Department of Health Care Services
Drug Medi-Cal Organized Delivery System Waiver
Implementation Plan for Regional Model encompassing Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Trinity Counties

NOTE: THROUGHOUT THIS DOCUMENT THE ENTITY SEEKING THE WAIVER – THE NINE COUNTIES IN CONJUNCTION WITH PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) WILL BE REFERRED TO AS THE "REGIONAL MODEL".

This document will be used by the Department of Health Care Services (DHCS) to help assess the readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and to determine capacity, access and network adequacy. The tool draws upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS will review and render an approval or denial of the Regional Model counties' participation in the Waiver.

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(Revised 2/3/15)

Part I
Plan Questions

This part is a series of questions that summarize the Regional Model's DMC-ODS plan.

Introduction to the Regional Model

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

- *Integration of Physical, Mental Health and Substance Use Services is essential to quality care and positive health outcomes.* Early in 2015, the counties determined that their individual efforts to provide Drug Medi-Cal services would be most effective if integrated with the current physical and mental health systems. This philosophy is reflected in the efforts to develop a model that focuses on limiting the practical and regulatory constraints that separate the various systems and that involves, as much as possible, all parts of the Medi-Cal health care delivery system including clinics and hospitals, as well as the mandated components of the Drug Medi-Cal model.
- *Continuum of Care:* The most effective health care system is one that is comprehensive and that facilitates the transition of clients among levels of care based upon their needs.
- *Regional Collaboration:* The Regional Model came about because of the culture of cooperation and collaboration that exists among the counties and with Partnership HealthPlan of California. The encouragement and strengthening of this collaboration will be key to the success of the Regional Model.
- *Client Engagement:* The necessity of engaging clients in their treatment is a key underlying philosophy for the proposed Regional Model, from the initial appointment throughout the treatment episode. Clients will receive services individualized to their needs, with specific treatment plans based on medical necessity and the client's ability to accept change.
- *Learning Continuum:* Staff in all health care and community support organizations will need to learn to work effectively in multidisciplinary teams, form productive relationships with clients, and reflect critically upon and change their own organizational practices based on new knowledge. The Regional Model will provide continual trainings and support to our providers and communities, through provider forums, trainings, and advisory groups and in other ways.

Areas for Future Development

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

- Youth System: Regional Model county representatives are working with the State on the development of the elements of the Youth System of Care. For the most part, the Regional Model will incorporate the elements of this model once it is developed.
- Sober living environments: Although the initial proposed Regional Model does not include sober living environments, we recognize that these may be key to many individuals' recovery and have a special significance in a regional model where

outpatient services are available in each community but residential services are regional. To the degree that there are some sober living environments already in our communities, we encourage their use but do not incorporate them as part of this Model.

1. Identify the county agencies and other entities involved in developing the Regional Model. (Check all that apply) Input from stakeholders in the development of the Regional Model implementation plan is required; however, all stakeholders listed are not required to participate.

   ☒ County Behavioral Health Agencies
   ☒ County Substance Use Disorder Agencies
   ☒ Providers of drug/alcohol treatment services in the communities
   ☒ Representatives of drug/alcohol treatment associations in the communities
   ☒ Physical Health Care Providers
   ☒ Medi-Cal Managed Care Plan
   ☒ Federally Qualified Health Centers (FQHCs)
   ☒ Clients/Client Advocate Groups
   ☒ County Executive Offices
   ☒ County Public Health
   ☒ County Social Services
   ☒ Foster Care Agencies
   ☒ Law Enforcement
   ☒ Court
   ☒ Probation Departments
   ☒ Education
   ☒ Recovery support service providers (including recovery residences)
   ☒ Health Information technology stakeholders
   ☒ Other (specify) Other interested community agencies and health care system participants.

2. How was community input collected?

   ☒ Community meetings
   ☒ County advisory groups
   ☐ Focus groups
   ☒ Other method(s) (explain briefly) Newsletters and other mailings to PHC providers; interviews with stakeholders and community leaders.

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

   ☒ Monthly (at least)
   ☐ Bi-monthly
   ☐ Quarterly
   ☐ Other: _____

   Review Note: One box must be checked.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

   ☒ SUD, MH, and physical health representatives in the participating counties have been holding regular meetings to discuss other topics prior to waiver discussions.
   ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.
   ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
   ☐ There were no regular meetings previously, but they will occur during implementation.
   ☐ There were no regular meetings previously, and none are anticipated.

5. What services will be available to DMC-ODS clients under this Regional Model plan?

   REQUIRED

   ☒ Withdrawal Management (minimum one level)
   ☒ Residential Services (minimum one level)
   ☒ Intensive Outpatient
   ☒ Outpatient
   ☒ Opioid (Narcotic) Treatment Programs
   ☒ Recovery Services
   ☒ Case Management
   ☒ Physician Consultation

   How will these required services be provided?
   ☐ All county operated
   ☐ Some county and some contracted
   ☒ All contracted with Partnership HealthPlan including some county operated providers

OPTIONAL

☒ Additional Medication Assisted Treatment
☐ Recovery Residences
☐ Other (specify) _____

6. Has the Regional Model established a toll free number for prospective clients to call to access DMC-ODS services?

   ☒ Yes (required)
   ☐ No. Plan to establish by: _____.

   Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. The Regional Model will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

   ☒ Yes (required)
   ☐ No

PART II
PLAN DESCRIPTION (Narrative)

In this part of the plan, the Regional Model must describe certain DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS reviews your plan description, you may need to make revisions.
- The Regional Model must submit a revised plan to DHCS whenever the Regional Model requests to add a new level of service.

Narrative Description

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

Review Note: Stakeholder engagement is required in development of the implementation plan.

The Regional Model entities have a long history of collaboration with each other and with other providers to develop solutions for systemic problems. Most of the Regional Model entities and their various treatment partners have collaborated over time to create a system of care that brought together a disparate and fragmented treatment arrangement. Perhaps one of the best examples of this collaboration is the development of the Regional Model itself, which has required extensive outreach, consultation, and cooperation among the 9 counties (Del Norte, Humboldt, Lake, Mendocino, Trinity, Shasta, Siskiyou, Lassen and Modoc), non-county treatment providers, community groups and Partnership HealthPlan since 2015, when the model was first proposed.

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

Over a two year period, county and PHC staff have met at least monthly to develop the parameters of the Regional Model. Within each county, representatives from prevention, residential, outpatient and detoxification providers, departmental staff, the

courts and probation meet regularly in a variety of settings, on matters that facilitate the development of an integrated continuum of substance use care for adults. The Regional Model participants now seek to create a comprehensive continuum of care based upon established benchmarks for length of stay and intensity of services. Clients would move within the continuum of services, from more or less intensive services based on recovery needs. ASAM criteria will be used to make placement and treatment decisions, based on clients functioning within the six ASAM dimensions. In addition, the system will include other key components, a telephone-based assessment and placement function, with a toll-free number and robust utilization management and care coordination processes.

Once the vision was vetted and finalized by the leadership of PHC and the participating counties, a workgroup made up of county SUD and PHC staff worked to establish the details of the multiple county client flow and program structure. During this process each county worked to inform their interested community and treatment partners, with concerns and suggestions being incorporated as the Model was developed. Outreach to representatives of community providers, key stakeholder groups, criminal justice, health care, mental health and other agencies was conducted in order to help structure the overall Regional Model concept. All of these stakeholders and interests will be involved in the implementation and improvement of the treatment and recovery services system. These conversations led to the decision for the Regional Model to include key components: a centralized telephone-based portal (call center) to provide initial assessments and assist in ensuring access to the appropriate level of care; a full continuum of care that facilitates the movement of clients to the most appropriate level of care; a comprehensive quality improvement process that focuses on outcomes and the effectiveness of treatment; a knowledge-driven system that relies on evidence-based practices and models; and a focus on client satisfaction. These components of the proposed Regional Model, and their underlying philosophies, are reflected throughout this document.

The list of individuals and groups that provided input into the Regional Model vary by county but overall consisted of the following:

- Offices of Education
- County Managers
- Children's Youth Systems including Child Welfare Services
- Federally Qualified Health Centers and other Clinics and Primary Care Professionals
- Probation Departments
- Adult Social Services Departments and Programs
- SUD Treatment Professionals and Providers
- Recovery Community participants
- Mental Health and Substance Use Advisory Boards
- Native American providers

During the Regional Model implementation process, there will be a wide variety of opportunities for involvement by the various stakeholder and community representatives. These will include ongoing and regularly scheduled meetings between Regional Model staff and SUD providers; discussion at Mental Health and Substance Abuse advisory board meetings; updates and presentations at a variety of elected and appointed bodies with public input and participation; ongoing collaborative meetings among the counties and PHC; continued outreach to specific stakeholders including education, criminal justice, physical health and mental health providers, and others. These encounters will include updates on the progress of the implementation plan and where and how improvements can be offered, discussed and analyzed.

In sum, the Regional Model participants will ensure ongoing involvement and effective communication through means such as:

- Updates and solicitation of feedback at provider and contractor meetings;
- Updates, review of data and solicitation of feedback at quarterly Quality Improvement meetings
- Updates, solicitation of feedback and efforts to better coordinate care involving mental health, physical health and managed care partners at least tri-annually
- Publishing of performance and outcome data on a variety of websites, including those of the counties and of Partnership HealthPlan with guidance on how to provide feedback or to participate more directly

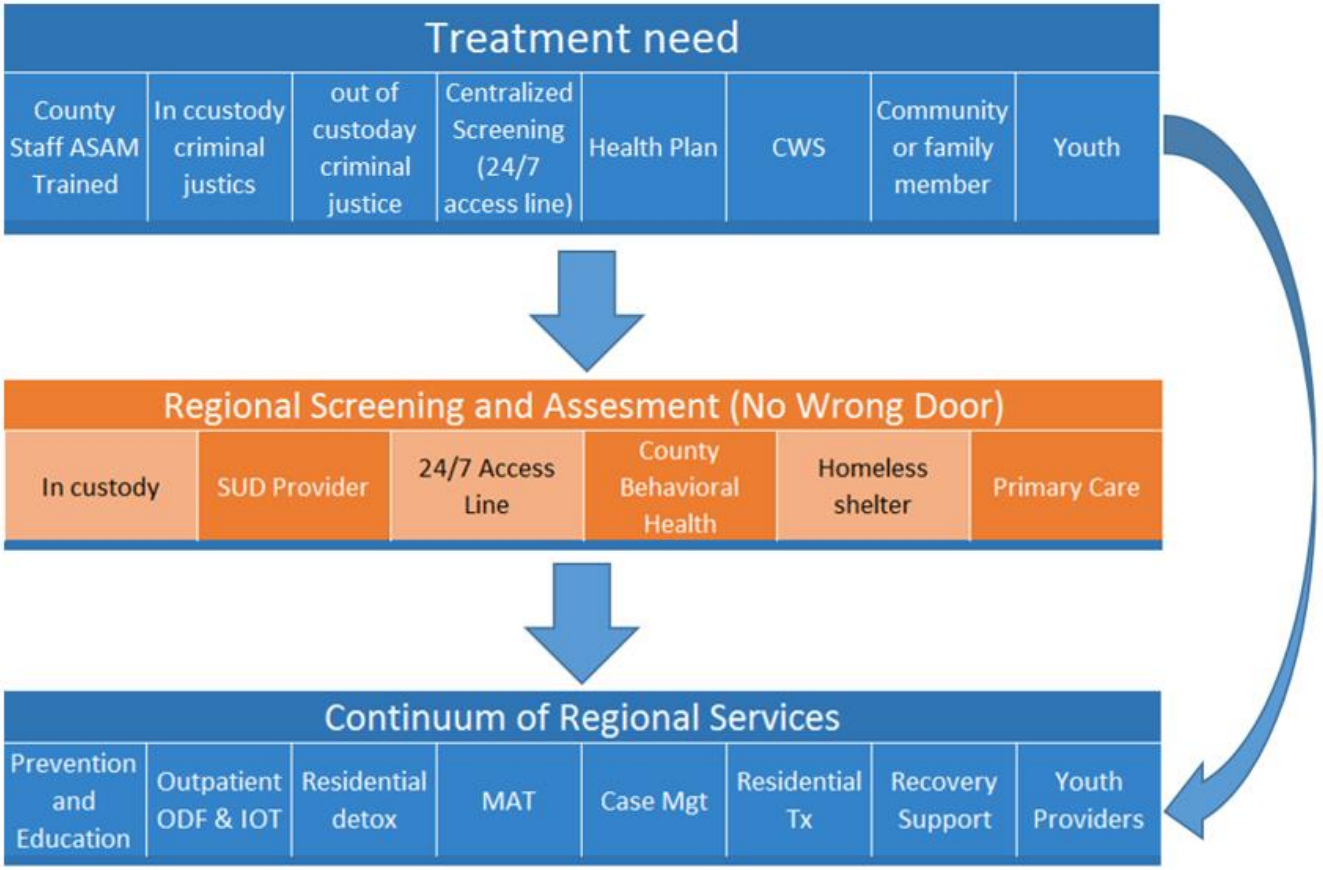
2. Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly.

Review Note: A flow chart may be included.

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

A brief overview of the client flow is shown below.

Client Flow



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

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

When a client's first point of contact is with a service provider and the provider does not have qualified (LPHA or LPHA-supervised and ASAM trained staff) available at the time of contact, the provider will facilitate a call to the Central Access Line. Providers will be encouraged to provide same day appointments wherever possible and to document all referrals and the outcomes of referrals to other levels of care or to other providers. In general, providers will be required to start treatment for eligible clients within 10 business days, and encouraged to treat them within 5 business days. In the unlikely event that admission to treatment will be greater than 10 business days due to capacity issues, providers will be required to link the beneficiary with another provider offering the appropriate ASAM level of care in an expeditious manner.

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

In the remainder of this section, the client flow and referral process are described in more detail, with particular emphasis on the referral process which varies depending on clients' circumstances. Separate sections are devoted to discussions about ASAM assessments, admissions to recommended levels of care, frequency of reassessments, transitions through levels of care, the role of case managers in care coordination, and timelines for movement among levels of care.

Client Flow

Central Access Line:
As described above, a client's first contact with Regional Model services might occur with a phone call to the Assess Line or an individual provider site, which then conducts a brief screening (defined below) and refers the client to an initial level of care (detoxification, outpatient, residential and/or Medication Assisted Treatment (MAT). A comprehensive ASAM assessment is subsequently conducted at the treatment site. All provider sites are assessment sites. Residential care placements require prior approval by PHC's utilization management department. This basic referral process will be mirrored in the Youth System and Medication Assisted Treatment systems with some variations required by the specific needs of the target population. Note that, as with the Regional Model as a whole, the capacity to serve youth will strengthen as the Model is implemented and grows over time.

Referrals and Entry Into the System; "No Wrong Door" Philosophy:
The Regional Model process for managing client entry into the adult system will be more structured than that for youth services programs, which will allow for more flexibility. Referrals for services will be made in three different ways; (1) Appointments will continue to be offered at outpatient service programs; (2) Calls to the Central Access Line will result in referrals, with utilization management authorizations and

referrals for residential treatment; and (3) Referrals to outpatient resources will be provided by various partner agencies, such as through authorized staff at probation and child welfare agencies.

- *Outpatient sites:* Clients can enter the system through outpatient service sites that will allow for drop-ins or appointments; no referral is required. The opportunity to schedule an admission into treatment will help the system welcome and engage with the client.
- *Entry through the Central Access Line:* A brief substance use and risk screening is administered and an initial level of care placement is made. If needed, residential referrals are routed to the utilization management department; outpatient referrals are made directly to treatment agencies. The date of Central Access Line call, date of referral to care, and actual date of first service ("intake show rate") are all recorded and used for performance objectives measurement. Treatment providers are required to attempt to reach out to patients that fail to attend treatments to assess motivational status and potentially offer another appointment.
- *Entry through partner agencies:* Criminal justice and/or child welfare agencies may seek to have certain professional staff authorized to admit clients into substance use treatment. These agencies generally need the capacity to directly screen and refer clients to treatment. Clients can be referred for approval for residential treatment or referred directly to outpatient provider sites for treatment. This will allow for more structured entry into the system with improved links between treatment providers and partner agencies and clients.
- *Entry through care coordination:* Programs serving clients with special needs or in special circumstances, such as Partnership HealthPlan's complex case management system; Intensive Outpatient Primary Care Management (IOPCM) programs in primary care sites or through the Whole Person Care model, will be reviewed by staff in the Central Access Line center and placed in the appropriate level of care. The Central Access Line can also refer clients with special needs for a full assessment prior to placement.
- *Same day referrals:* A counselor or program staff person can register, assess and meet with the client for an intake session and begin the treatment process the same day or within 24 hours of their initial call to the Central Access Line.
- *Same day treatment:*
    - *Referrals to same day residential treatment:* After a Central Access Line screening and utilization management approval, residential providers work with the clients to arrange for intake. If needed, the Regional Model will facilitate transportation, medication pick-up and delivery and other assistance to help ensure that clients enter residential treatment as soon as possible after the assessment. Same day intakes will be encouraged to improve access and client engagement and to reduce early terminations of treatment.
    - *Referrals to same day outpatient treatment:* A scheduled rotation of "on call" providers will be available for referrals from the Central Access Line.

The basic referral process will be mirrored in the Youth and Medication Assisted Treatment systems with some variations required by the specific needs of the targeted population. For MAT, clients will be screened and referred for services through the Central Access Line and referred to the MAT program best suited to the client's needs and place of residence.

Assessments

Ideally, the first level of assessment is at the primary care site. However, the first assessment may also occur when the client first seeks substance use treatment.

Brief Assessment at the Primary Care Site
PHC primary care providers will conduct a brief assessment based on the ASAM Criteria Immediate Need Profile and the ASAM level of placement tool and make referrals or provide further services consistent with that assessment.

ASAM assessments
Intake is the first session at all treatment sites across the system of care. An in-depth level of care assessment is conducted with each client, starting with a biopsychosocial assessment to determine if the beneficiary meets medical necessity based on the DSM and the ASAM criteria for placement. The 6-dimensional ASAM assessment will be conducted by licensed, license-waivered, or state certified AOD counselors working under the direction of clinic licensed staff, and will serve as the basis for confirming client placement decisions.

When a client needs a level of care not currently available in the system, such as partial hospitalization, they will be placed in the next higher or lower level of care that is safe and most appropriate to their needs. The goal will be to accommodate client choice wherever possible.

Frequency of assessments
Frequency of assessments
Clients can be re-assessed as often as necessary; an ASAM assessment is generally valid for 180 days. Generally, ASAM guidelines suggest the following reassessment schedule:
Level 1: Minimum monthly
Level 2: Minimum weekly
Level 3: Minimum weekly
Level 4: Minimum daily
Clients who return to the system following a break in treatment (discharge) will require a reassessment before they can be placed in care

Treatment Plans should be reevaluated every 30 to 45 days, unless there are significant changes warranting more frequent reassessments. Changes that could warrant a

reassessment and possibly a transfer to a higher or lower level of care include, but are not limited to, the following:

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

Case Management

Case managers' role in the client flow

While the term "case manager" has a variety of meanings, in the context of the Regional Model, case management functions may be provided by certified staff specifically designated as case managers, by treating clinicians or by other certified treatment site staff. The case management function manages client flow among levels of care after admission. The case manager will work with Plan staff to monitor the client transfer process, authorize extensions of stay in treatment, and trouble shoot for solutions for specific client problems and other client related issues that arise during treatment.

Case managers may be involved in transporting clients among levels of care. The case management function is to provide linkages to community services, assisting clients with applications for benefits and housing and in the meeting of instrumental needs such as enrollment in the SNAP program; medical and dental care; clothing, transportation, etc.

Timelines for movements between levels of care

The treatment system seeks to provide individualized treatment, tailored to a client's needs based on ASAM criteria and stage of change. There are no fixed lengths of stay for any program, although there are guidelines for the length of stay for most modalities:

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

The length of stay ranges serve as guidelines for the length of stay, or for when the stay should be reviewed for the need for an extension. Different standards will be used for youth. In the adult system, the duration of stay for detoxification services varies between 3 and 5 days; residential treatment approximately 25-35 days; outpatient services between 60-90 days, and intensive outpatient 30-60 days. Note that these timeframes may be longer for some clients, especially those with co-occurring conditions. In the youth system residential treatments will average about 30 days, intensive outpatient about 40-60 days and regular outpatient around 60-90 days.

Authorizations for residential treatment may be initiated at the residential treatment site or following an ASAM assessment made by other providers or the Central Access Line. A Treatment Authorization Request (TAR) and additional supporting documentation should be submitted at least 24 hours before the scheduled admission date and must be approved prior to the admission of the client. Requests for continuing authorization should be submitted at least seven calendar days before the expiration of the initial authorization.

Partnership HealthPlan's utilization management department will review the TAR and respond to the requesting agency within 24 hours with an Approved, Pending or Denied determination. Providers will be given 24 hours to provide further information for Pending TARs. If the TAR is denied, a written Notice of Action will be sent to the beneficiary notifying them of the authorization decision and they will be referred to the appropriate level of care.

3. Beneficiary Access Line. For the beneficiary toll free access number, what data will be collected (i.e., measure the number of calls, waiting times, and call abandonment)?

As noted above, beneficiaries can assess the system through the Central Access Line or at individual provider sites during business hours. The "no wrong door" philosophy is designed to encourage access and to facilitate client engagement and involvement. In addition to the access methods described above, each county will provide beneficiary access information through their information and referral resources. The Regional Model will have a toll-free number that will connect, during business hours, to the Central Access Line for immediate screenings and placement in treatment.

All access sites – the Central Access line, individual provider sites, partner agencies, etc. -- will be required to collect and report data on the efficacy of their client access, including the number of clients contacting the system and the times to first appointment.

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

All calls to the Central Access Line and the 24/7 access line will be logged and the following data collected:

- Number of calls, including the date, time and length of the call
- Number of calls requesting/requiring oral interpreter services for clients or potential clients
- First available appointment offered to the individual and first scheduled appointment times for face-to-face assessments
- Caller's name
- Call type (i.e., seeking referral, questions etc.) and whether emergency, urgent or routine
- Disposition including ASAM level of care for referrals
- Person who answered the call

Other data collected includes:
- Insurance type
- Disposition type (Specialty, Network, AOD, PCP, Community Resources)
- Total calls received
- Total calls answered
- Abandonment rate
- Average answered hold time (in seconds)
- Average abandoned hold time (in seconds)
- Number of complaint or grievance calls

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the Regional Model have with the required service levels? Describe how the Regional Model plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

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

A. Early Intervention (ASAM Level 0.5)

Primary care and other sites will perform Screening, Brief Intervention, and Referral to Treatment (SBIRT) activities for alcohol for adults, as currently required by DHCS. Beneficiaries at risk of developing alcohol disorders or those with an existing alcohol disorder are identified and offered: screening for adults, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage. PCPs will also screen for other substance use conditions using the Staying Healthy Assessment or another screening tool, and perform further assessment and potentially offer referral as clinically appropriate. These services will be available within each county in the Regional Model.

B. Outpatient Services (ASAM Level 1.0)
Outpatient services consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. Providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination. Services may be provided in-person, by telephone, or by tele-health in any appropriate setting in the community. These services will be available within each county in the Regional Model.

The Regional Model expects to have at least one general outpatient program in each county by the time of implementation, all D/MC certified or actively in the process. Where possible and indicated by need, the Regional Model will work to implement an array of approaches, including those for adolescents and adults, gender-specific and Spanish-language focused, by the end of Implementation Year 1.

C. Intensive Outpatient Services (ASAM Level 2.1)
Intensive outpatient involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week. Services include assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community. Ideally, these services will be available within each county in the Regional Model.

The Regional Model expects to have at least one D/MC certified intensive outpatient program in each county by the end of Implementation Year 1.

D. Withdrawal Management Services (ASAM Levels WM-1, WM-2, and WM-3.2)
Withdrawal Management/Detoxification services are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination. Beneficiaries receiving residential withdrawal management (WM 3.2) shall reside at the facility for monitoring during the detoxification process.

The Regional Model expects to offer withdrawal management at three sites by the time of Implementation; in Ukiah, Redding and Eureka, with additional sites added over the course of the implementation of the Plan.

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

E. Residential Treatment Services (ASAM Levels3.1 and 3.5)
Residential treatment is a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level3.5: Clinically-Managed High-Intensity Residential.

Beneficiaries are approved for residential treatment through a prior authorization process based on the results of the ASAM assessment. The length of stay for residential services may range from 1-90 days, unless a reassessment of medical necessity justifies a reauthorization/extension. Perinatal and criminal justice involved clients may receive longer lengths of stay based on medical necessity.

Residential treatment services include assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and coordination. All providers are required to accept and support patients who are receiving medication-assisted treatments.

Implementation of the Regional Model will have a significant impact on existing residential services. In the Regional Model, the focus will be on stabilizing clients and discharging them to lower levels of care for further treatment and recovery.

Currently, residential services lengths of stay tend to be in months not weeks. Residential clients may be referred to outpatient treatment but not routinely tracked or case managed. Residential providers under the Regional Model will be able to offer a full continuum of stabilization and rehabilitation services. The practice of keeping clients in residential treatment for lengthy periods, due to the lack of housing, will be substantially reduced due to plans to encourage added clean and sober housing in each county,. Residential services should provide "stabilization and discharge" and then, refer to an outpatient setting for continued rehabilitation and recovery services in the community.

This approach to residential services is based on research that indicates long residential stays without connection to community recovery services do not improve long term sobriety outcomes. The Regional Model will target a thirty-five day average length of stay. A key factor in facilitating reduced lengths of stay will be the development of community housing for outpatient clients. We plan to create this housing resource over time.

The Regional Model expects to have at least three residential providers, in Ukiah, Eureka and Redding, by the time of implementation, all either Drug Medi-Cal certified or actively in the process of receiving this certification. By the end of Implementation Year 1, the Model hopes to have at least one residential treatment facility for adolescents as part of the model. The Regional Model will also explore out-of-county facilities, including those in neighboring areas of Oregon and Nevada and in Bay Area (Phase I) counties, especially when there is a need to address a special need (i.e., Friendship House for Native American clients).

Providers list only 30 days prior to Implementation

3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	DHCS Licensed and DHCS/ASAM Designated Residential Providers

F. Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1)
The Regional Model will include contracts with licensed narcotic treatment programs to offer services to beneficiaries who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client plan determined by a licensed prescriber. Prescribed medications offered include methadone, buprenorphine, naloxone and disulfiram and other medications covered under the DMC-ODS formulary.

Services provided as part of an NTP include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services. Clients receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor. When medically necessary, additional services may be provided.

By the time of initial implementation, the Regional Model expects to have contracted with at least one out-of-county NTP provider providing some in-county services under the "hub and spoke" model. Additional NTP services within the Regional Model geography will be developed over the course of Implementation Year 1.

G. Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Levels 1, 2, 3)
The Regional Model will offer medically necessary MAT services through contracted providers. Services will include: assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.

The Regional Model will extend medication assisted treatments to beneficiaries with chronic alcohol related disorders as well as opiate addiction. Medication assisted therapies will include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse); uses are noted below.

- Opiate overdose prevention: naloxone (Narcan), provided currently on the state AOD formulary.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release), provided currently on the state AOD formulary. Note that methadone will continue to be available through the licensed narcotic treatment program.
- For tobacco cessation/nicotine replacement therapy and other treatments are available through the PHC formulary, with minimal, sensible prior authorization criteria.
- Alcohol use disorder: Naltrexone, acamprosate, disulfiram.

- Other, off-label MAT agents with limited evidence of effectiveness (such as topiramate and gabapentin) are available without prior authorization criteria on the PHC formulary, at the discretion of any licensed prescriber.

Additionally, on behalf of the Regional Model, Partnership HealthPlan is currently coordinating care and expanding the availability of non-methadone MAT by building the capacity of the entire health system to apply these treatments for beneficiaries with a substance use disorder. PHC is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, education on practice guidelines, and information on medication administration. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

Case managers will be provided to coordinate care with treatment and ancillary service providers and to facilitate transitions between levels of care. Beneficiaries may simultaneously participate in medication-assisted treatment and other ASAM levels of care.

The Regional Model expects to have MAT services available in each of the 9 counties by the time of implementation of the model, with additional services developed over the course of the implementation.

H. Recovery Services (ASAM Dimension 6, Recovery Environment)
Recovery services are available once a beneficiary has completed the primary course of treatment and during the transition process. Beneficiaries accessing recovery services are supported to manage their own health and health care, use effective self-management support strategies, and use community resources to provide ongoing support.

A broad range of recovery services will be available across the Regional Model network. Recovery services may be provided face-to face, by telephone, via the internet, or by community services and providers. Services may include: recovery monitoring (recovery coaching, monitoring via telephone and internet); substance abuse assistance (outreach, peer-to-peer services, relapse, prevention and substance abuse education); education and job skills (linkages to life skills, employment services, job trainings and education services); family support (linkages to childcare, parent education, child development support services, family/marriage education); support groups (linkages to self help and support, spiritual and faith-based support); ancillary services (linkages to housing assistance, transportation, case management , or individual services coordination). Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries.

I. Case Management Services
Case management will be provided at Regional Model provider sites. Services will be provided either by persons specifically designated as case managers or by provider

staff in the course of their delivery of treatment. Case management services will include, depending on medical necessity and assessment of individual needs:

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

Case management services may be provided by an LPHA or certified/certified-eligible counselor. Services may be provided face-to-face, by telephone, or by telemedicine and may be provided anywhere in the community. All case management services will be provided so as to be consistent with confidentiality requirements identified in 42 CFR, Part 2, in California law, and in the Health Insurance Portability and Accountability Act (HIPAA).

J. Physician Consultation

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

The Regional Model will include the availability of addiction specialty consultations for providers within the substance use system as well as for primary care and behavioral health providers. Consultations will also be available for the use of vivitrol, buprenorphine, other medications, and pain management to build the capacity of the entire health system to treat beneficiaries with substance use disorders. . The standards for such complementary medical services in ASAM level 1, 2, and 3 settings are defined in MHSUDS Information Notice 16-039

K. Recovery Residences

Recovery residences will not be part of the initial Regional Model.

L. Optional Service Levels Pending ASAM Utilization Review

The Regional Model will consider whether to offer additional optional services available under the waiver once baseline data on beneficiary ASAM service need and utilization has been collected and analyzed. If an unmet need for a service is determined, we will amend this plan to incorporate the additional service(s) and will initiate a RFP process to identify qualified providers.

M. Service Level Barriers

Barriers to care may include the following:

- The extremely low population density of many areas in the Regional Model geography – from as low as 2 persons per square mile to 10-15 per square mile -- can limit the accessibility of treatment and/or limit some of the features of effective treatment such as the involvement of friends or family members. These barriers also affect the availability of services that can assist in effective treatment such as physical or mental health care.
- The region includes some of the poorest California counties, with relatively lower education levels that can intensify the stigma associated with behavioral health care.
- The region includes some of the California counties with the highest levels of substance use, and therefore the greatest levels of need. . The drug overdose rate in the 9 counties from 2012-2014 was 26.9 per 100,000 population, compared to a rate of 11 per 100,000 in California as a whole.
- The region also faces significant workforce shortages, which can limit the system's ability to expand and to recruit the necessary staff.
- The ability to travel within the Regional Model counties can be severely limited by weather, as well as by the limited amount of transportation resources. This can have the effect of restricting access.
- DMC certification delays could present a barrier as the system seeks to grow. This may be especially problematic in the recruitment of out-of-state providers who may be the best suited to treat clients in the border counties.
- DMC certification may also be challenged as the Regional Model incorporates some features that are new in the DMC model, such as the "hub and spoke" arrangement for the provision of narcotic treatment therapy.
- The proposed phase-in of Native American programs may present a barrier to the system's overall effectiveness. The area encompassed by the Regional Model includes over twenty tribes. Native Americans are an important part of the Regional Model community as well as the current health system model.

N. Coordination with Surrounding Counties

Partnership HealthPlan has established strong relationships with surrounding counties' substance use service divisions, as PHC serves as the Medi-Cal plan for many counties outside of the regional model. Each of the Partnership HealthPlan counties that are not part of the Regional Model will have an MOU that allows for formal agreements pertaining to inter-county issues. PHC will be meeting periodically with all of its 14 counties substance use providers to discuss service models and best practices. The existing foundation of coordination will help ensure that beneficiaries who reside in an opt-out county will not experience a disruption of services.

The Regional Model will also work to establish strong working relationships with the surrounding counties that are not part of the PHC system and that have not opted in to Drug Medi-Cal.

5. Expansion of Services. Describe how the Regional Model plans to expand the required levels of services outlined in the standard terms and conditions (STCs). In the description, include the timeline for expansion.

Review Note: Include services identified in the implementation plan and also the projected timeline for the Regional Model to add additional level of services.

The proposed Regional Model includes all of the necessary services. In addition, PHC hopes to strengthen or expand the existing network through a pending grant funding process that will provide funding for capital improvements, training and staff development. These grant awards are anticipated for the summer of 2017.

Other service expansions will involve negotiations of provider contracts with additional entities, including some located in Oregon or Nevada as well as in surrounding counties. Within the first six months of the Regional Model implementation, PHC hopes to have established a process by which out of state providers can be included in the system.

6. Coordination with Mental Health. How will the Regional Model coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

Coordination of services is the basic premise and philosophy of this proposed Regional Plan. The organizing entities for the Regional Model are, collectively, responsible for the range of mental health services available to Medi-Cal beneficiaries. The 8 county agencies all have jurisdiction over their county's mental health system for the seriously mentally ill, and Partnership HealthPlan is responsible for the provision of mild to moderate mental health services within the Regional Model. In addition, several of the counties have worked to ensure that their staff can effectively serve those with co-occurring substance use and mental health disorders. PHC is also encouraging the co-location of mental health and substance use services through its pending grant program and other funding opportunities.

Starting in 2014 with the implementation of the mild to moderate mental health benefit, the counties and PHC, through its contract with Beacon Health Options, have worked to facilitate communication, referrals, and an effective continuum of mental health services. The implementation of the Regional Model will strengthen this system, providing a strong voice in the discussion of client's behavioral health needs.

All mild/moderate mental health providers will be expected to use the SBIRT or other screening tool to ensure early identification of client's substance use needs. Similarly,

all Regional Model providers will be required to access and facilitate client's mental h health needs.

7. Coordination with Physical Health. Describe how the Regional Model will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

As noted above, the basic philosophy and strength of the Regional Model is its ability to provide clients with an integrated and comprehensive health care service system. The network includes the primary care system for all of the clients in the Regional Model. All Partnership HealthPlan members, and thus all clients served by the Regional Model, have identified primary care sites and are linked to primary care upon their initial entry into the system. In addition, primary care sites will be expected to conduct SBIRT screenings as well as mental health screenings to ensure that clients have the appropriate access into the system.

Providers in the Regional Model will be part of the network of PHC providers that meet regularly and that work together in a variety of settings including provider advisory groups and formal committee processes. In addition, the Regional Model will sponsor trainings and other opportunities to better train primary care providers on the substance use system as well as the performance of MAT services. Similarly, substance use providers will be encouraged to participate in trainings focusing on the effective use of primary care resources.

As required by state regulation, and implicit in the ASAM assessment process, all patients entering ASAM level 1 and above treatment programs will have a comprehensive history and physical exam just before or soon after starting treatment. Wherever possible, this will be performed by the primary care provider or closely coordinated with the primary care clinician.

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

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

Comprehensive substance use, physical and mental health screening: all providers, including those in the current PHC system, will need continuing training and support on the use of screening tools, including the ASAM tools, the CAGE and AUDIT used in SBIRT, and the PHQ-2 and PHQ-9 (mental health tools required by HEDIS). Challenges in ensuring the effective use of these trainings include the many demands on providers' time and resources; and limitations on clinic space making it hard to co-locate SUD staff or other resources.

Beneficiary engagement and participation in an integrated care program: Effective outreach to beneficiaries is always a challenge and there will be a continuing need to educate the community, providers and potential beneficiaries on the resources available in the system. Participants in the Regional Model will build upon the networks and practices established in order to encourage effective use of the mild to moderate mental health service system. The success of these efforts can be seen in the relatively high penetration rates for the mild to moderate benefit, ranging from 5 to 7 percent across the region.

Shared development of care plans by the beneficiary, caregivers and all providers. This is perhaps the largest challenge facing the system, with the complex laws governing the exchange of information, individual providers' interpretations, and the need for broad acceptance of common tolls and understandings. Any State directives that would facilitate these exchanges would be most welcome.

Collaborative treatment planning with managed care: we do not anticipate barriers here.

Care coordination and effective communication among providers; this is a challenge in any complex system and effective communication will be key to the Regional Model's success. The Regional Model will rely upon the tools already identified and used by PHC as well as the counties in ensuring that the entire community is aware of the services available and how to access them.

Navigation support for patients and caregivers; this will be a function provided by case managements; care managers; patient navigators; peer support groups; and others in the system and the community.

Facilitation and tracking of referrals between systems: This will be a challenge that will require some providers to adopt an electronic health record; others to ensure that their data is being collected correctively, and the entire system in working to ensure that data can be transmitted successfully.

9. **Access.** Describe how the Regional Model will ensure access to all service modalities. Describe the efforts to ensure network adequacy. Describe how the Regional Model will establish and maintain the network by addressing the following:

- The anticipated number of Medi-Cal clients.
- The expected utilization of services.
- The numbers and types of providers required to furnish the contracted Medi-Cal services.
- Hours of operation of providers.
- Language capability for the county threshold languages
- Timeliness of first face-to-face visit, timeliness of services for urgent conditions and access afterhours care.
- The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.

Anticipated number of Medi-Cal clients: As of March 1, 2017, there are ____ Partnership HealthPlan Medi-Cal members in the 9 counties in the Regional Model. Relying on a variety of sources, we are estimating that ten percent of the overall population, or _____, will have substance use issues requiring some level of treatment. Of these, only a subset will voluntarily accept referral to treatment in any given year. Given PHC's experience with creating a delivery system for mild-moderate mental health, utilization will be low at first, perhaps ¼ of the level achievable 3 years later.

The expected utilization of services: The projected utilization of services was based on a variety of sources:

- Review of current Drug Medi-Cal systems in the participating counties
- Review of use of SUD services in states with Medicaid expansion with more robust SUD programs
  - Kentucky, rate in 2015: 1.5%/year; rate as of mid-2016: approximately 5%/year
  - Oregon rate estimated by Care Oregon in early 2017: less than 5%
- Review of utilization in other data bases, including____

The numbers and types of providers required to furnish the contracted Medi-Cal services: this was part of the utilization calculation noted above.

Hours of operation of providers.

Language capability for the county threshold languages: Spanish is the required threshold language in three counties (Modoc, Mendocino and Lake Counties); the remaining counties do not have a required threshold language. Throughout the Regional Model, providers will be required to provide interpretation and translation services to all clients. The Regional Model Quality Program will ensure that Regional Model providers comply with language access requirements. All forms and appropriate materials will be translated to the threshold languages and be made available to

Regional Model providers. Every effort will be made to have materials translated in an accurate and timely manner.

Timeliness of first face-to-face visit, timeliness of services for urgent conditions afterhours care: The Regional Model standard will be for each eligible client to be offered a first appointment within 15 days of referral or request for service for non-urgent services. Data to ensure that this standard is met. Providers will be monitored for the ready availability of their services and PHC will work with members and providers to ensure timely and effective access. In addition, the Model will include a 24/7 after hours line to facilitate care and access.

The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.

Draft access standards for SUD services (February, 2017)

Under the standards, all 9 counties defined as "small" (under 200,000 population)

Geographic standards for outpatient SUD services (except OTP): 60 miles or 90 minutes

Opioid treatment service standard 30 miles/45 minutes (unclear if buprenorphine programs in PCP sites would qualify; PHC also advocated for the OTP standard to be the same as for other SUD services.

Based on currently available service providers, meeting the SUD service standard will be doable. Assessment of the ability to meet the OTP standard is pending the response to PHC feedback to the draft standards.

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

Review Note: Include the frequency of training and whether it is required or optional.

Training provided will include:

- Motivation Interviewing, primarily for client engagement
- Living in Balance as a treatment strategy
- Seeking Safety, which works for both SUD and Mental Health
- Trauma Informed Care as well as CBT are in practice and will continue
- ASAM Training will be available to all, Primary Care, Mental Health/SUD, CWS and Probation

Training will be provided in a variety of modalities including in-person, webinars, and "train the trainer". In addition to the providers and staff directly providing substance use

treatment services, training on the basic tenets of ASAM and other models will be made available throughout the PHC system.

11. Technical Assistance. What technical assistance will the Regional Model need from DHCS?

Guidance on the most effective ways to facilitate the exchange of information within an integrated system that includes substance use services.
Guidance on the involvement of the Native American population and assistance in facilitating the improvement of this proposed model.

12. Quality Assurance. Describe the quality assurance activities the Regional Model will conduct. Include the Regional Model monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438.200, 438.202, 438.204 and with 438 Subpart E (External Quality Review Organizations). Please also list out the members of the Quality Improvement committee.

The Regional Model Quality Improvement Plan will include the following activities:

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

The QI Plan will monitor the following performance measures:

- number of days to first service at appropriate level of care after referral;
- 24/7 telephone access with non-English language capacity;
- Access to translation services in threshold language;
- Number, percentage and time period of prior authorization requests (for residential treatment) approved or denied;
- Review of Utilization Management activities, ensuring that interventions are appropriate to the assessed ASAM level of care.

Quality Improvement Committee:
Regional Plan QI activities will be incorporated into the larger QI activities of Partnership HealthPlan, including a multi-committee oversight structure that includes credentialing, peer review; policy and program consultation; and regular reporting. The Quality, Utilization and Access Committee (QUAC) will establish a subcommittee structure to ensure that Regional Plan activities are sufficiently monitored and reviewed. Through

this structure, PHC will ensure sufficient attention to critical incidents and client complaints; monitoring of audit results and information; obtaining input from standing or ad hoc subcommittees and review of the most effective provision of Drug Medi-Cal services in the context of an integrated health care system.

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

- Motivation Interviewing, primarily for client engagement
- Living in Balance as a treatment strategy
- Seeking Safety, which works for both SUD and Mental Health
- Trauma Informed Care as well as CBT are in practice and will continue
- ASAM Training will be available to all, Primary Care, Mental Health/SUD, CWS and Probation

As noted, the Regional Model as chosen the following evidence based practices for particular support: Motivational Interviewing; Living in Balance; Seeking Safety. The Regional Model will provide periodic trainings on each of these practices and facilitate a provider-sharing network to encourage skills and practice sharing among providers.

All providers will be required to use evidence based practices and will be expected to show fidelity to the models. This will be monitored via periodic chart reviews. Noncompliance will result in potential corrective action plans as well as denial of claims for services and repeated noncompliance may result in other actions to be outlined in the contract.

14. Assessment. Describe how and where the Regional Model will assess beneficiaries for medical necessity and ASAM Criteria placement. How will Regional Model ensure beneficiaries receive the correct level of placement?

In addition the Call Center, the Regional Model will identify and contract with agencies with staff trained and properly licensed to determine medical necessity both within the Regional Model network as well as at Beacon (mild/moderate mental health) service sites. The Call Center as well as PHC's Utilization Management program will continually review the placement of beneficiaries in the correct level of placement, relying on timely and periodic ASAM assessments and other tools.

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

This is basically the subject of this entire document.

16. Memorandum of Understanding. Submit a draft copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery. Signed MOU's must be submitted to DHCS within three months of the waiver implementation date.

N/A

17. Telehealth Services. If the Regional Model chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the Regional Model ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

Over the past few years, PHC, in conjunction with its subcontractor, Beacon Health Options, has developed a robust telehealth network via Tele-Med-2-U, a provider based in Roseville, California. This network will be expanded to include other telehealth providers; addiction specialists and the potential telehealth sites will be expanded to include Drug Medi-Cal treatment sites.

Existing technology and vendors will also be used to provide addiction specialist consultation services to primary care and other providers in the system.

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

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

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

19. Additional Medication Assisted Treatment (MAT). If the Regional Model chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

Currently, the PHC network offers medications beyond the NTP requirements and these services are being expanded. Through the Regional Model, PHC will expand the use of MAT interventions by expanding the use of the following medications:

- For reduction of alcohol craving: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol); topiramate (Topamax); gabapentin (Neurontin); acamprosate (Campral) and disulfiram (Antabuse).
- For opiate overdose prevention: naloxone (Narcan)
- For opiate use treatment: buprenorphine-naloxone (Suboxone), and naltrexone (oral and extended release). Methadone will continue to be available through the licensed narcotic treatment program
- For tobacco cessation/nicotine replacement therapy, nicotine patches, nicotine gum, nicotine lozenges, bupropion SR (Zyban), varenicline (Chantix) and nortriptyline (Pametor) or any combination of which proves most effective.

Currently, PHC integrates the use of MAT into primary care clinic settings and it plans to extend this through the Regional Model and other means. A comprehensive set of guidelines will be developed for providers to follow.

20. Residential Authorization. Describe the Regional Model's authorization process for residential services. Prior authorization is not required; however, the Regional Model needs to provide a standard timeline for completion of the authorization.

The Regional Model will require a prior authorization for all residential treatment, provided by the Central Access Center residency coordination unit. All requests for authorization will be completed within five business days.

Authorization for residential services will be based on ASAM assessment criteria.

Each County shall have an internal grievance process that allows a beneficiary, or provider on behalf of the beneficiary, to challenge a denial of coverage of services or denial of payment for services by a participating County.

DMC-ODS Projected Expenditure Modality Plan

County: _____ Implementation Date: _____

Include two years of projected expenditures and projected clients. Base years on proposed implementation date.

Services Provided By Modality (funded by DMC)	FY _____ Projected Expenditures*	FY _____ Projected Expenditures*	FY _____ Projected Clients	FY _____ Projected Clients
Withdrawal Management				
Level 1-WM				
Level 2-WM				
Level 3-WM				
Level 4-WM				
Residential				
Level 3.1				
Level 3.3				
Level 3.5				
Level 3.7				
Level 4				
Intensive Outpatient				
Outpatient				
Opioid (Narcotic) Treatment Programs				
Recovery Services				
Case Management				
Physician Consultation				
Total				

*Includes the FMAP, State and County Costs.

Services Provided by Modality	FY _____ Projected Expenditures	FY _____ Projected Expenditures	FY _____ Projected Clients	FY _____ Projected Clients
Recovery Residences				
Additional MAT				
Total				

Proposed Rates

County: _____

Counties must provide proposed rates for each modality identified in the DMC-ODS. Please note the following when proposing rates:

- Counties are required to provide a rate range or a standard rate for all modalities.
- If a county is not providing a level of service for Withdrawal Management or Residential, please mark the rate as n/a.
- For residential services, rates cannot include room and board expenditures.
- Level 4-Withdrawal Management is paid for through the fee for service system.

Services Provided By Modality (funded by DMC)	Proposed Rate Range	Service Length/Unit of Service (day, hour)
Withdrawal Management (WM)		
Level 1-WM		
Level 2-WM		
Level 3-WM		
Level 4-WM		
Residential		
Level 3.1		
Level 3.3		
Level 3.5		
Level 3.7		
Level 4		
Intensive Outpatient		
Outpatient		
Opioid (Narcotic) Treatment Programs		
Recovery Services		
Case Management		
Physician Consultation		

Rates Narrative

1. Describe the process used to develop the proposed rates above. Include data utilized and brief justifications for each proposed rate.

2. If rates for Intensive Outpatient, Outpatient or Opioid (Narcotic) Treatment Programs fall below the current state plan rate, please explain why the rate is lower.

3. If a rate range is utilized for a modality(ies), how will the county determine which providers will receive the lower or higher rate identified in a range?

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

_____	_____	_____
County Behavioral Health Director* (*for Los Angeles and Napa AOD Program Director)	County	Date

_____	_____	_____
Print Name	Title	Phone Number

Please mail the completed Implementation Plan to:
Department of Health Care Services
SUD Compliance Division
Attn: Marlies Perez
P.O. Box 997413, MS 2600
Sacramento, CA 95899-7413
Marlies.Perez@dhcs.ca.gov