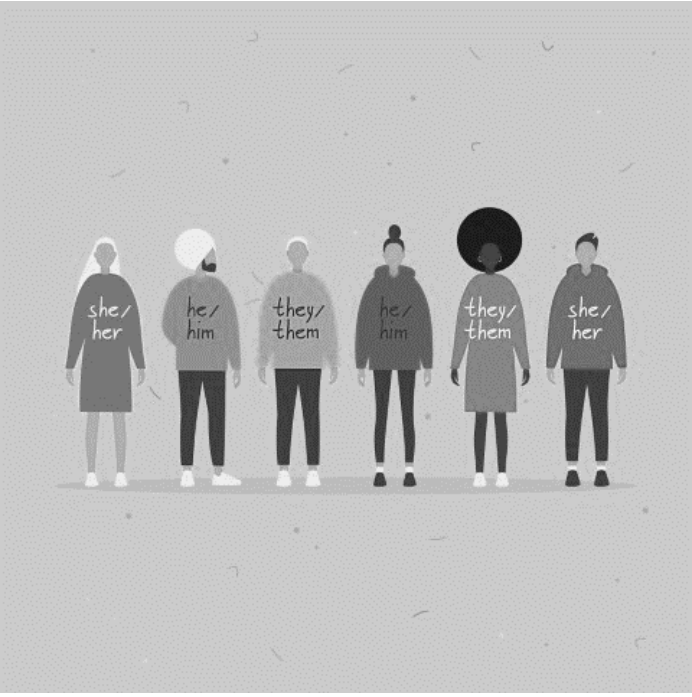
Sleep Safe bed was not medically necessary; the ALJ ruled the bed was medically necessary under the Medi-Cal criteria for Pediatric Beds and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program due to the nature and severity of the member's illness.



DISCRIMINATION AGAINST CCS MEMBERS

PHC takes a distinct look at cases to identify discrimination allegations. There was one discrimination case filed by a CCS member during this quarter. In this case, the member alleged discrimination due to PHC seeking the lowest cost services. After investigation, it was determined the allegation was not covered under civil law rights.

DISCRIMINATION



DISCRIMINATION CATEGORIES

PHC recognizes federal and state civil rights laws. Certified Civil Rights Coordinators investigate all allegations or suspensions of discrimination. There are 16 categories protected by federal and state civil rights laws; age, disability, basis of sex, gender, gender Identity, gender expression, sex stereotypes, sexual orientation, nationality, race or ethnicity, religion, language assistance services, limited English proficiency, group or character associations, auxiliary aids services, and genetic Information.

2Q21 DISCRIMINATION NUMBERS

There were 45 cases of alleged discrimination reported this quarter. This represents 4.4% of all cases. Of the 45 cases, 17 fell under one of the federal or state civil rights laws. Investigations found that discrimination likely occurred in eight (8) cases. These are the most serious cases and DHCS mandates they are reported to the Office of Civil Rights. A breakdown of the eight (8) cases found that in five (5) cases discrimination likely occurred by unlicensed office staff at provider offices. The other three (3) cases found discrimination likely occurred by a doctor.

2Q21 DISCRIMINATION TRENDS

The most commonly reported violation of a civil rights law was race, which was reported in nine (9) cases. Other reported violations include disability, religion, and sex.

Regarding race, examples of Grievances received include members reported being treated differently because of the color of their skin. Additionally, members reported differential treatment due to their ethnicity. Of the cases categorized under race, six (6) were found that discrimination was probable.

Regarding disability, most members reported a lack of care due to their mental or physical disability.

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by PHC's Grievance Registered Nurse team. A list of cases that were not previously reviewed by a PHC Medical Director is forwarded to PHC's Chief Medical Officer (CMO), of which a sample size is selected and evaluated. After review by the CMO, the cases are further reviewed by the Director of G&A. A final review then occurs with the Compliance Manager and Quality & Training Supervisor to identify opportunities for operational improvements.

THE RESULTS

The 2Q21 IRR results are still under evaluation, however, the 1Q21 results are available. A sample size of 21 cases was evaluated by the CMO. All cases were correctly classified as clinical or non-clinical by NCQA standards. However, other opportunities were identified. First, the Member Handbook should be more regularly cited as a point of reference in the resolution letters. A second opportunity is to ensure Care Coordination is engaged when members report a disruption in their continuity of care (COC) plans.

G&A leadership identified three (3) other improvement opportunities. First, we should continue efforts to improve on a thorough investigation methodology to ensure the case resolution addresses all of the member's concerns. Second, we should ensure a Second Level Grievance (SLG) is an independent investigation from the initial grievance and does not rely on the outcome of the original grievance. Third, beyond the initial acknowledgment call, employees should engage in additional attempts to contact the member if more information is needed to investigate their concerns. Lastly, a

SLG process should be implemented for discrimination cases. Traditionally, providing members the right to file a SLG has been reserved for denied Standard Grievances. However, leadership discovered the need to establish a process to handle SLGs involving alleged discrimination.

TIMELINESS

DHCS requires PHC to investigate cases within specific investigation Turnaround Times (TAT), ranging from 72 hours to 44 days. If a member's health, life, or limb is in immediate danger, the case must close within 72-hours. If not, the case must be investigated within 30-calendar days. A 14-day extension is allowed if the additional time benefits the member. DHCS also requires PHC to acknowledge receipt of a member's case by mail by the fifth calendar day.

For 2Q21, there were eight (8) late cases out of 817 cases subject to DHCS-TAT. Most of the late cases were due to cases being sent to an inoperable mailbox that resulted in cases being routed to G&A for processing after 30-days. There were also 12 late acknowledgment letters this quarter, some of which were due to the misrouted cases. The remainder of the late acknowledgement letters were due to internal processing errors.

2Q21 Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.0%	8	99.2%	
Ack-Letters	98.0%	12	98.8%	

MEMBER EXPERIENCE

REPORTING PERIOD

This section covers mid-year trends in member dissatisfaction. In this issue, we compare January 1, 2021, through June 30, 2021, against all of 2020.

DEFINING THE METRICS OF SUCCESS

PHC tracks member dissatisfaction through Appeals, Grievances, and Second Level Grievances. These unique case types provide key data points G&A can use to ensure favorable member satisfaction survey results through planning and adaptation.

Every year, PHC surveys our members to assess their overall satisfaction with their PHC Medi-Cal plan. General surveyed areas are:

- Getting care quickly
- Getting needed care
- Quality of provider's communication
- Customer service
- Claim processing

NO CURRENT THRESHOLD FINDINGS

NCQA categorizes cases in terms of access, attitude/service, billing/financial, quality of care, or quality of practitioner office. All cases are reviewed and categorized into one of the five categories. We monitor the categories from year-to-year for any notable increases. When a 10% increase is detected, this triggers a threshold indicator to flag a category as 'not met'. In this reporting period, there were no significant increases in member dissatisfaction from 2020 when related to Grievances only. The Grievances received this period equate to 56.3% of all Grievances reported in 2020.

An analysis of the data suggests that by the end of 2021, access, quality of provider office, and attitude/service may exceed the 10% threshold.

Appeals and Second Level Grievances filed this reporting period make up 45% of the 2020 volume. Despite the overall reduction in these case types, there was a slight increase in cases related to attitude/service. Cases increased from 20 cases in 2020 to 25 in this reporting period. G&A anticipates the threshold will be exceeded because of this increase. Please refer to the Supplemental PULSE Reports titled NCQA ME.7 Member Experience Threshold Report for more information.

DRIVERS AND OPPORTUNITIES

The three most frequently reported concerns were communication, poor attitude, and treatment plan disputes. All three of these fall under the NCQA category of attitude/service.

These communication issues were reported when members did not feel they were fully educated on the plan for their treatment. Concerns about poor attitude included mistreatment by doctors, nurses, or office staff. We also continue to see ongoing concerns regarding treatment plan disputes. One example of a treatment plan dispute is when a member disagrees with the course of their treatment. Ultimately, all cases are thoroughly reviewed by PHC's clinical staff to ensure our members are being provided the highest quality of care and the best chance at a successful health outcome.

THE UM EXPERIENCE

REPORTING PERIOD

This section highlights trends from January 1, 2021, to June 30, 2021, and compares them against all trends in 2020.

OVERVIEW

Members may file an Appeal when they are unhappy that a benefit or service has been denied. Once an Appeal is filed, PHC reviews our original decision to consider if we can partially or fully approve the request.

There are times when members are unhappy with the process to approve benefit requests. PHC works hard to make the authorization process create the smoothest experience possible for the member. This section reports our findings about members who encountered problems during the authorization or referral process.

DELAYED ACCESS TO SPECIALISTS

G&A received several cases regarding members' difficulty accessing care with specialists through the Referral Authorization Form (RAF) process. In this reporting period there were 44 cases regarding access issues. Specifically, members were most concerned with their RAF being delayed by their provider, which accounted for 59.1% of the access cases received. This is on pace to surpass the 45 access issues reported for 2020. We expect this will exceed the NCQA threshold by the end of 2021.

DISSATISFACTION WITH TAR PROCESS

Members can file a case if they feel their provider is not appropriately requesting a Treatment Authorization Request (TAR) for benefits or services that are not normally

covered under Medi-Cal. These are categorized as attitude/service issues. In this reporting period, we recorded 54 grievances, compared to 107 grievances in 2020. This category is potentially at risk for not meeting the threshold.

Members can also file a case if they are unhappy with PHC's decision to deny a TAR, which is classified in the billing/financial category.

A total of 53 billing/financial cases were reported in this period, compared to 104 cases reported in 2020. If case volumes continue to trend upward through 2021, we are at risk for not meeting the metric.

Generally, the most common complaints regarding TARs were for durable medical equipment (DME) at 40%, surpassing medication from 2020's billing/financial results.

# Reported Concerns With TAR Process	
Medication	17
DME	21
Ancillary	2
Diagnostic	11
Surgery	1
Other	1
Total	53

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2021, through June 30, 2021.

APPOINTMENTS

The PHC Medi-Cal Handbook defines timely access to care as the following:

Urgent Care	48 hours
Non-urgent: w/PCP	10 Business Days
Non-urgent: w/Specialist	15 Business Days
Non-urgent: w/Mental Health	10 Business Days
Non-urgent: w/Ancillary Service	15 Business Days
Telephone Wait Times	10 minutes

G&A regularly reviews member concerns regarding timely access to care. Typically, members are not aware of these timeframes until educated during the Grievance process. COVID-19 continues to have long-lasting effects across the health care system, as understaffing continues to affect wait times.

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – Members reported 23 concerns against their primary care provider (PCP) regarding access to appointments in person or by phone during this reporting period. Members expressed concerns about long wait times, telephone inaccessibility, or a provider refusing to see a member. Both Ole Health and Marin Community Clinic each had four (4) cases filed against of them. Southern counties accounted for 17 of these complaints, of which Solano and Marin County providers had the most filed cases.

Specialists – PHC approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists, orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure timely appointments are available for our members. The chief concern was appointment availability, as members had difficulty scheduling timely appointments.

MEETING CULTURAL & LINGUISTIC NEEDS

PHC monitors our provider network to ensure it meets the cultural, ethnic, racial, gender, and linguistic needs of our diverse membership. There were 14 reported cases filed against medical groups, individual doctors, or office staff. Nine (9) cases were filed against providers in the southern region counties and five (5) providers in the northern region counties. The most commonly reported problem remained alleged discrimination due to race or ethnicity. We did not identify any providers that had more than one case filed against them.

AGAINST PROVIDERS

REPORTING PERIOD

This NCQA Spotlight highlights trends discovered from January 1, 2021, through June 30, 2021.

OVERVIEW

NCQA's Credentialing and Recredentialing guideline, Standard 5, (a.k.a. CR5) focuses on identifying and acting on important quality and safety issues in a timely manner during the interval between formal credentialing. G&A does our part by tracking when a member alleges a concern against a provider. Those types of Grievances are assessed and given a Severity Rating 1 through 4. The severity levels are described as follows:

- *Level 1: General Service* – such as rudeness, attitude, problems scheduling appointments
- *Level 2:* Refusal or Barrier to Care – such as delayed/refused TAR or RAF, refused to see member
- *Level 3:* Potential Legal Risk – such as discrimination, HIPAA violation, alleged abuse, or fraud, waste, abuse (FWA)
- *Level 4:* Potential Quality Issue (PQI) – such as a missed diagnosis or treatment that did not follow standard of care

PHC's goal is to ensure all members receive high quality health care services. Therefore, cases with a Severity Rating of 4 receive increased oversight. After these cases are investigated through the G&A process, they are referred to our Quality Department for additional investigation of the provider. The result of a provider investigation may be escalated to PHC committees. The results of the Quality Department's investigation are confidential and only shared with the provider involved. This is protected by law under California Evidence Code 1157. Section 1157 of the California Evidence Code creates an exemption from discovery for proceedings and records of certain organized medical committees responsible for evaluating and improving the quality of care.

INDIVIDUAL PROVIDERS & OFFICE STAFF

NCQA requires specific oversight of individual providers and office staff. In this reporting period, 36 Grievances were filed against an individual provider. In 91.6% of the cases filed, providers had only one case filed against them. Severity Rating 1 was the most common rating given to 55.6% of all cases falling within this rating. Reported PQI cases dropped to five (5), down from nine (9) filed during the prior reporting period. The most common concerns were related to treatment plan disputes.

There were 18 cases filed against office staff. The most common concern was difficulty with scheduling appointments. Of all cases against office staff during this period, 39% began as alleged discrimination cases. Data analysis shows that alleged discrimination continues to be more likely to occur by office staff rather than by an individual provider.

Solano County Health Services had four (4) grievances filed against their providers and office staff, three (3) of which were referred to the Quality Department for review for PQI.

MEDICAL GROUP

G&A reviews cases filed against medical groups to ensure PHC's standard for quality of care is met. Marin Community Clinic continues to be an outlier, as previously reported. There are a myriad of concerns, including quality of care, attitude/service, access, discrimination, and PQI.

Continued on page 13

PHC is a non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC is available to Medi-Cal-qualifying residences in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

AGAINST PROVIDERS, CONT.

Also notable, there were seven (7) cases against Adventist Health, and five (5) cases against Ole Health.

For this period, 83 cases were filed against medical groups. Attitude/service issues made up 59% of all reported concerns, and included concerns such as needing to reschedule appointments due to a provider not reviewing the member's medical history. Access issues accounted for 26% of all concerns, with the most frequent complaint being that appointments are difficult to make within a reasonable timeframe. Cases identified as PQI increased from the prior reporting period from 4% to 11% and were referred to the Quality Department for further review.

HOSPITALS

During this reporting period, we saw some minor improvement in the number of cases reported against hospitals. The number of cases against hospitals fell from 17 cases in 2020 to 11 in the same reporting period. PQI cases remained steady at 35% of the concerns reported. Most concerns filed were service-related. The most common concern was dissatisfaction with the care or treatment received while in the hospital.

There was one case reporting alleged discrimination against a hospital. This is a change from the previous CR5 report, which did not report discrimination allegations against any hospitals.

CONTACT US

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Fairfield, CA 94534

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Redding, CA 96001

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

3Q21 Grievance and Appeals PULSE Report: Supplemental Data
NCQA ME.7: Member Experience Threshold Report
REPORTING PERIOD: 1/1/2020 - 12/31/2020 and 1/1/2021 - 6/30/2021
Mid-Year Report

ACCREDITED NCQA HEALTH PLAN

Grievances Only
Reporting Period: Annual 2020 vs. January-June 2021

	Previous Period: 2020			Current Period: Jan-June 2021				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	528	488,359	1.1	357	599,450	0.6	1.19	Yes
Attitude/Service	1,400	488,359	2.9	769	599,450	1.3	3.15	Yes
Billing/Financial	399	488,359	0.8	186	599,450	0.3	0.90	Yes
Quality of Care	80	488,359	0.2	39	599,450	0.1	0.18	Yes
Quality of Provider Office	7	488,359	0.0	7	599,450	0.0	0.02	Yes
TOTAL	2,414	488,359	4.9	1,358	599,450	2.3	5.44	Yes

Appeals & Second Level Grievances
Reporting Period: Annual 2020 vs. January-June 2021

	Previous Period: 2020			Current Period: Jan-June 2021				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	66	488,359	0.1	29	599,450	0.0	0.15	Yes
Attitude/Service	20	488,359	0.0	25	599,450	0.0	0.05	Yes
Billing/Financial	633	488,359	1.3	269	599,450	0.4	1.43	Yes
Quality of Care	0	488,359	0.0	0	599,450	0.0	0.00	Yes
Quality of Provider Office	0	488,359	0.0	0	599,450	0.0	0.00	Yes
TOTAL	719	488,359	1.5	323	599,450	0.5	1.62	Yes

Purpose of report: Grievance & Appeals evaluates Member Experience year-over-year to assess member dissatisfaction. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and intervention(s) maybe required. This report is published biannually. The March report provides an annual depiction of the two years under evaluation. The September report provides a mid-year update. All data is reported with a 95% confidence level.

Published September 2021

PARTNERSHIP HEALTHPLAN of CALIFORNIA

3Q21 Grievance and Appeals PULSE Report: Supplemental Data
NCQA UM 1B: Member Experience-UM Threshold Report
REPORTING PERIOD: 1/1/2020 - 12/31/2020 and 1/1/2021 - 6/30/2021
Mid-Year Report

ACCREDITED NCQA HEALTH PLAN

Grievances Only Reporting Period: Annual 2020 vs. January-June 2021								
	Previous Period: 2020			Current Period: Jan-June 2021				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	45	488,359	0.1	44	599,450	0.1	0.10	Yes
Attitude/Service	107	488,359	0.2	54	599,450	0.1	0.24	Yes
Billing/Financial	104	488,359	0.2	53	599,450	0.1	0.23	Yes
Quality of Care	0	488,359	0.0	0	599,450	0.0	0.00	Yes
Quality of Provider Office	0	488,359	0.0	0	599,450	0.0	0.00	Yes
TOTAL	256	488,359	0.5	151	599,450	0.3	0.58	Yes

Purpose of report: It reflects a subset of data from the ME.7 Member Experience Report. Data reflects member-reported dissatisfaction related to experiences with the TAR and RAF process. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and an intervention(s) maybe required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides an mid-year update. All data is reported with a 95% confidence level.

Published September 2021

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN ACCREDITED

NMT / NEMT Transportation Benefit

- ***Aaron Maxwell***, Transportation Program Manager
- *September 21, 2021*

Transportation Benefits

Emergency Medical Transportation

Includes air and ground transport

Must be to the nearest hospital capable of meeting medical needs.

Requested by calling 911

Non-Emergency Medical Transportation (NEMT)

Door-to-door assistance required

Medical management may be required during transport

Non-emergency ambulance, litter van/gurney, wheelchair van or medical air transport

Non-Medical Transportation (NMT)

Member does not require assistance

Member must attest they have no other way to get to their Medi-Cal covered service

Least costliest mode of transport: Gas mileage reimbursement, taxi, public transportation or train

CCS and EPSDT Regulations

Under 21 only

May also receive meals, lodging and parking

Eligible for gas mileage reimbursement regardless of family access to vehicle

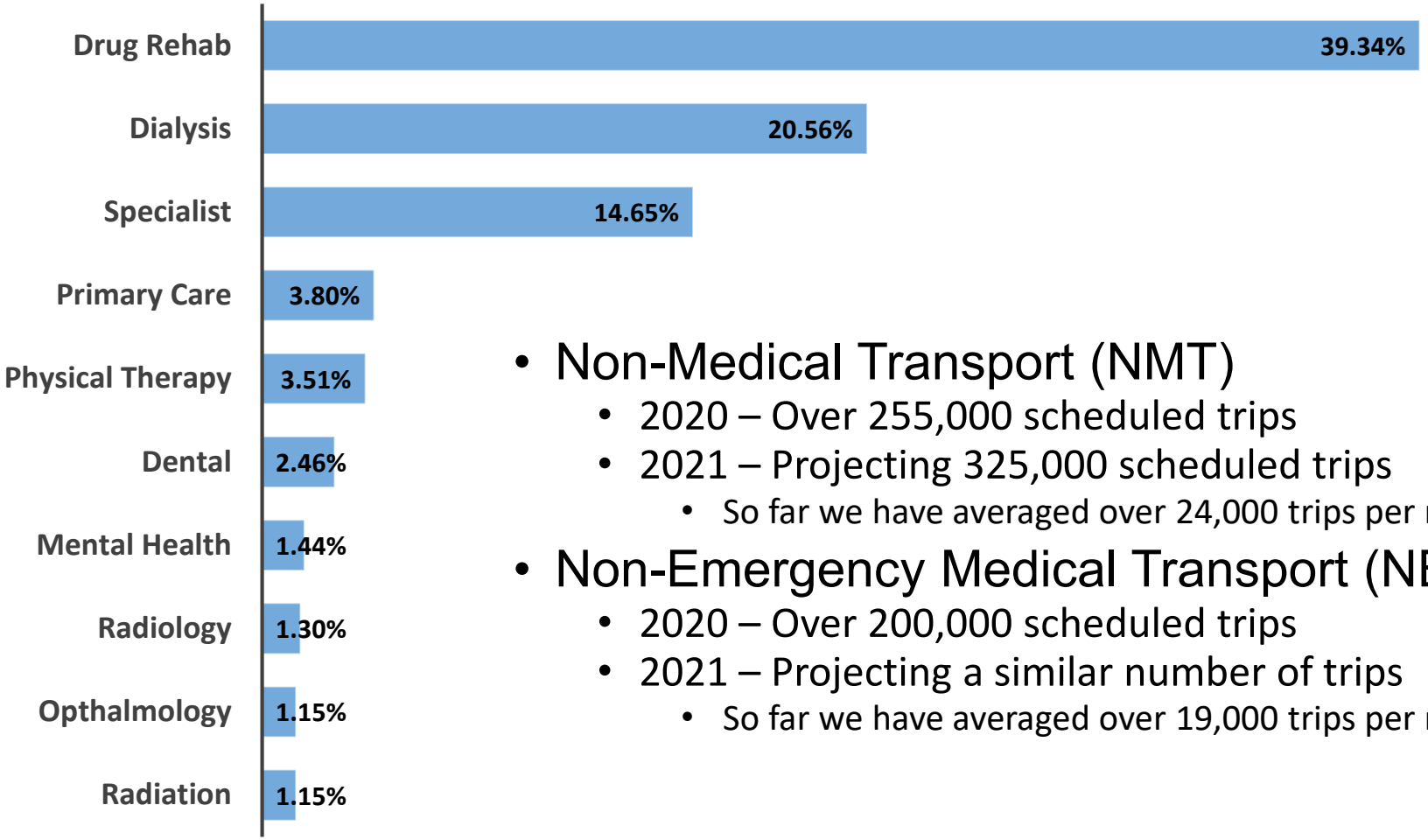
How to Access Transportation Benefits

- **How to Schedule Non-Medical Transport**
  - Patients or providers can contact MTM at **1-888-828-1254** to arrange NMT services.

- **How to Schedule Non-Emergency Medical Transport**
  - Patients and providers can contact PHC Care Coordination at **1-800-809-1350** to be connected with the appropriate NEMT provider.

- **If a member needs emergency transport, please dial 911**

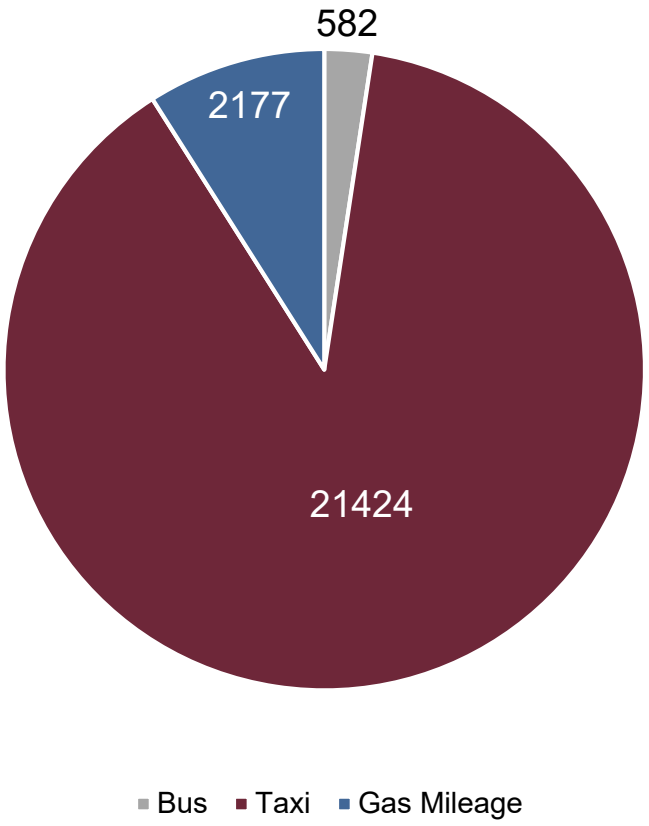
Top 10 Destinations & Utilization



- Non-Medical Transport (NMT)
  - 2020 – Over 255,000 scheduled trips
  - 2021 – Projecting 325,000 scheduled trips
    - So far we have averaged over 24,000 trips per month
- Non-Emergency Medical Transport (NEMT)
  - 2020 – Over 200,000 scheduled trips
  - 2021 – Projecting a similar number of trips
    - So far we have averaged over 19,000 trips per month

MTM Utilization & Complaints

MTM Average Monthly Trips
Jan 2021 - Jun 2021



MTM Complaints
Jan 2021 - Jun 2021

- Out of just over 194,000 requested trips during this time period, 99.87% were complaint free.
- Only 3 MTM transportation vendors had complaint ratio's over 1%
  - Over this 6 month time period the total combined complaints against these 3 vendors was 20.
- By far the most common complaint seen is for provider no shows. During this time period MTM's provider no shows accounted for 0.18% of scheduled transports.

Referrals or Questions

PHC Transportation Team

1-800-809-1350

Fax: 530-351-9055

Email: transportationhelpdesk@partnershiphp.org

Melissa McCartney, Director, Care Coordination Operations
Aaron Maxwell, Manager, Transportation Programs

Northern Region Team – Redding

Brandi Walker, Lead Transportation Specialist
Myron Carter, Transportation Specialist

Southern Region Team – Fairfield

Rosa Silva, Lead Transportation Specialist
Nefer Crayton, Transportation Specialist
Lizzy Nicolai, Transportation Specialist

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCCP2028				**Lead Department: Health Services**	
Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 11/13/2019 **Effective Date:** ~~TBD~~ 07/01/2020			**Next Review Date:** ~~04/14/2022~~09/08/2022 **Last Review Date:** ~~04/14/2021~~09/08/2021		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~04/14/2021~~09/08/2021	

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

A. Administration
~~A.~~B. Behavioral Health
~~B.~~C. Claims
~~C.~~D. Health Services
~~D.~~E. Member Services
~~E.~~F. Provider Relations

III. DEFINITIONS

A. Adolescents – As defined for Drug Medi-Cal (DMC) purposes, adolescents are eligible beneficiaries from the twelfth (12th) birthday up to the twenty-first (21st) birthday.
B. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.
C. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
D. Behavioral Health Clinical Director – The Partnership HealthPlan of California (PHC) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of ~~the Utilization Management (UM) program~~PHC activities. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use disorder treatment related services.

E. Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

F. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with Title 42 Code of Federal Regulations (CFR) 438.210 (a) (4) or, in the case of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), services that meet the criteria specified in Title 22, Code of California Regulations (CCR) Sections 51303 and 51340.1

G. Non-Urgent Request – A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

H. Program Beneficiary – A person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

I. Residential Treatment – As defined for DMC purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

J. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
   2. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (PHC) to process Treatment Authorization Requests (TARs) for residential substance use disorder treatment services.

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)
   1. Partnership HealthPlan of California (PHC) authorizes residential treatment services for substance use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:
      a. Adults (Age 21 or older)
         1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of

Tobacco Related Disorders and Non-Substance Related Disorders).

2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM Criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to PHC.

b. Adolescents (From the twelfth [12th] birthday up to the twenty-first [21st] birthday)

1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to PHC.

2. PHC utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. PHC shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview

1. When the Medi-Cal eligible beneficiary presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary of the assessment findings and a treatment plan to the PHC Health Services Department for review.
   a. TAR determinations cannot be made by PHC until all required documents and information are received.
   b. TARs should be submitted electronically via PHC's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to PHC's Health Services Department for review.
3. PHC's LPHA staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within 5 business days of receipt of the request.
   a. PHC's LPHA staff includes LCSWs and LMFT's who can approve and defer (pend) the TAR, or deny the TAR for administrative reasons ~~non-medical necessity determinations.~~ (e.g. TAR not required, duplicate request, or invalid code). Any decision requiring medical necessity determination will be referred to a Physician as per 3.b. below. The LCSW or LMFT reviews the information received from the residential treatment provider utilizing the approved review guidelines as described in section VI.A. above.
   b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.E. above) or Physician Designee for further evaluation. When a TAR requires clinician review, the LCSW or LMFT attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.
   c. Notification of approved TARs will be provided to the provider at the time of decision, but no

later than 24 hours from the date of decision.

4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process
1. PHC will review the program beneficiary's progress periodically throughout their length of stay as appropriate.
2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to PHC no later than five business days prior to the expiration of the previous authorization.
   a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and PHC will review and notify the provider of the determination (approved, modified, deferred/pended, or denied) within 5 business days of receipt of the request.
2. Adults (Age 21 or older)
   a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from PHC.
   b. After completing 90 days of treatment, PHC may approve extensions of the stay based upon medical necessity and the treatment plan.
   ~~b. Adults, age 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS-licensed facility for a maximum of 90 days.~~
   ~~c. After completing 90 days of treatment, an adult program beneficiary may receive one 30-day extension, if that extension is medically necessary and approved by PHC, per 365-day period.~~
3. Adolescents (From the twelfth [12th] birthday up to the twenty-first [21st] birthday)
   ~~a. Adolescent program beneficiaries will be discharged by day 30 unless extenuating circumstances exist.~~
   ~~b.~~a. ~~Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period for residential treatment.~~ Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
   ~~c. After completing 30 days of treatment, adolescents may receive one 30-day extension if that extension is medically necessary, per 365-day period.~~
   ~~d.~~b. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
4. Pregnant/Post-Partum Beneficiaries
   a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy). Extension beyond 60 days will require prior approval from PHC and must be to a non-perinatal level of care.
   b. Providers will be required to provide proof of pregnancy or delivery date for each new TAR submitted to PHC.

D. Notification of Denials/Modifications/Appeals Process
1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if applicable, will be provided to the provider and Medi-Cal eligible beneficiary at the time of decision, but no later than 24 hours from the date of decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

Policy/Procedure Number: MCCP2028		Lead Department: Health Services
Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization		☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/13/2019 **Effective Date:** TBD	**Next Review Date: 04/14/202209/08/2022** **Last Review Date: 04/14/202109/08/2021**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
B. Drug Medi-Cal Organized Delivery System (DMC-ODS) Quality Assurance-CToolkit (Revision 3 dated 06-12-19)
C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
D. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
~~D.~~E. Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-021 Drug Medi-Cal Organized Delivery System – Updated Policy on Residential Treatment Limitations (May 14, 2021)
~~E.~~F. InterQual® Behavioral Health Criteria
~~F.~~G. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2021) UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:

04/08/20, 04/14/21; 09/08/21

PREVIOUSLY APPLIED TO:

N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: July 8, 2021

Behavioral Health Information Notice No: 21-032

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: County of Responsibility and Reimbursement for Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

PURPOSE To ensure beneficiaries moving to new counties are able to access timely SUD treatment during the period of time between Inter-County Transfer initiation and completion and to clarify existing county responsibility for out-of-county hospitalizations.

BACKGROUND:

The Department of Health Care Services (DHCS) uses the Short Doyle billing system for DMC and DMC-ODS. The Short Doyle billing system queries the DHCS Medi-Cal Eligibility Data System (MEDS) to determine eligibility before reimbursing claims. MEDS has a field labeled County of Residence, which can be changed by a County Eligibility Worker when a beneficiary indicates a change of address and initiates an Inter-County Transfer. The County of Residence field indicates the beneficiary's current residence. MEDS also has a field labeled County of Responsibility. This field determines which Medi-Cal Managed Care Plan the beneficiary is eligible to join, and which counties are

responsible for covering Substance Use Disorder Services. The County of Responsibility is changed at the end of an Inter-County Transfer process.

Differences in Residence County and County of Responsibility occur: 1) during the interim period between the time an Inter-County Transfer is initiated and the time it is completed; and 2) when a beneficiary lives in a county other than the County of Responsibility, e.g., foster children and college students. In all other circumstances, the Residence County and County of Responsibility should be the same.

In the Drug Medi-Cal Organized Delivery System, billing historically was tied to County of Responsibility. This means that claims were denied by the Short Doyle billing system when a beneficiary moved to a new county, initiated an Inter-County Transfer, and started receiving SUD treatment services, until the Inter-County Transfer was complete and the County of Residence was changed.

Definitions:

- *County of Responsibility:* the field in MEDS that indicates the county that has control of the case record in MEDS and is the county that can make eligibility and demographic information updates to the MEDS record. This county has financial responsibility for behavioral health services, consistent with the county contract with DHCS. Providers can verify Medi-Cal eligibility in three ways: POS system (BIC Card reader), Automated Eligibility Verification system (AEVS) [1] or the Medi-Cal website.
- *County of Residence*: the field in MEDS and MEDSLITE indicating the county in which the beneficiary resides.
- *County of Service:* the county where the behavioral health provider is physically located.

POLICY:

The County of Responsibility field in MEDS and MEDSLITE is the official source for determining which payer is responsible to pay claims for medically necessary substance use disorder services provided to eligible beneficiaries, no matter where the beneficiary is located or residing, unless or until an Inter-County Transfer has been initiated to change the residence.

Counties and providers should use the County of Responsibility to determine which county is responsible to provide authorizations for substance use disorder services

[1] For more information, see EVS Medi-Cal: FAQs, Medi-Cal: Transaction Services Available or Medi-Cal: Transaction Enrollment Requirements

(whenever authorizations are needed to approve care) and to pay claims for medically necessary services for eligible beneficiaries. The only exception to this policy is when a beneficiary has initiated an Inter-County Transfer to confirm a change of residence. In that case, the County of Residence is responsible for authorizations and claims.

If a provider requests an authorization for service of a county DMC-ODS or DMC State Plan County for a beneficiary that has initiated an Inter-County Transfer to another county, the County of Responsibility must notify the provider that an Inter-County Transfer has been initiated, and the provider must then request the authorization from the County of Residence. The beneficiary's County of Residence must be updated in MEDS prior to the provider requesting authorization.

Short-Doyle has been modified so claims from DMC and DMC-ODS counties are no longer denied, as long as the beneficiary's County of Responsibility or County of Residence matches the submitting county. Previously denied claims may be resubmitted if they meet the following criteria:

- The original claim was submitted within twelve months of the service provision and denied by Short-Doyle, and;
- At the time of resubmission, the claim is no older than 24 months from the date of service provision.

Claims that do not meet this criteria, such as those that were not submitted previously due to anticipated denial, or claims for services rendered more than 24 months ago, may not be retroactively reimbursed.

As a reminder, providers should always check Medi-Cal eligibility and verify that the beneficiary is Medi-Cal eligible, and should verify which county is responsible for reimbursing for that beneficiary's care.

QUESTIONS

Questions regarding this BHIN may be directed to the County Monitoring Section at CountySupport@dhcs.ca.gov.

Sincerely,

Original signed by

Kelly Pfeifer, M.D.
Deputy Director
Behavioral Health

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: July 22, 2021

Behavioral Health Information Notice No: 21-041

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Behavioral Health Planning Council
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators
United Parents

SUBJECT: Medi-Cal Peer Support Specialist Certification Program Implementation

PURPOSE: To provide the standards for implementing the Medi-Cal Peer Support Specialist Certification Program.

REFERENCE: Centers for Medicare and Medicaid Services State Medicaid Directors Letter #07-011
Welfare and Institutions Code, Division 9, Part 3, Article 1.4, Chapter 7

BACKGROUND:
DHCS acknowledges the role that peer support specialists (hereafter referred to as "peers") can play in California's behavioral health systems, and recognizes that peers have long acted as a part of the prevention, early intervention, treatment, and recovery process for individuals living with Mental Health (MH) conditions and Substance Use Disorders (SUD)s. As individuals with either lived experience, or as the parents, caregivers and family members of individuals living with MH and/or SUD conditions,

peers personally understand the experience of the individuals they serve and can help clarify the most effective set of services for each individual's recovery needs.

Senate Bill (SB) 803, chaptered in 2020, authorized DHCS to seek federal approvals to add peer support specialists as a Medi-Cal provider type and peer support services as a distinct service type in counties opting to participate in this program. DHCS is pursuing these federal approvals through the Medicaid waiver and State Plan Amendment processes.

SB 803 also directed DHCS to develop state standards for Medi-Cal Peer Support Specialist Certification Programs that may be implemented by counties, or county-contracted entities, who opt in to provide these programs. This certification is required for Medi-Cal reimbursement, but does not impact peer programs under other funding sources. DHCS has worked extensively with stakeholders to develop these state standards, including multiple behavioral health and peer-led associations, county partners, representatives from various non-profit organizations, representatives from peer-run organizations, existing peer support specialists, consumers, and other interested individuals.

This BHIN provides state standards for California's Medi-Cal Peer Support Specialist Certification Programs and the steps counties who opt in must take to implement these programs. Future guidance will be provided on the implementation of the Peer Support Services Medi-Cal benefit.

POLICY:
SB 803 created the statutory authority for DHCS to establish Medi-Cal statewide certification program standards while counties, or county-contracted entities, are responsible for implementing the programs at the local level. (W&I Code Section 14045.14) By July 1, 2022, DHCS must:

1. Establish statewide requirements to use in developing certification programs
2. Define the qualifications, range of responsibilities, practice guidelines, and supervision standards for peer support specialists
3. Determine the process for initial certification
4. Determine curriculum and core competencies required for certification, including areas of specialization
5. Specify peer support specialist employment training requirements
6. Establish a code of ethics
7. Determine a biennial certification renewal process, including continuing education requirements
8. Determine a process for investigation of complaints and corrective action

9. Determine a process for an individual employed as a peer support specialist on January 1, 2022, to obtain certification
10. Determine requirements for peer support specialist certification reciprocity between counties and out of state

California Medi-Cal Peer Support Specialist Certification Program Standards

Medi-Cal Peer Support Specialist Certification Programs can be established either by counties, or an agency representing counties. The County Behavioral Health Directors' Association (CBHDA) has identified the California Mental Health Services Authority (CalMHSA) as the entity that will represent counties for the implementation of a State-approved Medi-Cal Peer Support Specialist Certification Program, to support consistency statewide.

CalMHSA, on behalf of the counties they represent, and any other counties that seek to implement their own Medi-Cal Peer Support Specialist Certification Program, must adhere to the standards set forth in Enclosure 1 of this BHIN and must submit to DHCS their application with supporting documents that will be used to implement their program in accordance with Enclosure 2.

Each Medi-Cal Peer Support Specialist Certification Program must ensure that certified peers meet the following qualifications:

1. Be at least 18 years of age.
2. Possess a high school diploma or equivalent degree.
3. Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver or family member of a consumer.
4. Be willing to share their experience.
5. Have a strong dedication to recovery.
6. Agree, in writing, to adhere to a code of ethics.
7. Successfully complete the curriculum and training requirements for a peer support specialist.
8. Pass a certification examination approved by DHCS for a peer support specialist.

Counties, or an agency representing a county, pursuing the development of a Medi-Cal Peer Support Specialist Certification Program will be subject to periodic reviews conducted by DHCS to ensure adherence to all federal and state requirements, and must submit annual peer support specialist program reports to the department.

Application and Submission Requirements

DHCS encourages counties to take advantage of the opportunity to work with CalMHSA for their certification programs. Any county not working with CalMHSA must notify

DHCS by August 6, 2021. Counties can send this information to DHCS via email at Peers@dhcs.ca.gov.

CalMHSA, on behalf of counties they represent, and any other counties developing their own certification programs must apply to DHCS by submitting the documents listed in Enclosure 2, and receive approval, prior to implementing a certification program. The program plan shall include: proposed policies and procedures for a candidate's initial certification, including the training curriculum for peers and peer supervisors; the certification exam; the process for biennial and lapsed renewals; the curriculum for the identified areas of specialization; the grandparenting process for qualifying peers; the complaints and corrective actions process; and a certification fee schedule.

Medi-Cal Peer Support Specialist Certification Program plans must be in an electronic format and sent to Peers@dhcs.ca.gov. The opportunity for counties to implement a certification program will be made available annually. For FY 2021-22, counties must submit the certification plan documents prior to November 19, 2021.

List of Enclosures

1. Standards for Initial Certification, Biennial Renewal, Lapsed Certification, Areas of Specialization, Grandparenting, State/County Reciprocity, Complaints and Corrective Actions
2. Medi-Cal Peer Support Specialist Certification Program Plan Submission Requirements
3. Medi-Cal Code of Ethics for Peer Support Specialists in California
4. Practice Guidelines and Supervision Standards
5. Reporting Requirements

Sincerely,

Marlies Perez, Division Chief
Community Services Division

ENCLOSURE 1

1. Initial Certification
2. Biennial Renewal
3. Lapsed Certification
4. Areas of Specialization,
5. Grandparenting, State/County Reciprocity
6. Complaints and Corrective Actions

1. Standards for Initial Certification of a Peer Support Specialist

For an initial certification of a peer support specialist, a Medi-Cal Peer Support Specialist Certification Program must:

A. Ensure a candidate agrees to adhere to the Medi-Cal Code of Ethics for Peer Support Specialists
B. Ensure a candidate has completed the training curriculum that includes 80 hours of training - including didactic learning
C. Ensure the candidate has passed the initial certification exam

A. Medi-Cal Code of Ethics

The Medi-Cal Code of Ethics for Peer Support Specialists is contained in Enclosure 3 and posted on the DHCS Peers webpage. DHCS will update the Code of Ethics as appropriate and certification programs must ensure that candidates agree to adhere to the most recent version posted.

B. Training Curriculum

The training curriculum must incorporate the following core competencies:

1. The concepts of hope, recovery, and wellness.
2. The role of advocacy.
3. The role of consumers and family members.
4. Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.
5. Cultural and structural competence trainings.
6. Trauma-informed care.
7. Group facilitation skills.
8. Self-awareness and self-care.
9. Co-occurring disorders of mental health and substance use.
10. Conflict resolution.
11. Professional boundaries and ethics.
12. Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.

13. Safety and crisis planning.
14. Navigation of, and referral to, other services.
15. Documentation skills and standards.
16. Confidentiality.
17. Digital literacy.

C. Certification Exam
Upon a candidate's completion of the training, a Medi-Cal Peer Support Specialist Certification Program must administer an examination that has been approved by DHCS. The Medi-Cal Peer Support Specialist Certification Program must provide reasonable accommodations to candidates taking the examination, as needed, including verbal testing and testing in prevalent languages.

2. *Standards for Biennial Renewal*
A Medi-Cal Peer Support Specialist Certification Program must provide a process for biennial certification renewal for certified peer support specialists. This process must include making available continued education trainings and ensuring that renewal candidates perform 20 hours of continuing education every two years. The continuing education must include updates on applicable laws and evidence based best practices. A Medi-Cal Peer Support Specialist Certification Program must also ensure that certified peer support specialists reaffirm in writing the most recent version of the Medi-Cal Code of Ethics for Peer Support Specialists in California every two years.

3. Lapsed Certification
For peer support specialists whose certification lapsed, but is still within four years of when certification renewal was due, a Medi-Cal Peer Support Specialist Certification Program must allow certification if the candidate completes 40 hours of refresher training[1], passes the Medi-Cal Peer Support Specialist Certification Program examination, and must affirm, in writing, the most recent version of the Medi-Cal Code of Ethics for Peer Support Specialists in California.

4. Areas of Specialization
A Medi-Cal Peer Support Specialist Certification Program must implement a curriculum in the area of specialization for "Parent, Caregiver, and Family Member Peers" upon implementation of the Peer Support Specialist Certification Program.

The following three areas of specialization must also be implemented by January 1, 2023:
- Crisis Services

[1] This training must still cover the core competencies, but would be a condensed version of the full 80 hour curriculum. This refresher curriculum must also be approved by DHCS.

- Forensic (Justice Involved)
- Homelessness

These areas of specialization must be developed in addition to the requirements for certification in the core competencies, and the curriculums must be approved by DHCS.

DHCS will continue to collect information on areas of specialization that may be added at a later date. Any additional areas of specialization must be approved by DHCS.

5. Grandparenting and Out-of-State Reciprocity

For individuals who are employed as a peer as of January 1, 2022 and seek certification under these standards, known in this BHIN as grandparenting, or those individuals certified out of state and are seeking to be certified under these standards, a Medi-Cal Peer Support Specialist Certification Program must grant certification if the individual has:

Either:

- 1 year of paid or unpaid work experience (1550 hours) as a peer specialist AND 20 hours of continuing education (CEs), including law and ethics. CEs can be in relevant professional competencies obtained via relevant in-state, out of state or national educational forums.

  OR

- 1550 hours in 3 years, with 500 hours completed within the last 12 months, working as a peer specialist AND 20 hours of continuing education (CEs), including law and ethics. CEs can be in relevant professional competencies obtained via relevant in-state, out of state or national educational forums.

AND has all of the following:

- Completion of a peer training(s)
- 3 Letters of Recommendation as outlined:
  - One from a supervisor
  - One from a colleague/professional
  - One self-recommendation describing their current role and responsibilities as a peer support specialist
- Pass the Medi-Cal Peer Support Specialist Certification Program Exam

As with the initial certification, the Medi-Cal Peer Support Specialist Certification Program must provide reasonable accommodations to the candidate as requested, including verbal testing and testing in prevalent languages.

Peers employed as a peer January 1, 2022 and seeking certification through the grandparenting process must complete or begin the process by December 31, 2022. After this date, peers seeking certification under a Medi-Cal Peer Support Specialist Certification Program must complete the initial certification process. Peers with out of state certification seeking reciprocity have no sunset date to seek certification.

6. County Reciprocity
Peer Support Specialists who are certified through a DHCS approved Medi-Cal Peer Support Specialist Certification Program will be recognized as a Certified Peer Support Specialist in all counties throughout California however, only counties electing to participate in the Medi-Cal peers benefit will have the ability to be federally reimbursed for behavioral health peer services provided to Medi-Cal beneficiaries.

7. *Complaints and Corrective Actions*
A Medi-Cal Peer Support Specialist Certification Program must also submit a process for reviewing complaints and corrective actions, including the suspension and revocation of certification, as well as the appeals process for DHCS approval. DHCS will approve processes that include the following:

- Specifications for the Medi-Cal Peer Support Specialist Certification Program to investigate submitted complaints within a specified timeframe.
- A disciplinary process for substantiated allegations that requires either education hours, suspension, and/or revocation.
- An appeal process.

Monitoring of the program will be incorporated into DHCS' current processes, including DHCS' triennial audits and the EQRO quality improvement program efforts.

ENCLOSURE 2 – Medi-Cal Peer Support Specialist Certification Program Plan Submission requirements

Submission Package for Medi-Cal Peer Support Specialist Certification Program		
CalMHSA, on behalf of represented counties, and other counties who seek to implement a Medi-Cal Peer Support Specialist Certification Program must submit a plan for DHCS approval of how the certification program will meet all of the federal and state requirements for the certification and oversight of peer support specialists (W&I Code 14045.14 (a)(1)). Please include the signature of the authorized representative from CalMHSA, or the county Behavioral Health Director. The plan must include the following:		
☐	Initial Certification Policies And Procedures	How applicants can apply for certification and how the training curriculum and the exam will be administered.
☐	Certification Exam	The exam that applicants will be required to take. Also include the alternative ways the exam will be administered for those with difficulty taking written exams. Include accommodations that will be available for those with disabilities, or those who require translations or interpreters, including the prevalent languages in which the exam will be made available.
☐	Biennial Certification Renewal Policies And Procedures	How the program will make continuing education (CE) training available for certified peers, how certified peers can demonstrate successful completion of CE training, and how peers can submit a renewal of the Code of Ethics.
☐	Training Curriculum For: • Peer Support Specialist • Parent, Caregiver and Family Member Peers • Peer Supervisors	The curriculum for initial certification, the curriculum for lapsed certification, a curriculum for the area of specialization for parent, caregiver and family member peers, and peer supervisors.
☐	Certification Fee Schedule	Per W&I Code Section 14045.18, a participating county, or an agency representing a participating county, is authorized to establish a certification fee schedule for the purpose of supporting the activities associated with the ongoing administration of the peer support specialist certification program. Before the fee schedule may be implemented, the department shall review and either approve or disapprove the fee schedule of the participating county or an agency representing the participating county.

☐	Grandparenting/Reciprocity Process	The policies and procedures for how an applicant can apply for certification and how the program will operationalize reviewing applications and issuing the certification.
☐	Complaints/Corrective Actions Process	The policies and procedures for how complaints will be submitted and processed, including a timeline, disciplinary actions, and appeals process.
☐	Reporting Process	The policies and procedures for the timely submission of the identified data to meet the reporting requirements.

ENCLOSURE 3 – Medi-Cal Code of Ethics for Peer Support Specialists in California

Purpose	Peer support services are recovery-oriented and resiliency-focused services for those managing behavioral health challenges as well as the parents, family members, and caregivers that support them. Peer support services are evidence-based practices that provide role models to inspire hope, demonstrate a life of recovery and resiliency, and encourage real advocacy. This Values and Ethics document promotes a consistent message to those who are providing, receiving, and supervising services from a Peer Support Specialist. The Values and Ethics described here formalizes and advances peer support services in California's behavioral health system of care. For the purpose of this document "Peer Support Specialist" refers to anyone who is providing services in the behavioral health field using their "lived experience" to establish mutuality and build resiliency and recovery.
Values	**Ethical Standards**
Hope	Peer Support Specialists: • Inspire hope in those engaging in services by living a life of Recovery and/or Resiliency.
Person-Driven	Peer Support Specialists: • Support individuals receiving services and their support network within the context of the individual's worldview, to achieve their goals based upon their needs and wants. • Focus on self-determination, as defined by the person engaging in services, and support the person's participation in their own recovery. • Inform others about options, provide information about choices, and then respect peers' decisions. • Encourage people to look at the options, take risks, learn from mistakes, and grow toward healthy interdependence with others. • Uphold the principle of non-coercion as essential to recovery and encourage those engaging in services to make their own decisions, even when the person engaging in services is under mandated treatment. • Assist those they support to access additional resources. • Disclose lived experiences of recovery in a way that maintains the focus on and is beneficial to the person engaging in services. • Support the recovery process for the peer, allowing the person to direct their own process.

	• Shall not force any values or beliefs onto the person engaging in services. • Recognize there are many pathways to recovery that can be very different than their own journey.
Family Driven and Child-Centered	Peer Support Specialists: • Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs. • Respect and value the beliefs, opinions, and preferences of children, youth, family members, parents, and caregivers in service planning. • Promote the family members' voices and the articulation of their values in planning and evaluating behavioral health related challenges or concerns. • Support other family members as peers with a common background and history. • Disclose personal lived experiences of building resiliency in a way that focuses on and is beneficial to the child, youth, family member, parent, or caregiver engaging in services. • Build supports on the strengths of the child, youth, family, or caregiver. • Build partnerships with others who are involved in the care of our children, youth, or adult family members. • Communicate clearly and honestly with children, youth, family members, and caregivers.
Holistic Wellness	Peer Support Specialists: • Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs. • Practice in a holistic manner that considers and addresses the whole health of those engaging in services. • Recognize the impact of co-occurring challenges (substance use, developmental and physical challenges) in the recovery resiliency journey and provide supports sensitive to those needs. • Recognize the impact of trauma on the recovery/resiliency journey and provide the support specific to those challenges. • Honor the right of persons engaging in services to choose alternative treatments and practices, including culturally-specific traditional methods, healing arts, including acupuncture and meditation, spiritual practices or secular beliefs, and harm reduction practices.
Authenticity	Peer Support Specialists: • Practice honest and direct communication in a culturally relevant manner, saying what is on their mind in a respectful way. Difficult circumstances are addressed with those who are directly involved. Direct communication

	moves beyond the fear of conflict or hurting other people to the ability to work together to resolve challenges with caring and compassion. • Share own lived experience to provide hope and inspiration for recovery. • Practice healthy disclosure about their own experience focused on providing hope and direction toward recovery and/or resiliency. • Work within their scope of practice as defined by this Code of Ethics and their employing agency. • Remain aware of their skills and limitations, and do not provide services or represent themselves as an expert in areas for which they do not have sufficient knowledge or expertise. • Know that maintaining the authenticity and integrity of their role is critical to the effectiveness of peer support services. • Seek supervision, peer support services, and/or other contact with peer colleagues or other supports to stay within their scope of practice.
Cultural Responsiveness & Humility	Peer Support Specialists: • Acknowledge the importance of language and culture, intersecting identities, knowledge, and acceptance of dynamics of cultural differences, expansion of cultural knowledge, curiosity, and adaptation of services to meet culturally unique needs. • Strive to provide culturally responsive and relevant services to those they support. • Respect cultural identities and preferences of those engaging in services and their families and respect the right of others to hold opinions, beliefs, and values different from their own. • Shall not discriminate against others on the basis of gender, race, ethnicity, sexual orientation or gender identity, age, religion, national origin, marital status, political belief, or mental or physical differences. • Shall not discriminate against others on the basis of any other preference, personal characteristic, condition, state, or cultural factor protected under Federal, State or local law. • Seek further information, education, and training in cultural competence as necessary to assist those they support.
Respect	Peer Support Specialists: • Provide a welcoming environment for persons engaging in services. • Approach each person, youth, parent or family member with openness, genuine interest, and appreciation. • Accept each person/family and situation as unique. • Provide empathy and able to “put oneself in the other person’s shoes.” • Will make an honest effort to empathize with the emotional connection and cultural context that the persons engaging in services bring to the

	recovery/ resiliency relationship. • View everyone as having something important and unique to contribute. • Value and treat others with kindness, warmth, dignity, and without judgment. • Accept each other and are open to sharing with people from many diverse backgrounds including ethnicity,educational levels, socio-economic background, sexual preference, and religion/spirituality. • Honor and make room for everyone's opinions and see each other as equally capable of contributing. • Demonstrate respect toward those supported, colleagues and the community. • Use language that is respectful, "person-first," and culturally mindful to, and with, those supported, colleagues and the community. • Never use language that could be construed as, or is, derogatory, insulting, or demeaning in written, electronic, or verbal communications. • Communicate with co-workers and colleagues in ways that promote hope, compassion, and solution-focused interactions.
Integrity	Peer Support Specialists: • Act in accordance with the highest standards of professional integrity. • Avoid relationships or commitments that conflict with the interests of persons engaging in services, impairprofessional judgment, imply a conflict of interest, or create risk of harm to those supported. • Conduct themselves in a way that does not jeopardize the integrity of the peer relationship. • Seek supervision to handle any real or potential conflicts when and if a dual relationship is unavoidable. • Follow organizational policies and guidelines regarding giving and receiving gifts. • Consider the cultural context and other potential considerations related to gifts. • Do not lend, give, or receive money or payment for any services to, or from, persons they support. • Demonstrate accountability in fulfilling commitments. • Resist influences that interfere with professional performance. • Shall not commit fraud, waste or abuse in the delivery of Medi-Cal services. • Cooperate with complaint investigations and supply information requested during complaint investigations unless such disclosure of information would violate the confidentiality requirements of Subpart 2, Title 42, Code of Federal Regulations.

	• Shall not provide services under the influence of any amount of alcohol, marijuana, or illicit drugs. “Illicit drugs” means any substance defied as a drug in Section 11014, Chapter 1, Division 10, Health and Safety Code, except:
	  ○ Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, in accordance with Section 4036, Chapter 9, Division 2, Business and Professions Code, and used in the dosage and frequency prescribed; or
	  ○ Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert.
	• Shall not secure a certification by fraud, deceit, or misrepresentation. This includes, but is not limited to:
	  ○ Making a false statement on any application for certification.
	  ○ Withholding material information on any application for certification.
	  ○ Impersonating another Peer Support Specialist or permitting or allowing another person to use their certification for the purpose of providing peer support services.
	• Shall not engage in gross negligence or incompetence in the performance of peer support services. This includes:
	• Failing to maintain records consistent with sound judgement, the standards of the profession, and the nature of the services being rendered.

Advocacy	Peer Support Specialists: • Support the formulation, development, enactment, and implementation of public policies of concern to theprofession. • Demonstrate and promote activities that respect diversity. • Support and defend human rights and freedoms regardless of nationality, national origin, gender identity, ethnicity, religion or spiritual persuasion, language, disability, sexual identity, or socio-economic status. Human rights include civil and political rights, such as the right to life, liberty, and freedom of expression; social, cultural, and economic rights including the right to cultural expression, the right to have basic needs met, and the right to work and receive an education. • Advocate for inclusion of those supported in all aspects of services. • Advocate for the full involvement of those supported in the communities of their choice and will promote their value to those communities. • Understand, encourage, and empower self-advocacy. • Recognize that all individuals/families have the right to live in the safest and least restrictive, culturally congruent environment. • Strive to eliminate stigma and discrimination

Confidentiality	Peer Support Specialists: • Respect the rights, dignity, privacy, and confidentiality of persons engaging in services at all times. • Respect the right to privacy of those supported and shall not solicit private information from those supported unless it is essential. Once private information is shared, standards of confidentiality apply. • Respect confidential information shared by colleagues in the course of their professional relationships andinteractions unless such information relates to an unethical or illegal activity. However, confidentiality should be honored when Peers are supporting clients with a substance use disorder where the illegal activity is limited to personal use of substances. • Comply with all applicable federal and state confidentiality laws and guidelines. (In accordance with Part 2, Title 42, Code of Federal Regulations and HIPAA requirements). • Discuss with persons engaging in services, and other interested parties, the nature of confidentiality andlimitations of the right to confidentiality.
Safety & Protection	Peer Support Specialists: • Never engage in romantic or sexual/intimate activities with the persons engaging in services. • Shall not provide services to individuals with whom they have had a prior romantic or sexual relationship. • Shall not engage in exploitive relationships with coworkers or those they support to further their personal,religious, political, or business interests. • Follow applicable federal, state and local laws in the prevention of harm. • Inform appropriate persons when disclosure is necessary to prevent serious, foreseeable, and imminent harm to persons served or other identifiable persons. In all instances, Peer Support Specialists should disclose the least amount of confidential information necessary to achieve the desired purpose. • Never intimidate, threaten, harass, use undue influence, physical force, or verbal abuse, or make unwarranted promises of benefits to persons engaging in services. • Recognize the unique nature of the peer relationship and seek supervision and/or peer support services, as necessary, to maintain appropriate boundaries with persons engaging in services. • Treat colleagues with respect, courtesy, fairness, and good faith, and uphold the Code of Ethics. Strive to provide a safe environment that is respectful of the impact of trauma on persons engaging in services.
Education	Peer Support Specialists:

	• Remain current regarding new developments in recovery, resiliency and wellness theories, methods, and approaches of related disciplines/systems with whom those who are engaging in services interface. • Accept responsibility for continuing education and professional development as part of their commitment to provide quality services. • Become familiar with local resources for self-sufficiency, including benefits and employment opportunities and supportive resources for families, parents, and caregivers.
Mutuality	Peer Support Specialists: • Engage in a relationship of mutual responsibility where power is shared and the Peer Support Specialist and the persons engaging in services are equally responsible for maintaining a peer relationship that is mutually beneficial. • Take responsibility for voicing their own needs and feelings. • Make decisions in collaboration with persons served and do not make decisions for persons engaging in services. • Ensure that people give and take the lead in discussions, everyone is offered a chance to speak, and decisions are made in collaboration with one another.
Reciprocity	Peer Support Specialists: • Ensure that the relationship is reciprocal. Every participant in the peer relationship both gives and receives in a fluid, constantly changing dynamic. • Belief that peer relationships are not hierarchical; no one is more qualified, advanced, or better than another. • Learn from each other. • View asking for help as reaching across (not up nor down).
Strengths-Based	Peer Support Specialists: • Provide strength-based services acknowledging that every person has skills, gifts, and talents they can use to better their lives. • Focus on what is strong, not what is wrong. • Assist others to identify these strengths and explore how those identified strengths can be used for their benefit.
Wellness, Recovery and Resiliency	Peer Support Specialists: • Engage in and model regular self-care activities. • Communicate and behave in ways that promote wellness, recovery, and resiliency. • Use language that reflects wellness, recovery, and resiliency principles. • Shall not impose limitations on the possibility for wellness, recovery, and

resiliency of those engaging in services.
- Recognize the importance of supportive relationships and community in wellness, recovery and resiliency and encourage persons to identify and develop natural supports.
- Promote self-sufficiency in the wellness, recovery, and resiliency journey.

Wellness is the conscious and deliberate process of creating and adapting patterns of behavior that lead to improved health in the following wellness dimensions: Emotional, Financial, Social, Spiritual, Educational/Occupational, Physical, Intellectual, and Environmental.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. This process of change recognizes cultural diversity and inclusion and honors the different routes to resilience and recovery based on the individual and their cultural community.

Resiliency is an inner capacity that, when nurtured, facilitated, and supported, empowers individuals and communities to successfully meet life's challenges with a sense of self-determination, mastery and hope.

By signing below, I agree not to violate, or assist in or abet the violation of, or conspire to violate, any provision or term of this Code of Ethics. All Peer Support Specialists shall be notified, in writing, of any changes to this Code of Ethics.

Name (printed)

Name (signature)
Date (mm/dd/yyyy)

Enclosure 4 – Practice Guidelines and Supervision Standards

Practice Guidelines

Counties must use the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, *What are Peer Recovery Support Services*.

Supervision Standards

DHCS acknowledges the efficacy and evidenced based practice of the utilization of certified peer support specialists as supervisors of other peers. DHCS highly encourages the employment of peers as peer supervisors. However, due to the variability of counties and availability of the peer workforce, DHCS will allow the utilization of other behavioral health professionals as follows:

Peer Support Specialist Supervisors must meet at least one of the below qualifications:

- Have a Medi-Cal Peer Support Specialist Certification Program certification; have two years of experience working in the behavioral health system; and have completed a DHCS approved peer support supervisory training curriculum.
  OR

- Be a non-peer behavioral health professional (including registered & certified SUD counselors) who has worked in the behavioral health system for a minimum of two years, and has completed a DHCS approved peer support supervisory training;
  OR

- Have a high school diploma or GED, four years of behavioral health direct service experience that may include peer support services; and have completed an approved peer support supervisory training curriculum.

ENCLOSURE 5 – Annual Reporting Requirements

California Peer Support Specialist Certification Program Annual Reporting Requirements			
Reports must reflect information on certifications occurring within a fiscal year (July 1 – June 30), and are due to DHCS by the December 31st following the end of the fiscal year. DHCS may add additional reporting requirements in subsequent years. Reports must contain the following information:			
1) Number Of Peer Support Specialists Certified:			[field]
2) Number Of Applicants That Did Not Receive Certification:			[field]
3) Number Of Applicants Employed In Peer Services Prior To Certification:			[field]
4) Number Of Applicants Certified In An Area Of Specialization:			
	a) Crisis Services	[field]	
	b) Homeless	[field]	
	c) Forensic	[field]	
	d) Parent, Caregiver and Family Member Peer	[field]	
5) Number Of Certified Peers That Renewed Certification:			[field]
6) Number Of Peer Supervisor Trainings Provided:			[field]
7) (For FY 2021-2022) Number of Applicants that received Certification through Grandparenting Process:			[field]
8) Number of Applicants that received Certification through State Reciprocity:			[field]
9) Peer Support Specialist Demographics			
	a) Age		
	i. 18-25	[field]	
	ii. 26-64	[field]	

	iii. 65+	[field]
	b) Gender Identity	
	i. Male	[field]
	ii. Female	[field]
	iii. Non-binary	[field]
	c) Race/Ethnicity	
	i. American Indian/Alaskan Native	[field]
	ii. Asian/Pacific Islander	[field]
	iii. Black	[field]
	iv. Hispanic	[field]
	v. White	[field]
	vi. Not Reported	[field]
	d) Proficient Languages (multi-lingual peers may be counted under multiple fields)	
	i. Arabic	[field]
	ii. Armenian	[field]
	iii. Cambodian	[field]
	iv. Chinese (combined Cantonese or Mandarin)	[field]
	v. English	[field]
	vi. Farsi	[field]
	vii. Hmong	[field]
	viii. Korean	[field]
	ix. Russian	[field]

	x. Spanish	[field]
	xi. Tagalog	[field]
	xii. Vietnamese	[field]

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: UPDATED: August 6, 2021

Behavioral Health Information Notice No: 21-043

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: UPDATED: Requirements for COVID-19 vaccination, vaccination verification, masking and testing for behavioral health facility workers

PURPOSE: Inform counties and behavioral health providers about updated public health requirements related to vaccination, vaccination verification, mask uce, and testing for workers

REFERENCE: Order of the State Public Health Officer Health Care Worker Vaccine Requirement
Order of the State Public Health Officer Unvaccinated Workers in High Risk Settings (ca.gov)

BACKGROUND:
The California Department of Public Health (CDPH) issued new requirements for health care and congregate care facilities to decrease the risk of COVID-19 outbreaks, given emergence of more contagious variants and recent surges of COVID-19 cases. DHCS requires all behavioral health facilities to follow CDPH public health orders. This Behavioral Health (BH) Information Notice covers new requirements for (1) vaccination, (2) vaccination verification, (3) masking, and (4) testing. Please note the guidance

applies to all mental health and substance use disorder facilities, including outpatient, residential, and inpatient.

The COVID-19 pandemic remains a significant challenge in California. COVID-19 vaccines are effective in reducing infection and serious disease. California is currently experiencing the fastest increase in COVID-19 cases during the entire pandemic with 11.2 new cases per 100,000 people per day, with case rates increasing fivefold within two months. The Delta variant, which is very highly contagious and possibly more virulent, is currently the most common variant causing new infections in California.

Unvaccinated persons are more likely to get infected and spread the virus, which is transmitted through the air. Most current hospitalizations and deaths are among unvaccinated persons. Thanks to vaccinations and to measures taken since March 2020, California's health care system is currently able to address the increase in cases and hospitalizations. However, additional statewide facility-directed measures are necessary to protect particularly vulnerable populations, and ensure a sufficient, consistent supply of workers in high-risk health care and congregate settings.

Hospitals, skilled nursing facilities (SNFs), and the other health care facility types identified in this order are particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death. Further, the congregate and residential settings in this order share several features. They all are residential facilities where the residents have little ability to control the persons with whom they interact. There is frequent exposure to staff and other residents. In many of these settings, the residents are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both.

Vaccinations have been available in California from December 2020 to the present, and from January 1, 2021, to July 12, 2021, a total of 9,056 confirmed COVID-19 outbreaks and 110,734 outbreak-related cases were reported to CDPH. The two most common settings for these outbreaks were residential care facilities (22.7%) and SNFs (9.7%). There have been over 4,000 outbreaks in residential care facilities, over 2,000 outbreaks in SNFs, over 450 outbreaks in hospitals, over 200 outbreaks in correctional facilities, and over 450 outbreaks reported in shelters in California to date. CDPH also noted increasing numbers of health care workers as new positive cases, despite vaccinations being prioritized for this group when vaccines initially became available. Recent outbreaks in health care, SNFs, and other congregate settings have frequently been traced to unvaccinated staff members.

Thus, current requirements of staff in health care settings, such as universal mask requirements for all staff, are not proving sufficient to prevent transmission of the Delta variant, which is more transmissible and may cause more severe illness. Vaccination against COVID-19 is the most effective means of preventing infection with the COVID-19 virus, and subsequent transmission and outbreaks. As we respond to the dramatic increase in cases, transmission prevention measures must be increased for the significant proportion of unvaccinated health and congregate care workers remaining to reduce the chance of transmission to vulnerable populations. Reinforcement of well-fitting facemasks for source control, emphasis on increased respiratory protection with respirators in some settings, and regular testing (when appropriately followed by isolation of individuals who test positive), should contribute to reduction of transmission risk in these high-risk settings to mitigate the absence of vaccination protection.
For these reasons, COVID-19 remains a concern to public health and, in order to prevent its further spread in hospitals, SNFs, high-risk congregate settings and other health care settings, limited and temporary public health requirements are necessary at this time.

In workplaces, employers are subject to the Cal/OSHA COVID-19 Emergency Temporary Standards (ETS) or in some workplaces the CalOSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

POLICY:

1. Health Care Vaccine Requirement - UPDATE: August 6, 2021

1. All workers who provide services or work in facilities described in subdivision (a) have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021:

- a. Health Care Facilities:
  - i. General Acute Care Hospitals
  - ii. Skilled Nursing Facilities (including Subacute Facilities)
  - iii. Intermediate Care Facilities
  - iv. Acute Psychiatric Hospitals
  - v. Adult Day Health Care Centers
  - vi. Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
  - vii. Ambulatory Surgery Centers
  - viii. Chemical Dependency Recovery Hospitals
  - ix. Clinics & Doctor Offices (including behavioral health, surgical)
  - x. Congregate Living Health Facilities

xi. Dialysis Centers
xii. Hospice Facilities
xiii. Pediatric Day Health and Respite Care Facilities
xiv. Residential Substance Use Treatment and Mental Health Treatment Facilities

Children's residential facilities licensed by the California Department of Social Services are not included in this public health order.

b. Two-dose vaccines include: Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization. The one-dose vaccine is: Johnson and Johnson [J&J]/Janssen. All COVID-19 vaccines that are currently authorized for emergency use can be found at the following links:

i. By the US Food and Drug Administration (FDA), are listed at the FDA COVID-19 Vaccines webpage.
ii. By the World Health Organization (WHO), are listed at the WHO COVID-19 Vaccines webpage.

c. "Worker" refers to all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose. This includes workers serving in health care or other health care settings who have the potential for direct or indirect exposure to patients or SARS-CoV-2 airborne aerosols. Workers include, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

2. Workers may be exempt from the vaccination requirements under section (1) only upon providing the operator of the facility a declination form, signed by the individual stating either of the following: (1) the worker is declining vaccination based on Religious Beliefs, or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

a. To be eligible for a Qualified Medical Reasons exemption the worker must also provide to their employer a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and

indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

3. If an operator of a facility listed above under section (1) deems a worker to have met the requirements of an exemption pursuant to section (2), the unvaccinated exempt worker must meet the following requirements when entering or working in such facility:

a. Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services. Testing must occur twice weekly for unvaccinated exempt workers in acute health care and long-term care settings, and once weekly for such workers in other health care settings.

b. Wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, at all times while in the facility.

4. Consistent with applicable privacy laws and regulations, the operator of the facility must maintain records of workers' vaccination or exemption status. If the worker is exempt pursuant to section (2), the operator of the facility then also must maintain records of the workers' testing results pursuant to section (3).

a. The facility must provide such records to the local or state Public Health Officer or their designee promptly upon request, and in any event no later than the next business day after receiving the request.

b. Operators of the facilities subject to the requirement under section (1) must maintain records pursuant to the CDPH Guidance for Vaccine Records Guidelines & Standards with the following information: (1) full name and date of birth; (2) vaccine manufacturer; and (3) date of vaccine administration (for first dose and, if applicable, second dose).

c. For unvaccinated workers: signed declination forms with written health care provider's statement where applicable, as described in section (2) above. Testing records pursuant to section (3) must be maintained.

5. Nothing in this Order limits otherwise applicable requirements related to Personal Protective Equipment, personnel training, and infection control policies and practices.

6. Facilities covered by this Order are encouraged to provide on-site vaccinations, easy access to nearby vaccinations, and education and outreach on vaccinations, including:

a. access to epidemiologists, physicians, and other counselors who can answer questions or concerns related to vaccinations and provide culturally sensitive advice; and

b. access to online resources providing up to date information on COVID-19 science and research.

7. This Order shall take effect on August 5, 2021, and facilities must be in full compliance with the Order by September 30, 2021.

8. This Order is issued pursuant to Health and Safety Code sections 120125, 120140, 120175,120195 and 131080 and other applicable law.

9. The July 26 Public Health Order will continue to apply.

2. Vaccination Verification:

All facilities identified above must verify vaccine status of all workers, paid or unpaid.

A. Pursuant to the CDPH Guidance for Vaccine Records Guidelines & Standards, only the following modes may be used as proof of vaccination:
   1. COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card) which includes name of person vaccinated, type of vaccine provided and date last dose administered); OR
   2. A photo of a Vaccination Record Card as a separate document; OR
   3. A photo of the client's Vaccination Record Card stored on a phone or electronic device; OR
   4. Documentation of COVID-19 vaccination from a health care provider; OR
   5. Digital record that includes a QR code that when scanned by a SMART Health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type.; OR
   6. Documentation of vaccination from other contracted employers who follow these vaccination records guidelines and standards.

      In the absence of knowledge to the contrary, a facility may accept the documentation presented as valid.

B. Facilities must have a plan in place for tracking verified worker vaccination status. Records of vaccination verification must be made available, upon request, to the local health jurisdiction for purposes of case investigation.

C. Workers who are not fully vaccinated, or for whom vaccine status is unknown or documentation is not provided, must be considered unvaccinated.

   See CDPH Guidance for Vaccine Records Guidelines & Standards for information on how individuals may obtain a record of their vaccine. A digital

copy of vaccine records for vaccinations administered in CA is also available at myvaccinerecord.cdph.ca.gov.

3. Respirator or mask requirements:

A. All facilities identified above must strictly adhere to current CDPH Masking Guidance. To the extent they are already applicable, facilities must also continue to adhere to Cal/OSHA's standards for Aerosol Transmissible Diseases (ATD), which requires respirator use in areas where suspected and confirmed COVID-19 cases may be present, and the Emergency Temporary Standards (ETS) that requires all unvaccinated workers be provided a respirator upon request.

B. Acute Health Care and Long-Term Care Settings:
In addition to respirators required under Title 8 of the California Code of Regulations, facilities must provide respirators to all unvaccinated or incompletely vaccinated workers who work in indoor work settings where (1) care is provided to patients or residents, or (2) to which patients or residents have access for any purpose. Workers are strongly encouraged to wear respirators in all such settings. The facility must provide the respirators at no cost, and workers must be instructed how to properly wear the respirator and how to perform a seal check according to the manufacturer's instructions.

C. High-Risk Congregate Settings and Other Health Care Settings:
Where Title 8 of the California Code of Regulations does not require the use of respirators, facilities shall provide all unvaccinated or incompletely vaccinated workers with FDA-cleared surgical masks. Workers are required to wear FDA-cleared surgical masks in indoor settings anywhere they are working with another person.

Additional Information Regarding Masking Requirements – UPDATE: July 31, 2021

Masks are required for all individuals, in the following indoor settings, regardless of vaccination status (and surgical masks are recommended):

1. Healthcare settings
2. State and local correctional facilities and detention centers
3. Homeless shelters
4. Long Term Care Settings & Adult and Senior Care Facilities

Additionally, masks are required for unvaccinated individuals in indoor public settings and businesses (examples: retail, restaurants, theaters, family entertainment centers, meetings, state and local government offices serving the public).

See State Health Officer Order, issued on July 26, 2021, for a full list of high-risk congregate and other healthcare settings where surgical masks are required for unvaccinated workers, and recommendations for respirator use for unvaccinated workers in healthcare and long-term care facilities in situations or settings not covered by Cal OSHA ETS or ATD.

For additional information on the July 28, 2021 CDPH Guidance for the Use of Masks, types of masks, the most effective masks, and ensuring a well-fitted mask, individuals should refer to CDPH Get the Most out of Masking and see CDPH Masking Guidance Frequently Asked Questions for more information.

4. Testing requirements:

A. Acute Health Care and Long-Term Care Settings:
   1. Asymptomatic **unvaccinated** or incompletely vaccinated workers are **required to undergo** diagnostic screening testing.
   2. Workers may choose either antigen or molecular tests to satisfy this requirement, but unvaccinated or incompletely vaccinated workers must be tested **at least twice weekly** with either PCR testing or antigen testing. Any PCR (molecular) or antigen test used must either have Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.

B. High-Risk Congregate Settings and Other Health Care Settings:
   1. Asymptomatic **unvaccinated** or incompletely vaccinated workers are **required to undergo** diagnostic screening testing.
   2. Workers may choose either antigen or molecular tests to satisfy this requirement, but unvaccinated or incompletely vaccinated workers must be tested **at least once weekly** with either PCR testing or antigen testing. More frequent testing improves outbreak prevention and control and is encouraged, especially with antigen testing. Any PCR (molecular) or antigen test used must either have Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.

C. All Facilities:
   1. Unvaccinated or incompletely vaccinated workers must also observe all other infection control requirements, including masking, and are not exempted from the testing requirement even if they have a medical contraindication to vaccination, since they are still potentially able to spread the illness. Previous history of COVID-19 from which the individual

recovered more than 90 days earlier, or a previous positive antibody test for COVID-19, **do not** waive this requirement for testing.

2. Diagnostic screening testing of asymptomatic fully vaccinated workers is not currently required. However, fully vaccinated workers may consider continuing routine diagnostic screening testing if they have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact the level of protection provided by COVID-19 vaccine.
3. Facilities with workers required to undergo workplace diagnostic screening testing should have a plan in place for tracking test results, conducting workplace contact tracing, and must report results to local public health departments. There are IT platforms available that can facilitate these processes for facilities.

Testing costs are coverable on employee insurance. Facilities may obtain information about free antigen testing (and how to obtain follow-up PCR testing) on the CDPH testing website. Free testing may also be available through the local public health department for uninsured employees.

As a reminder, employees testing positive for COVID-19 must follow CDPH isolation guidance, and cannot work in health care settings (the flexibilities allowing work in health care under specified conditions expired June 30, 2021). See links for details:

- Self-isolation Instructions for Individuals Who Have or Likely Have COVID-19 (ca.gov)
- California Department of Public Health Self-Isolation Instructions for Individuals with COVID-19
- Guidance on Returning to Work or School Following COVID-19 Diagnosis
- Responding to COVID-19 in the Workplace for Employers: This guidance is not intended for use in managing or preventing outbreaks in healthcare, congregate living settings, or other workplaces where the California Aerosol Transmissible Diseases (ATD) standard (title 8 section 5199) applies. Employers should also consult:
    - CDC guidance for businesses and small businesses for information on preventing outbreaks;
    - Cal/OSHA guidance to ensure that they are complying with legal requirements for worker protection; and
    - The California statewide industry-specific guidance to reduce risk during and after reopening of businesses.

5. Definitions:

For purposes of the Public Health Order and this BH Information Notice, the following definitions apply:

A. "Fully Vaccinated" means individuals who are considered fully vaccinated for COVID-19: two weeks or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization), or two weeks or more after they have received a single-dose vaccine (Johnson and Johnson [J&J]/Janssen). COVID-19 vaccines that are currently authorized for emergency use:
   a. By the US Food and Drug Administration, are listed at https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.
   b. By the World Health Organization, are listed at https://extranet.who.int/pqweb/vaccines/covid-19-vaccines

B. "Incompletely vaccinated" means persons who have received at least one dose of COVID-19 vaccine but do not meet the definition of **fully vaccinated.**

C. "Respirator" means a respiratory protection device approved by the National Institute for Occupational Safety and Health (NIOSH) to protect the wearer from particulate matter, such as an N95 filtering facepiece respirator.

D. "Unvaccinated" means persons who have not received any doses of COVID-19 vaccine or whose status is unknown.

E. "WHO Yellow Card" refers to the original World Health Organization International Certificate of Vaccination or Prophylaxis issued to the individual following administration of the COVID-19 vaccine in a foreign country.

F. "Worker" refers to all paid and unpaid persons serving in health care, other health care or congregate settings who have the potential for direct or indirect exposure to patients/clients/residents or SARS-CoV-2 airborne aerosols. Workers include, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

6. Terms of Public Health Order:

The Terms of the Public Health Order supersede any conflicting terms in any other CDPH orders, directives, or guidance.

Except to the extent the Public Health Order provides otherwise, all other terms in the Order of June 11, 2021 remain in effect and shall continue to apply statewide. The Order shall take effect on August 9, 2021, at 12:01 am. Facilities must be in full compliance with the Order by August 23, 2021.

The Order is issued pursuant to Health and Safety Code sections 120125, 120140, 120175,120195 and 131080 and other applicable law.

Sincerely,

Original signed by

Kelly Pfeifer, M.D.
Deputy Director
Behavioral Health

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: July 29, 2021

Behavioral Health Information Notice No: 21-045

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal Organized Delivery System (DMC-ODS) peer support services implementation fiscal plan guide

PURPOSE: To provide guidance for DMC-ODS counties to establish peer support services rates.

BACKGROUND:
Pursuant to Senate Bill 803 (Beall, Chapter 150, Statutes of 2020) the Department of Health Care Services (DHCS) will seek approval from the Centers for Medicare & Medicaid Services (CMS) to implement peer support services within the DMC-ODS. This letter transmits the instructions and template for submitting county fiscal plans.

To allow for peer support services to go live for DMC-ODS counties on January 1, 2022 (pending CMS approval), the peer support services rate setting process invites counties to submit rates outside the rate setting process that normally occurs annually in late winter/early spring. Counties will need to submit DMC-ODS rates by September 30, 2021 to ensure the ability to bill for Medi-Cal peer support services on January 1, 2022 (pending CMS approval). DHCS is unable to guarantee a January 1, 2022 start date for DMC-ODS rates submitted past this deadline. However, counties may choose to submit DMC-ODS rates at any time and DHCS will enable the service as soon as possible.

If you have any questions regarding the submission of your county DMC-ODS Waiver Fiscal Plan, contact BHFSOps@dhcs.ca.gov. Counties can submit their Fiscal Plan to the Behavioral Health Financing Section, Operations Unit at BHFSOps@dhcs.ca.gov.

Sincerely,

Marlies Perez, Chief
Community Services Division

Attachment

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 9, 2021

Behavioral Health Information Notice No: 21-046
Supercedes BHIN No.: 20-009

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Updated guidance for behavioral health programs regarding COVID-19 public health emergency flexibilities

PURPOSE: Provide counties and providers with information on the status of public health emergency flexibilities as of August 2021. This Behavioral Health Information Notice (BHIN) updates and supersedes BHIN 20-009.

REFERENCE: DHCS COVID-19 Response website

BACKGROUND:

DHCS was given authority to grant flexibility for certain requirements through Executive Orders (EO) N-43-20 and N-55-20, which are sunsetting (see Executive Order N-08-21 for details of when particular provisions end) and through a Section 1135 waiver granted

by the Centers for Medicare and Medicaid Services (CMS), effective March 15, 2020. See DHCS COVID-19 Response website for updated information notices related other Executive Order flexibilities related to Driving Under the Influence (DUI) Programs, Alcohol and Other Drug (AOD) programs, and residential and inpatient mental health treatment facilities.

This BHIN supersedes BHIN 20-009. Information regarding BH telehealth policy is outlined separately in BHIN 21-047.

POLICY:

1. **5150 Evaluations and 5151 Assessments**
   W&I Code section 5150 evaluations and W&I Code section 5151 assessments may be performed by authorized providers via telehealth (synchronous audio and video) pursuant to W&I Code sections 5008(a), 5151 (b) and 5150.5(a). This may include releases from involuntary evaluation and treatment, as appropriate. These services are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the individual has Medi-Cal coverage for the service and all Medi-Cal requirements are met.

2. **Additional Time to Complete Counselor Certification Requirements: Flexibility expires September 30, 2021.**
   California Code of Regulations, Title 9, §13035(f)(1) requires AOD registered counselors to obtain certification as an AOD counselor, from a DHCS recognized certifying organization, within five (5) years of the date of registration.

3. **Adapting Oversight Requirements to Prioritize Patient Needs and Accommodate Workforce Challenges**
   DHCS is no longer providing blanket workforce flexibilities. DHCS encourages counties to reach out to their DHCS liaison with concerns about meeting DHCS mandated regulatory or reporting requirements and deadlines due to the impact of the public health emergency, as individual exceptions may be considered.

4. **Emergency Enrollment in Medi-Cal for Specialty Mental Health Service Providers**
   The streamlined enrollment process for providers ended June 30, 2021. Providers should use the standard enrollment process going forward.

5. Alcohol and Other Drug (AOD) Residential and Outpatient Treatment Facility Flexibilities

DHCS is no longer providing blanket flexibilities. DHCS encourages providers to reach out to their DHCS liaison if questions. See BHIN 20-017, Alcohol and Other Drug Facilities, for more information, on the DHCS COVID-19 Response website.

6. Temporary Suspension of MHSA Program On-site Reviews

Per W&I Code section 5897(d), DHCS is required to conduct MHSA program reviews of county performance contracts once every three years. Due to the public health emergency, the MHSA program on-site reviews were temporarily suspended. DHCS will be reaching out to counties to schedule and resume onsite reviews.

7. Signature Requirements

Release of Information: DHCS does not have oversight authority over federal requirements. HIPAA requires all authorizations for release of information to have a signature in order to be valid per 45 CFR 164.508. There is no indication from the federal Office of Civil Rights, Health and Human Services that they have waived this requirement due to COVID.

Informed Consent for Anti-psychotic Medications:
Flexibility expires September 30, 2021.

California regulations[1] require that mental health facilities maintain a consent form signed by a patient to receive anti-psychotic medications. The flexibility in paragraph 11 of Executive Order N-55-20 waiving this requirement expires September 30, 2021, and section 852 of Title 9 of the California Code of regulations shall go back into effect. If a patient chooses not to sign the consent form, the provider shall document in the patient's chart that the patient understands the nature and effect of the anti-psychotic medication(s) and consents to administration of the medication(s), but does not want to sign the consent form. Facilities are not expected to obtain signatures on these documents for patients that started and discontinued services during the COVID-19 public health emergency, or who discontinued services during the emergency period. During the COVID-19 public health emergency, Facilities must document in the patient's medical record the reason for the missing or late signature. This requirement only applies to anti-psychotic medications, not psychotropic medications generally.

[1] Cal. Code Regs., tit.9, § §852.

Signatures on treatment plans.
When a signature is required on a client plan and a beneficiary is unavailable to sign the plan, such as when the service is done by telehealth or telephone, the reason for the missing signature shall be documented in the client plan. It is not necessary to obtain the signature when the client returns to in-person care. The following approaches are appropriate:

- Documenting in the chart that oral consent was obtained in the course of telehealth services,
- Use of electronic signatures, such as via DocuSign or similar services, if the e-signature service has a business associate agreement with the applicable covered entity,
- Obtaining wet signatures when an in-person visit is made, and
- Documenting the reasons for any signatures that are late or missing.

Signatures consenting to telehealth or telephone visits.
California law requires a patient's consent to receive services via telehealth or via telephone to be documented in the client chart. Documentation of verbal consent is sufficient. California law does not specify the frequency a provider is required to obtain consent from a patient. For facilities that participate in Medi-Cal, the DHCS licensing and certification division will accept a one-time consent in the client file.

8. Process to Request Fee Reductions or Waivers
SB 601 went into effect on January 1, 2020. The new law, set forth in Gov. Code Section, 11009.5, authorizes the DHCS to establish a process to reduce or waive any fees required to obtain a license, renew or activate a license, or replace a physical license for display, when a business has been displaced, or experiences economic hardship as a result of an emergency.

DHCS Mental Health Rehabilitation Centers (MHRC), Psychiatric Health Facilities (PHF), Narcotic Treatment Programs (NTP), Driving Under the Influence (DUI) programs, or substance use disorder (SUD) residential and outpatient facilities**,** that have a license or certification issued by LCD, may submit a written request to DHCS for a fee reduction or waiver:

- Identify whether the request is for a reduction or waiver of fee(s);
- Identify the type of fee requested to be reduced or waived (i.e., renewal application fee, relocation fee, etc.) and the specific fee amount being requested to pay if seeking a fee reduction;
- Describe how this reduction or waiver is specific to the COVID-19 emergency;

- Describe the economic hardship or displacement that occurred due to the emergency;
- Identify the provider type (MHRC, PHF, NTP, DUI, SUD Residential or Outpatient);
- Identify the provider number and legal entity name;
- Identify the program/facility name;
- Identify the facility physical address;
- Identify the facility mailing address; and
- Identify the Program Director and contact person.

Sincerely,

Original signed by

Kelly Pfeifer, M.D.
Deputy Director
Behavioral Health

DHCS COVID-19 Frequently Asked Questions:
Behavioral Health
Updated August 9, 2021

Operational Requirements

1. May providers share SUD diagnosis information during this emergency?

This is a federal, not state issue. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance which allows providers to share patient SUD diagnosis information that would normally be protected under 42 CFR Part 2 in instances of a bona fide medical emergency. Usage of the medical emergency exception must be documented by providers.

Data Reporting

2. Can DHCS clarify current expectation for the various county data reporting requirements?

Flexibilities on data reporting rescinded as of June 30, 2021. All county reporting requirements are in place.

Provider Enrollment

3. How can providers enroll in Medi-Cal during the public health emergency?

Providers should use the regular enrollment process; the flexibility allowing accelerated enrollment ended June 30, 2021.

4. How can providers waive fingerprinting requirements?

The flexibility for alternate pathways to obtain fingerprints for background checks was rescinded as of June 30, 2021.

Licensing and Certification

5. **Can DHCS waive the requirement that SUD treatment programs maintain a minimum of 30% licensed staff?**
   Pursuant to California Code of Regulations Title 9 Chapter 8 Section 13010, at least 30% of staff providing counseling services in all AOD programs shall be licensed or certified.

6. **Can individual providers receive a waiver to operate above their licensed capacity?**

   This flexibility rescinded as of June 30, 2021. For questions related to a specific facility, contact: LCDQuestions@dhcs.ca.gov. MHRCs and PHFs should email MHLC@dhcs.ca.gov.

7. **What are the licensure requirements to allow SUD residential programs to relocate into new locations on an emergency basis?**

   In accordance with California Code of Regulations Title 9 Chapter 5 Section 10527(c), facilities that move operations to new locations shall submit a Supplemental Application (DHCS 5255) within 60 days from the date of the move.

8. **Are facilities able to provide treatment or recovery services outside the facility service location if there are concerns about providing treatment at the location due to COVID-19?**

   Providers should contact their Licensing Analyst for questions.

Billing

9. ***Can DHCS can consider parity with respect to requirements of the specialty MH and SUD systems where we are disadvantaging DMC-ODS systems with 6 months to work denials versus 12 months in the MH system?***

   DHCS has addressed the issue of denials, and now accept 12 months to work denials in both SUD systems and MH systems.

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 12, 2021

Behavioral Health Information Notice No: 21-048

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal Organized Delivery System (DMC- ODS)
Treatment Perception Survey (TPS)

PURPOSE: Guidance to DMC-ODS counties for the submission of client satisfaction survey data

BACKGROUND:

DHCS is required to maintain a plan for oversight and monitoring of DMC-ODS providers, counties and the Partnership Health Plan of California regional model ("plans") to ensure compliance and corrective action with standards, access, and delivery of quality care and services. At least once per year, DHCS shall monitor the plans through an External Quality Review Organization (EQRO), Behavioral Health Concepts (BHC), Inc. in coordination with the University of California,Los Angeles (UCLA), BHC is required to review client satisfaction surveys conducted by the plans participating in the DMC-ODS Waiver.

Each DMC-ODS plan shall survey clients at each of the providers within the plan's network annually, using a valid client satisfaction survey. The EQRO will validate

the findings during its annual reviews of the plan. The administration of this survey by the plan will also address the data collection needs for DMC-ODS evaluation required by the Centers for Medicare and Medicaid Services. The information gathered from the surveys will support DMC-ODS Quality Improvement efforts and provide key information on the impacts of the new continuum of care.

The TPS for adults was developed by UCLA based on San Francisco County's validated survey, and through consultation with DHCS, individual counties, the Substance Abuse Prevention Treatment Committee of the County Behavioral Health Director's Association of California, the DMC-ODS EQRO Clinical Committee, BHC, andother stakeholder input. The TPS for youth was based on Los Angeles County's youth survey.

DHCS has contracted with UCLA to scan and process the paper survey forms, collect the online and automated phone survey data, receive electronic data files from counties (if applicable), analyze the data, and prepare regional-, county- and provider-level summary and statewide reports.

POLICY:
Plans shall administer the TPS to both adults and youth at least once annually, following the instructions provided below. However, as a best practice, plans can conduct more frequent client satisfaction surveys and/or include additional survey questions as long as the standard TPS items are utilized.

The annual survey for DMC-ODS plans will take place on **September 20-24, 2021.** The survey is available for adults (ages 18 and older) and youth (ages 12 to 17) in 13 languages, including English, Chinese, Spanish, Tagalog, Vietnamese, Russian, Arabic,Korean, Eastern and Western Armenian, Cambodian, Hmong, and Farsi.

Plans will have the option of using paper forms (one-page and large print), secure online survey links, and/or an automated phone survey. Paper survey forms must be submitted to UCLA no later than **Monday, October 11, 2021.**

Detailed instructions, as well as the data collection materials are posted on the TPS website at: http://uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

UCLA will scan the paper survey forms and aggregate all the survey data received directly (online survey and automated phone survey) by plan. UCLA will

analyze the data, and prepare regional-, county- and provider-level and statewide summary reports. UCLA's goal is to provide these reports to the plans within three months of the survey period. In addition, through the annual EQRO review, BHC will assess client satisfaction by reviewing the TPS data along with any other client survey data provided by the plan.

If you have questions or feedback about the survey or collection procedures, please contact Marylou Gilbert with UCLA at MarylouGilbert@mednet.ucla.edu.

Sincerely,

Original signed by

Shaina Zurlin, LCSW, PsyD, Chief
Medi-Cal Behavioral Health Division

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 13, 2021

Behavioral Health Information Notice No: 21-049

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal (DMC) State Plan and Medication Assisted Treatment (MAT) Reimbursement Rates for Fiscal Year (FY) 2021-22

PURPOSE: This Information Notice transmits FY 2021-22 reimbursement rates for DMC services in State Plan counties and Narcotic Treatment Program (NTP) services and MAT provided in DMC Organized Delivery System (DMC-ODS) counties. These rates are effective July 1, 2021 through June 30, 2022.

REFERENCE: California Code of Regulations (CCR), Title 22, Section 51516.1
Welfare and Institutions Code (W&I) Sections 14021.51, 14021.6, and 14021.9,
MHSUD Information Notice 16-063

Discussion:

The Department of Health Care Services (DHCS) developed Statewide Maximum Allowable (SMA) and Uniform Statewide Daily Reimburement (USDR) rates in accordance with W&I Sections 14021.51, 14021.6, 14021.9, and the 1115 Waiver. Exhibit A displays SMA rates for State Plan services provided by State Plan counties

and the USDR rate for MAT Methadone dosing provided in a NTP. Exhibit B displays the USDR for Buprenorphine Mono, Buprenorphine Combo, Disulfiram, and Naloxone dosing in NTPs in DMC-ODS counties. These rate are effective for dates of service from July 1, 2021 through June 30, 2022.

DHCS has also developed rates for additional forms of buprenorphine and naltrexone (film and injectables) that are FDA approved to treat Opioid use disorders. CMS approved the use of these forms of medication in the 1115 renewal. DHCS will notify counties via email and System Change Schedule on the DHCS Portal when the new rates are deployed in the Short Doyle Medi-Cal (SDMC) Billing System. Rates for these MATs are retroactive to January 1, 2021.

Billing

For DMC State Plan billing for service dates on or after July 1, 2021, please refer to the following tables when populating the procedure and modifiers on the 837P electronic claim file of DMC claims submitted for adjudication.

Non-Perinatal Service Groups, Types, and Billing Codes

Service Group	Service Type	Billing Codes		
		Procedure Code	Modifier	Modifier
IOT	Intensive Outpatient Treatment	H0015		
NAL	Naltrexone (NAL) generic	S5000	HG	
NAL	Naltrexone (NAL) brand name	S5001	HG	
NTP	NTP – Individual Counseling	H0004	HG	
NTP	NTP – Group Counseling	H0005	HG	
NTP	NTP – Methadone	H0020	HG	
ODF	ODF – Individual Counseling	H0004		
ODF	ODF – Group Counseling	H0005		
RES	Residential – Short-Term – EPSDT	H0018		
RES	Residential – Long-Term – EPSDT	H0019		

Perinatal Service Groups, Types, and Billing Codes

Service Group	Service Type	Billing Codes		
		Procedure Code	Modifier	Modifier
IOT	Intensive Outpatient Treatment	H0015	HD	
NTP	NTP – Individual Counseling	H0004	HD	HG
NTP	NTP – Group Counseling	H0005	HD	HG
NTP	NTP – Methadone	H0020	HD	HG
ODF	ODF – Individual Counseling	H0004	HD	
ODF	ODF – Group Counseling	H0005	HD	
RES	Residential – Short-Term	H0018	HD	
RES	Residential – Long-Term	H0019	HD	

For billing in DMC ODS counties for service dates on or after July 1, 2021, please refer to the following tables when populating the procedure and modifiers on the 837P electronic claim file.

Non-Perinatal Service Groups, Types, and Billing Codes

Service Group	Service Type	Billing Codes				
		Procedure Code	Modifier	Modifier	Modifier	Modifier
MAT	NTP Additional MAT Dosing: Generic	S5000	UA	HG		
MAT	NTP Add'l MAT Dosing: Generic - Youth	S5000	UA	HG	HA	
MAT	NTP Add'l MAT Dosing: Brand name	S5001	UA	HG		
MAT	NTP Add'l MAT Dosing: Brand name - Youth	S5001	UA	HG	HA	
NTP	NTP Dosing – Methadone	H0020	UA	HG		
NTP	NTP Dosing – Methadone –Youth	H0020	UA	HG	HA	
NTP	NTP Individual Counseling	H0004	UA	HG		
NTP	NTP Individual Counseling – Youth	H0004	UA	HG	HA	
NTP	NTP Group Counseling	H0005	UA	HG		
NTP	NTP Group Counseling – Youth	H0005	UA	HG	HA	

Perinatal Service Groups, Types, and Billing Codes

Service Group	Service Type	Billing Codes				
		Procedure Code	Modifier	Modifier	Modifier	Modifier
MAT	NTP Add'l MAT Dosing: generic – Perinatal	S5000	UA	HG	HD	
MAT	NTP Add'l MAT Dosing: generic – Perinatal, Youth	S5000	UA	HG	HD	HA
MAT	NTP Add'l MAT Dosing: brand name – Perinatal	S5001	UA	HG	HD	
MAT	NTP Add'l MAT Dosing: brand name – Perinatal, Youth	S5001	UA	HG	HD	HA
NTP	NTP Dosing – Methadone – Perinatal	H0020	UA	HG	HD	
NTP	NTP Dosing – Methadone – Perinatal, Youth	H0020	UA	HG	HD	HA
NTP	NTP Individual Counseling – Perinatal	H0004	UA	HG	HD	
NTP	NTP Individual Counseling – Perinatal, Youth	H0004	UA	HG	HD	HA
NTP	NTP Group Counseling – Perinatal	H0005	UA	HG	HD	
NTP	NTP Group Counseling – Perinatal, Youth	H0005	UA	HG	HD	HA

QUESTIONS

Questions regarding the DMC or MAT rates may be directed to Behavioral Health Financing Section at BHFSOps@dhcs.ca.gov.

Sincerely,

Original signed by

Brian Fitzgerald, Chief
Local Governmental Financing Division

Enclosures

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 20, 2021

Behavioral Health Information Notice No: 21-052

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Reimbursement of Specialty Mental Health and Drug Medi-Cal Administrative Costs Effective July 1, 2021

REFERENCE: Executive Order N-55-20; BHIN 20-033; Executive Order N-08-21

PURPOSE: To inform Mental Health Plans (MHPs), Drug Medi-Cal-Organized Delivery System (DMC-ODS) Counties, and DMC State Plan Counties of a change in the limit applied to administrative costs for the Medi-Cal Specialty Mental Health Services (SMHS) Program, the DMC-ODS program, and the DMC State Plan program.

BACKGROUND:
On April 22, 2020, Governor Newsom issued Executive Order N-55-20. Paragraph 9 of the Executive Order stated, "Notwithstanding Welfare and Institutions Code section 14711(c), DHCS may reimburse county behavioral health departments for administrative costs related to Short-Doyle Medi-Cal Claims up to 30 percent of the total actual cost of direct client services." Governor Newsom issued Executive Order N-08-21 on June 11, 2021, which ends this accommodation effective July 1, 2021. As a result,

DHCS will reimburse county behavioral health departments for administrative costs incurred after June 30, 2021 up to 15% of their total actual cost of direct client services.

POLICY:
Effective with costs incurred after July 1, 2021, DHCS will limit administrative costs incurred by counties to administer the Medi-Cal SMHS program, DMC-ODS program, and DMC State Plan Program at 15 percent of the actual cost for direct client services in each program. DHCS has posted updated claim forms for each program that will allow counties to separate administrative costs incurred after June 30, 2021, from those incurred before July 1, 2021. Please use the appropriate claim form based on the service period for the claim. Revised administrative claim forms for MHPs can be downloaded from DHCS MentalHealth Forms, and DMC administrative claim forms are listed at Drug Medi-Cal Treatment Program Forms.

DHCS will also update cost report forms to allow counties to separately report administrative costs subject to the 30 percent limit from administrative costs subject to the 15 percent limit.

DHCS is not making any changes to the reimbursement flexibilities addressed in BHIN 20-031, which were approved by CMS and will remain in effect until the end of the federal public health emergency.

For questions regarding administrative claiming changes outlined in this notice, please e-mail BHFSOps@dhcs.ca.gov.

Sincerely,

Lindy Harrington
Deputy Director
Health Care Financing