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

NOTE: THROUGHOUT THIS DOCUMENT THE ENTITY SEEKING THE WAIVER – THE EIGHT 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.

Table of Contents

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

(Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano and Trinity Counties)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

TABLE OF CONTENTS

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 share philosophies and goals for the Regional Model. These shared values underlie the components of the model and the benefits that it is expected to 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, mental health providers, 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.
- *Recognition and Reliance on the Substance Use and Related Services currently provided through the PHC system:* Currently, the Partnership HealthPlan network includes a number of clinics and primary care providers that are providing services that are also part of the ODS waiver scope of services. These include outpatient services provided in mental health sites where the staff are competent and trained to provide integrated mental health and substance use services; clinics providing Medication Assisted Treatment through X-waivered primary care physicians; hospitals providing clinical withdrawal services in order to address the needs of

complex emergency room patients. Additionally, many of the clinics in the Regional Model counties have received additional federal monies for the development of substance use services. While this Plan is written without assuming any changes in State legislation (e.g., pending SB 323 that would allow clinics to be Drug Medi-Cal certified), it does assume that the expertise and services currently available within the PHC care network will remain available to the Drug Medi-Cal program.

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.
- Recovery residences/sober living environments: Although the initial proposed Regional Model does not include recovery residences, we recognize that these are 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 recovery residences 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

X All contracted with Partnership HealthPlan including some county operated providers

OPTIONAL

X 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

8. The Regional Model will comply with all quarterly reporting requirements as Contained in in the STCs.

☒ Yes (required) (as discussed w/ DHCS representatives, PHC will provide all reports on behalf of entire model)
☐ No

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

☒ 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 their community 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, since the Model was first proposed in 2015, has required extensive outreach, consultation, and cooperation among the 8 counties (Humboldt, Mendocino, Trinity, Shasta, Siskiyou, Solano, Lassen and Modoc), non-county treatment providers, community groups and Partnership HealthPlan.

The eight 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 a client's functioning within the six ASAM dimensions. In addition, the system will include other key components, such as a telephone-based screening and placement function, with a toll-free number and a robust utilization management and care coordination processes.

Once the vision was vetted and finalized by the leadership of PHC and the participating counties, a workgroup made up of county Substance Use Department (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 developed. Outreach to representatives of community providers, key stakeholder groups, criminal justice, health care, mental health and other agencies was conducted and is ongoing, 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 screenings 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 consist 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.

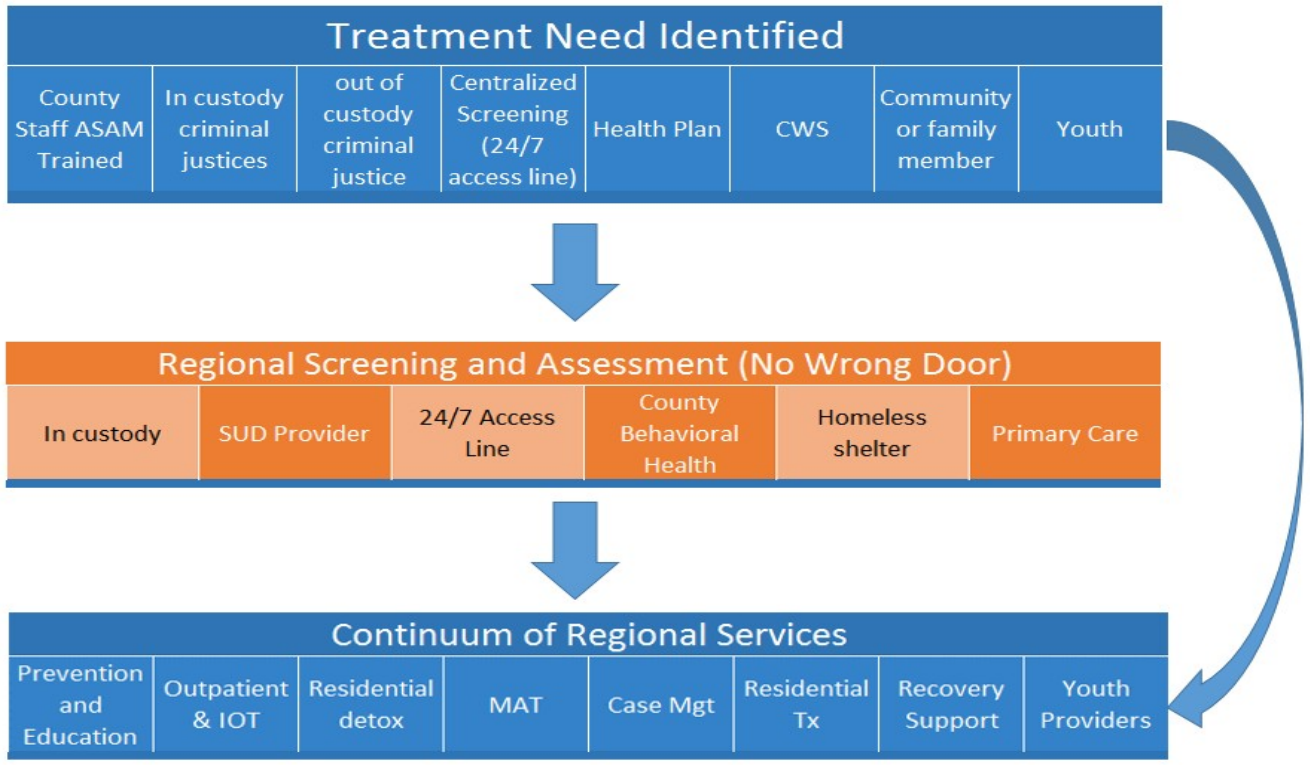
2. Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, how admissions to the recommended 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 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; 2 days for those with urgent needs. In the unlikely event that admission to treatment will take longer 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 determines that the medical necessity criteria has not been met and that the beneficiary is not entitled to services under the Regional Model, a written Notice of Action will be issued in accordance with 42 CFR 438.404.

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 Central Access 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 potential 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.

Access Line services will meet all regulatory requirements including ADA-accessibility and will be available in prevalent non-English languages. Members will be notified that interpretation services are free. The Access Line number will be widely disseminated; published in member handbooks and newsletters; on the Plan's website and posted broadly at provider and partner sites. The Access Line phone number will be toll-free.

As will be described later in this section, the Regional Model will build upon current efforts to identify and address the needs of persons that are high utilizers of health care services and others at risk of unsuccessful transitions through intensified case management services and targeted programs (see p. 16). Over time, the Central Access Line will build the tools to most effectively identify such individuals in order to ensure that they are linked to case management services as soon as possible.

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 and these programs will work to link and refer clients needing other levels of care; (2) Calls to the Central Access Line will result in referrals for all levels of services including case management, and will facilitate Utilization Management authorizations and referrals for residential treatment; and (3) Referrals to outpatient and other resources will be provided by various partner agencies, such as through staff at probation and child welfare agencies.

- *Outpatient sites:* Clients can enter the system through outpatient service sites that allow for drop-ins or same day 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. In some cases the Central Access Line will work to link the client to case management services. 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 screen and refer 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.

- *Clients who are high utilizers of health care services and/or at risk of unsuccessful transitions:* The Regional Model will build upon the work of Partnership HealthPlan and many of its partner clinics and counties, as well as the experience of the new State MAT grant providers to ensure that the Regional Model is effective at addressing the needs of these populations. These include the following:
    - *Whole Person Care* projects in Shasta, Mendocino and Solano Counties are targeted at high utilizers (defined by a variety of measures, including substance use treatment needs) and focus on ensuring that they receive comprehensive and integrated health and social services.
    - The PHC-funded *Intensive Outpatient Primary Care Management (IOPCM)* programs – slated to prepare clinics for the upcoming *Health Homes* models – require clinics in all of the Regional Model Counties[1] to provide comprehensive case management and service structures to address the needs of those who are high utilizers of health care services and/or those with complex behavioral and physical health conditions, including substance use treatment needs.
    - Through a two-year effort funded by the California Health Care Foundation, PHC, and clinics in Mendocino and Shasta Counties have developed comprehensive opiate treatment systems that incorporate the continuum of substance use services in order to better treat individuals at risk of unsuccessful transitions.
    - The recently approved Medication Assisted Treatment expansion grants and the incorporation of the "hub and spoke" model throughout all of the Regional Model counties has provided another opportunity to address the more difficult clients, including high utilizers and those at risk of unsuccessful transitions. PHC is working with the three grantees that are in Regional Model Counties (Aegis Treatment Centers, Bright Heart Health and MedMark) and the relevant communities to facilitate the implementation of the model and its incorporation into current systems and services. The Regional Model counties and these agencies and community clinics are meeting to develop the protocols to ensure that

clients with complex conditions and/or high levels of needs will be served effectively and collaboratively.

- PHC's service delivery model includes a *complex case management programs*, staffed by clinicians and health care guides, that provides telephonic case management to beneficiaries with chronic conditions; who are pregnant; or who may have significant issues (potentially including substance use) that make it difficult for them to manage their health care.

Among other benefits, all of these efforts have enabled PHC to work with behavioral health care providers to better identify the high utilizers that affect both County-run and PHC systems and to work with all of our partners to develop the case management and service support skills that will significantly benefit the Regional Model for ODS Services.

The Regional Model's specific processes for addressing the needs of those who are high utilizers of care and/or at risk of unsuccessful transitions are as follows:

(1) High utilizers and those at risk of unsuccessful transitions will be identified by the PHC Utilization Management Department and by referrals from providers and others familiar with clients 'circumstances. Data reviewed will include multiple emergency room or hospital visits; incomplete treatment episodes; and other benchmarks based upon health care utilization trends. In addition, the Regional Model will work with local mental health departments and with local criminal justice agencies to further identify individuals needing special attention in order to successfully complete treatment.

(2) These clients will be linked to case management services[2] as well as other services suited to their special needs and conditions.

(3) Case management services will also be targeted towards populations that have been shown to be more likely to be at risk of unsuccessful transitions including those with co-occurring mental health and substance use needs.

The basic referral and client flow processes 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 preferences, 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 apply the Screening, Brief Intervention, Referral and Treatment (SBIRT) tool to make referrals or provide further services consistent with that

[1] Currently Siskiyou, Lassen, Modoc and Trinity Counties do not have IOPCM programs, but all counties will be in the Health Homes model; the State has targeted the implementation for 2018.

[2] See p.25 for a further discussion of case management services provided through the Regional Model.

assessment. Partnership HealthPlan requires pediatric providers to follow the Bright Futures program; the American Academy of Pediatrics screening framework. PHC-contracted physicians screen for tobacco, alcohol and drug use starting at age 11 and annually thereafter, using the "Car, Relax, Alone, Forget, Friends, Trouble" (CRAAFT) tool.

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
Clients can be re-assessed as often as necessary; an ASAM assessment is generally valid for 180 days. 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 90 days, unless there are significant changes warranting more frequent reassessments. Changes that could warrant a reassessment and possibly a transfer to a higher or lower level of care include, but are not limited to, the following:

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

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. One of the key case management functions is to manage 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 troubleshoot for specific client problems and to address other client related issues that may 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	
NTP Services	6 to 12 months	

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 by 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.

Time Requirements for Transitions Once a Client is determined to Need a Level of Care

The Regional Model will ensure timely access to services for all those needing services:

- The initial determination of medical necessity will be provided within ten days of a request or referral for treatment, with five days as the preferred period of time to determination.
- The subsequent ASAM assessments for referral to the proper treatment level will be provided no later than two business days for urgent cases[3] and ten business days for non-urgent assessments.
- As noted, requests for approval of entry into residential treatment will be acted on within 24 hours.

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 access 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 with an "after hours" line to provide information and necessary referrals during non-business hours.

Note that the Central Access Line facilitates all services provided through the Regional Model, while the after-hours line provides after hours services to address urgent situations and to facilitate the links to services that will be completed during business hours. All access sites – the Central Access line, the after-hours 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.

Central Access Line and the after-hours line will meet all regulatory requirements including ADA-accessibility and availability in prevalent non-English languages. Members will be notified that interpretation services are free. The Central Access Line and after hours line numbers will be widely disseminated and noted on Partnership HealthPlan member cards; published in member handbooks and newsletters; on the Plan's website; on 211 and on-line resources, and posted broadly at provider and partner sites. Both the Central Access Line and after hours line phone numbers will be toll-free.

Currently Partnership HealthPlan members are encouraged to access services and there are no barriers or approvals needed for a member to access primary care or most mental health care services covered by the Plan (those for mild to moderate mental health conditions). The penetration rate for mild to moderate mental health services is one of the highest in California, largely due to the Plan's aggressive efforts to publicize

[3] Urgent needs will be determined based upon Title 22 criteria, and include factors such as pregnancy; injection drug use; etc.

and trouble-shoot to encourage the use of these services. This same philosophy will be applied to the Regional Model, with all clients encouraged to seek services at provider sites or call the Central Access Line. In addition to promoting the use of these services through the Plan's various communication channels, as described above, the

Regional Model will regularly review utilization data to identify areas that may need special attention. This special attention may include measures ranging from postcards to all Medi-Cal beneficiaries in the area to advise them of how to access services to presentations before groups ranging from probation/parole drop-in centers to County advisory boards; ad campaigns; etc.

The Central Access Line will be staffed by certified drug counselors and supervised by Licensed Practitioners in the Healing Arts (LPHA), as well as administrative staff, to ensure that clients can be quickly and effectively linked to services. The after-hours line will be similarly staffed, although the focus will be more limited – to determine the urgency of the need, help de-escalate when needed, and ensure that the client is effectively referred to treatment or to further assessment during business hours.

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 after-hours 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 will include:

- 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. This list will be used for billing purposes for the Short Doyle 2 system.

A. Early Intervention (ASAM Level 0.5)
Primary care and other sites will perform Screening, Brief Intervention, and Referral to Treatment (SBIRT) activities for adults, as currently required by DHCS. Beneficiaries at risk of substance use problems 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 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 throughout the 14-county Partnership HealthPlan network, including the eight Regional Model counties.

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 management; collateral services; crisis intervention services; and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community. These services will be available within each county in the Regional Model.

The Regional Model will have at least one general outpatient program in each county by the time of implementation, all D/MC certified. 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 or other required -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 time of initial implementation.

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 in at least five sites by the time of Implementation; in Fairfield, Vallejo, Ukiah, Redding and Eureka, with additional sites added over the course of the implementation of the Plan[4]. See Appendix A for a summary of network-wide services and a list of sites and locations.

E. Residential Treatment Services (ASAM Levels 3.1 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. Specifically, perinatal clients can receive residential care up to the length of the pregnancy and

[4] It should be noted that withdrawal management also occurs in hospital emergency rooms and inpatient units. As part of the implementation of the Regional Model, PHC will work with hospitals to provide trainings and linkages to the ODS scope of programs.

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 for adults. A key factor in facilitating reduced lengths of stay will be the development of community housing for outpatient clients. We hope to facilitate the creation of this housing resource over time.

The Regional Model expects to have at least six residential providers, in Vallejo, Martinez, Ukiah, Clear Lake, Eureka and Redding, by the time of implementation, all Drug Medi-Cal certified at ASAM Level 3.1. 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 as well as additional levels of adult residential care. 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).

Within three years of implementation, the Regional Model will include all levels of residential care within the model. This will be achieved in a variety of ways. During 2017, Partnership HealthPlan awarded $2 million in grants to providers throughout the eight-county area to develop services. A significant portion of these funds went to residential facilities. Further, a recently issued RFP allots $25 million throughout the

[5] Specifically, most clients will be limited to two non-continuous regimens for adults in any one-year period. One extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period. If it is determined that clients need further residential care (or other services not included under the ODS waiver) PHC will work with the counties and other entities to identify alternate funding sources to pay for this care. These clients may also be referred to non-residential levels of care, such as intensive outpatient services.

PHC service area, and funds may be sought for recovery residences and related services.

Overall, the Regional Model will expand the availability of ASAM residential levels through the following methods:

- Financial and technical support to existing providers to expand services, as noted above.
- Identifying additional providers, both within and out of the service area, and developing contracts with these providers.
- As specific needs are identified and thus potential ODS reimbursements more certain, PHC will work with existing and potential providers to explore residential services available to Regional Model clients.

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. Services are provided in accordance with an individualized client plan determined by a licensed prescriber. Prescribed medications offered will include methadone, buprenorphine, naloxone and disulfiram and other medications covered under the DMC- ODS formulary.

Services provided as part of an NTP will 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 several NTP providers providing services under the “hub and spoke” model. Currently, there are no methadone clinics within the 8-county “footprint” but several new sites are expected as the result of the recent State Medication Assisted Treatment (MAT) expansion grant awards including clinics in Solano, Shasta and potentially Humboldt Counties. Methadone will also be available in all of the Regional Model counties except Modoc, through the hub and spoke model. (Note that Modoc County clients currently can access MAT services with buprenorphine in-county. They will be able to receive methadone treatment from spokes located in Susanville or elsewhere; over time we will work to develop more convenient resources for Modoc members who need methadone as their MAT service. PHC will continue to assist Modoc members with transportation issues.)

In early 2018, Aegis Treatment Centers will establish a “hub” clinic in Redding. For the first year of Implementation, methadone will thus be available, via the hub and spoke model, with the hubs in Redding and Chico, and spokes in other parts of Shasta County, and in Lassen, Trinity, and Siskiyou Counties. Spokes in Mendocino and Humboldt Counties will be connected to either the Redding or Chico sites, with some Mendocino members receiving their services from the Santa Rosa treatment center. In Solano

County, Medmark spokes will be in Fairfield and Vallejo, with the hub in Martinez (Contra Costa County).

By year two, it is anticipated that an additional hub may be located in Eureka, in Humboldt County; spokes in Del Norte, Mendocino and Humboldt Counties would then be realigned to connect to this site.

The Regional County PHC network currently includes extensive availability of Medication Assisted Treatment with buprenorphine. Clinical data indicate that buprenorphine is at least as effective as methadone for most populations. In Year One of the model we will thus have MAT services available in all 8 of the Regional Model counties, at multiple sites. MAT services are currently available in 7 of the 8 counties and continue to expand. PHC will continue to work with primary care providers to become "X waivered" to be able to serve a significant number of clients; these outreach and education efforts will be intensified in the coming months.

As is currently required under State law, Partnership HealthPlan will be facilitating the transporting of clients from and to the hubs and spokes and providing related support services for members seeking these services.

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.
- 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 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 expanded MAT services available in most of the 8 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, by telehealth, or by community services and providers. Services may include: recovery monitoring (recovery coaching, monitoring via telephone and internet); peer-to-peer services and relapse prevention services. Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries. Note that PHC is developing a peer support training plan.

I. Case Management Services
Case management will be provided at Regional Model provider sites, generally as part of the ASAM level services provided. 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 community services such as physical or mental health care, transportation, housing resources, the SNAP program, etc.

Case management services may be provided by an LPHA or certified counselor. Services may be provided face-to-face, by telephone, or by telehealth 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).

The model for case management services will allow for tailoring to specific client needs and focus on “warm handoffs” if a client is changing case managers:

- In some cases, as with clients that are high utilizers of health care services and/or at high risk of unsuccessful transitions, the client may have a case manager assigned as part of PHC and its partner counties and clinics current efforts to focus on these clients and to address their needs. With the onset of the implementation of the Regional Model, the Plan will work to ensure that all those currently providing case management services to this target population will be provided the necessary training and education to address their clients’ comprehensive needs.
- In some cases, clients may transfer from one case manager to another, because of changes in level and location of care or the development of needs that require special case management skills. Case managers will be required to document “warm handoffs” and seamless transitions.
- The Regional Model and its member counties and providers will work to provide continuous education and linkages to all those who provide services that support case management, including clinic/hospital “navigators”; PHC’s telephonic care coordination unit; housing and social services outreach workers, etc. For instance, a presentation on the Regional Model was recently provided to the annual gathering of Shasta County case managers to start this education and outreach effort.

Some of the providers that are currently providing substance use treatment services within the Regional Model counties have case management incorporated into their service delivery system. In addition, the newly established MAT expansion ‘hub and spoke’ providers also include case management as part of their service delivery system. As noted earlier, PHC provides telephonic case management through its various complex case management programs. Thus, the over-arching goal for the Regional Model will be to ensure that case managers are working together and providing a coordinated approach to the needs of the client. It is not possible, or advisable, to describe a “one fits all” model to case management given the diverse approaches that are currently available in the various areas, and the broad array of potential client needs.

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 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 -- limits 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 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 limits on 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.
- 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 Partnership HealthPlan system as well as the PHC Drug Medi-Cal Regional Model.
- Regulatory barriers to including community clinics in the model could present significant barriers. Currently, such clinics cannot be Drug Medi-Cal certified and are thus barred from being full participants in the model, despite their extensive experience and, in many cases, receipt of significant federal funds to address substance use disorders. Pending legislation (SB 323-Mitchell) would eliminate this regulatory barrier. It is worth noting that the Vermont hub and spoke model, on which the State's MAT Expansion grants were based, includes the full participation of Federally Qualified Health Centers in a way that is not possible in the current California regulatory structure.

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 8 Regional Model counties. PHC will be meeting periodically with all of its 14 counties substance use providers to discuss service models and best practices, and to address potential inter-county issues. The existing foundation of coordination will help ensure that beneficiaries who reside in an opt-out county will not experience 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, including those that have not opted in to the ODS waiver.

5. 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? Please briefly describe the Regional Model structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

The Regional Model will include both substance use and services for mild to moderate mental health conditions in its integrated delivery network. The remaining portion of mental health services are those provided by the county mental health plans for those with moderate to severe mental health conditions.

As part of its effective implementation of the mild/moderate mental health benefit, PHC has developed a series of tools and oversight processes to facilitate transitions and/or referrals between the PHC and county systems for those with mental health needs. These include:

- Regular reports to each county mental health plan detailing the circumstances and transitions for clients between the two mental health systems;
- Established communication and liaison structures outlined in a MOU between PHC and the individual county mental health plan;
- PHC review of regular reports detailing utilization and care coordination data including complaints and grievances.
- Case by case "trouble shooting" when needed.

With the implementation of the Regional Model, the tools and oversight processes described above will be adjusted to include the Regional Model benefits and service structure. This will include:

- Development/amendment of current referral processes to ensure effective transition or co-treatment of clients;
- Amendment of the current MOU's with the county mental health plans to ensure that the established communication and liaison structures incorporate substance use treatment services;
- Development of additional reports and data sources to allow for effective

monitoring of co-treatment and treatment transitions for substance use clients needing county-level mental health services;
- Continued case by case “trouble shooting” when needed.

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.

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 health needs.

6. 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?

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. Primary care sites are monitored through a variety of means, including facility site reviews; review of standard reports on primary care utilization and access; and with follow-up on all client complaints and grievances and the associated structure that addresses grievance trends and concerns. These reviews are monitored through the Plan’s overall Quality Review structure; described in Attachment B.

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, patients entering ASAM level 1 and above treatment programs will be encouraged to 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.

The current PHC quality management and monitoring system, summarized above, will be amended to ensure the Plan and its county/provider partners in the Quality Review process can monitor substance use treatment linkages to primary care. Data reviewed

will include:

- Utilization data
- Complaints and grievances
- Clinical outcomes
- Facility site and treatment plans audits and reviews

The quality review process is described further below.

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

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

Comprehensive substance use, physical and mental health screening: all 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 tools include the many demands on providers' time and resources; and limitations on clinic space making it hard to co-locate SUD staff or other resources.

Beneficiary engagement and participation in an integrated care program: Effective outreach to 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 one of the larger 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: while we do not anticipate significant barriers here the Regional Model will need to work closely with all providers

to ensure that they understand the features of the physical, mental health and substance use treatment systems. This information will be incorporated into the ongoing trainings offered periodically for all PHC providers; into the materials distributed by our Provider Relations staff; and through other means.

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. Effective movement through levels of care and referrals across the system will be encouraged through contractual requirements; financial support and/or incentives; and data collection/sharing at the Plan level.

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

- The anticipated number of Medi-Cal clients.
- The expected utilization of services by service types.
- The numbers and types of provider's required to furnish the contracted Medi-Cal services.
- A demonstration of how the current network of providers compares to the expected utilization by service type.
- Hours of operation of providers.
- Language capability for the county threshold languages.
- Specific access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
- The geographic locations of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.
- How will the Regional Model address service gaps, including access to MAT services?
- As an appendix document, please include a list of network providers indicating if

they provide MAT, their current patient load, their total DMC-ODS patient capacity and the populations they treat (i.e., adolescent, adult, perinatal).

Anticipated number of Medi-Cal clients:

On March 1, 2017, there were 285,071 Partnership HealthPlan Medi-Cal members in the 8 counties in the Regional Model. Relying on a variety of sources, we estimate that ten percent of the overall population 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.

The table below provides the projected range of utilization, based upon March 1, 2017 Medi-Cal enrollments and review of current county cost reports and experience. Note that these data are extensively addressed in the Regional Model Fiscal Plan which is currently under review.

County	3/1/2017 Medi-Cal Population*	10% of March Medi-Cal Population**	Initial Projected Utilization***
Humboldt	55,653	5,565	652
Lassen	7,949	795	107
Mendocino	40,168	4,017	444
Modoc	3,159	316	38
Shasta	63,873	6,387	1022
Siskiyou	18,900	1,890	275
Solano	90,411	9,041	977
Trinity	4,958	496	74
TOTAL	**285,071**	**28,507**	**3589**

*Note that the numbers reflect the Medi-Cal population assigned to PHC; there may be additional fee-for-service Medi-Cal clients not reflected in these numbers.

**These numbers provide a general estimate of the number of beneficiaries with substance use treatment needs; it provides a maximum number since not all those who need services will seek treatment and since a number of those who do seek treatment may be treated in the current system including MAT services provided by community clinics.

***These projections are based upon county cost-reports; review of PHC data on the number of members with substance use diagnoses; and other discussions. They generally provide the "floor" for the range that might seek treatment at the time of implementation.

NOTE that these projections and their indications for the Regional Model are addressed in greater detail in the associated Fiscal Plan for the Model. Note that the contents of the Fiscal Plan are currently being discussed by PHC and DHCS staff and may be slightly different than the numbers presented here.

Expected utilization of services by service type:
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%

Number and types of providers required to furnish the contracted Medi-Cal services: Based upon the reference sources noted above, the early implementation of the Regional Model assumes approximately 30% to 40% of services will be provided in the outpatient or intensive outpatient settings; 15% to 25% in residential settings; and the rest served in the other parts of the system.

Outpatient: In order to serve the expected number of those seeking treatment at implementation, the Regional Model will include outpatient services in all counties. Most counties will also have intensive outpatient services available at the time of Implementation. Within one year of Implementation, all counties will have both outpatient and intensive outpatient services...

Withdrawal: At implementation, designated sites for withdrawal services will be available in Shasta, Humboldt, Mendocino and Solano Counties. Within the first year of operation, withdrawal services will be available in all counties. Note, however, that in some cases these services will be available through PHC's non-Drug Medi-Cal system (i.e., the current clinic and hospital service structure).

NTP: At the time of implementation, NTP providers will have spokes in every county except Modoc and hubs in Shasta, Humboldt, and Solano Counties. Modoc residents will either travel to the closest NTP hub or spoke, or receive Medication Assisted Treatment services through in-county outpatient care sites.

Residential: At the time of implementation, residential services will be available in Shasta, Humboldt, and Mendocino Counties. Regional Model beneficiaries will also receive residential services from contracted providers in nearby counties (e.g., Contra Costa for Solano residents; Lake and Sonoma for Mendocino residents).

Appendix A provides further details.

Comparison of current network of providers to the expected utilization by service type: As detailed in Appendix A, the Regional Model will be able to meet expected utilization demand by the projected date of implementation (July 1, 2018).

Hours of operation for providers: In general, providers will operate from 8:00 or 9:00 a.m. through 5 p.m. on business days, with after hour coverage provided by the after-hours line and identified 24/7 provider sites; see Attachment A for further details.

Language capability for the county threshold language: Spanish is the required threshold language in three counties (Modoc, Mendocino and Solano Counties); Tagalog is required in one county (Solano). 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, regardless of county. 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.

Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeless of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans
The Regional Model standard will be for each eligible client to be offered a first appointment within 10 days of referral or request for service for non-urgent services. 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 access. See Attachment B for further details on the Quality Management program.

Geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities: As shown in Appendix A, even without taking into account the services provided through the current PHC system (dual diagnosis-capable mental health providers; clinics; etc.) the network at the time of implementation provides key services in most areas with more in the process of development/licensure.

How will the Regional Model address service gaps, including access to MAT services? The Regional Model will meet all access standards through a combination of on-site and telehealth services. In terms of on-site services, the Plan will expand its current network of telehealth services to address substance use needs. The Plan also has a variety of provider support services, including "e-Consult" and the identification of specialists to assist providers in the treatment of difficult conditions. Addiction specialists will be added to the list of services available through telehealth and our provider consultation services. This will be achieved by the end of Implementation Year One.

The preference, of course, is to serve individuals with disabilities in the same sites and programs that are available to all members. Partnership HealthPlan

has worked to ensure that our providers are equipped to serve those with disabilities, most recently through a $2 million grant program that helped providers in all PHC counties. This philosophy will continue as we work with our substance use treatment network to encourage broad accessibility for all clients.

Finally, in accordance with recent State legislation and directives, Partnership HealthPlan has developed an extensive transportation network to meet the needs of all of our members, including those with disabilities.

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

- Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of the need for services.
- Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.
- Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- Establish mechanisms to ensure that network providers comply with the timely access requirements.
- Monitor network providers regularly to determine compliance with timely access requirements.
- Take corrective action if there is a failure to comply with timely access requirements.

All provider contracts will outline the standards for access to care, in accordance with Title 22 and distinguishing between services needed on an urgent basis and those with less urgency. Compliance with these contract requirements will be accomplished through the following:

- First face to face visit: In general, first appointments will be scheduled as soon as possible, with a 10-day standard for the initial intake appointment after the request for outpatient services.
- Urgent conditions: Services for urgent conditions will be provided within 48 hours.
- Emergencies: the appropriate medical service will be contacted as soon as the condition is identified;
- Afterhours care: Care needed outside of regular business hours will be coordinated by the after-hours line and identified contract providers.

These standards will be reinforced through provider education and contacts; monitoring of providers through “secret shopper” calls; monitoring of complaints and grievances; and facility site reviews including interviews with staff and review of treatment plans.

All contracts with providers will require that hours of operation for services to Medi-Cal beneficiaries must be no less than those available for other clients. Contractors will be required to provide timely access data and to comply with all Plan monitoring activities.

The Plan’s Quality Improvement Department will require corrective action plans as necessary in order to ensure full compliance with these requirements.

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 Regional Model wants to provide but needs assistance?

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

Training on Evidence Based Practices (EBPs) _will be offered in person at least once a year and continuously via webinar and "train the trainer" models. The following trainings are strongly encouraged but not required:

- Living in Balance
- Seeking Safety
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Trauma Informed Care

Trainings will include guidance on the clinical application of EBLPs and how to adapt and implement them among culturally diverse populations. Regional Model providers must implement two or more of the above listed EBPs and demonstrate that their staff are sufficiently trained and competent in the application of these EBPs.

Quality and compliance trainings will be required for all Regional Model providers and provided continuously. These will include:

- ASAM Criteria: PHC is working to ensure that all ODS model providers are trained on ASAM and able to incorporate ASAM as a part of their admission and treatment procedures.
- Compliance Trainings will include clinical supervision and documentation as well as relevant regulations, administrative procedures and billing requirements.
- Quality (required trainings)
    - Documentation and adherence to regulatory standards
    - Quality improvement practices

As the model is implemented, trainings for peer providers will be developed and These trainings will be made available to the entire PHC network, in recognition of the current and developing focus on substance use services in many clinics and other provider sites.

The participants in the Regional Model are grateful for the assistance already received from DHCS and its contractors in the development and presentation of trainings. Continued assistance will be sought, especially in the area of peer trainings.

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

- Data on the status of Drug Medi-Cal certifications within and near the 8 counties in the Regional Model.
- Assistance in incorporating identified out of state providers into the Regional Model service delivery system.
- As noted above, assistance in the provision and development of trainings, including those for peers.
- Guidance in the necessary adaptations of the model for adolescents.
- 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.
- Facilitation and guidance on the integration of Federally Qualified Health Centers and other primary care clinics into the integrated Drug Medi-Cal service delivery system.
- In our various meetings with the DHCS officials we have identified several ways in which the Regional Model will differ from the single county model including: reporting of encounter data (crosswalk to CalOMS); adaptations of the processes for quality improvement monitoring; PHC provision of system-wide reports instead of individual county cost reports; adaptations to the audit process; and others. Technical assistance will be needed to educate and, as appropriate, adapt PHC practices to the ODS model to facilitate an overall integrated regulatory approach.

12. Quality Assurance. Describe the quality assurance activities the Regional Model will conduct. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at the minimum include:

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

.

Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a minimum, plans shall specify:

- How to submit a grievance, appeal and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record keeping
- Continuation of benefits
- Requirements of state fair hearings

The Regional Model Quality Improvement Plan will include monitoring of all of the elements listed and 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

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 at least bi-monthly reporting. The Quality, Utilization and Access Committee (QUAC) will establish a subcommittee structure to ensure that Regional Plan activities are sufficiently monitored and reviewed on at least a bimonthly basis. 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.

Partnership HealthPlan's Quality Improvement structure is well developed and comprehensive. The Plan is currently moving to seek accreditation from the National Commission on Quality Assurance (NCQA). The Regional Model service delivery system will be incorporated into this model which will include the following structure (described in more detail in Appendix B).

Oversight structure: Reports on quality issues as well as changes in policies and procedures and other clinical issues will be addressed by a Drug Medi-Cal Provider Advisory Committee (PAC) that will include representatives of providers and counties as well as key PHC leadership.

Data collection and oversight: Providers will be required to report on the following:

- Timeliness of first initial contact to face to face appointment

- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services for the first dose of NTP or other MAT services
- Access to after-hours care
- Responsiveness of the Central Access Line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with substance use services
- Telephone access line and services in the prevalent non-English languages

The Plan will audit all of these reports with findings presented to the quality oversight committees.

Appendix C provides an overview of PHC's complaints and grievance processes which will encompass substance use services once the new benefits are implemented.

Grievances, Appeals and State Fair Hearings

Beneficiaries will be advised that they may submit a grievance or complaint any time after an issue, by calling the PHC Member Services Department; online, in person or by mail. Appeals may be filed, by phone, in person or by mail within 60 calendar days of a service denial or action on a complaint or grievance. Beneficiaries will also be advised that they may request State Fair hearings if the member has filed an appeal and received a "Notice of Appeal Resolution" letter telling the member that PHC will still not provide services or PHC did not provide a "Notice of Appeal Resolution" letter telling the member of the decision and it has been past 30 days. Members will be advised of the ways to contact the State in order to request a Fair Hearing and/or an expedited Fair Hearing.

Grievances and appeals are acknowledged within 5 calendar days and acted upon within 30 calendar days unless the beneficiary is advised, within 30 calendar days, that the Plan needs an additional 14 calendar days during which to act on the grievance or appeal.

Once received the Plan enters the grievance into a centralized log within one working day of the receipt. This log shall include the name of the beneficiary; date of receipt of the grievance; date the acknowledgement of the grievance sent; nature of problem; final disposition of grievance; date written decision sent to beneficiary; documentation of reason that there has not been a final disposition of the grievance; document of appear or state fair hearing request.

Individuals who file a grievance or appeal within 10 calendar days from the date the notice was mailed will continue to receive the same type and level of services until a final decision on the grievance and/or appeal has been reached.

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 has chosen the following evidence based practices for particular support: Motivational Interviewing and Cognitive Behavioral Therapy. All providers will be required to incorporate these practices into their programs.

As noted earlier, the Regional Model will provide periodic trainings on these and other 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. Repeated noncompliance may result in other actions to be outlined in the contract.

14. 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.

15. 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 as described in Section 152 “Care Coordination” of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s) the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

N/A

16. 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. Currently, the network is operated in clinics and mental health provider sites.

Another expected telehealth provider, Bright Heart Health, will be retained for NTP and potentially other services. This service operates via an initial in-person intake appointment, followed by telehealth services delivered either in a pre-existing telehealth site (such as a clinic) or on the client's personal device at home or elsewhere.

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

17. 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?

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 times for services.

In general, contracts will be "evergreen" with termination provisions that can be exercised by either party, based on failures to comply or for terminations without cause.

Providers who do not receive a contract can file protests of the decision by email or hard copy to the Partnership HealthPlan CEO. The CEO shall review the stated reasons for the appeal and provide a response to the provider within 30 calendar days. The decision of the CEO shall be final.

At this point, it is expected that all current DMC providers in good standing with the State will receive a contract with the Regional Model. However, if in some instances that is not the case, the Plan will work with each affected beneficiary to ensure continuity of care.

18. 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

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.

19. Residential Authorization. Describe the Regional Model's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

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 addressed within 24 hours.
PHC's Utilization Management Department will review the request in the context of the ASAM assessment criteria and the limits on residential care addressed earlier in this document.

20. One Year Provisional Period. If the Regional Model is unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC-ODS requirement that the Regional Model cannot begin upon implementation. Also include timeline with deliverables.

As shown in Appendix, the Regional Model *currently* has in place almost all of the mandatory elements and expects to have all in place by the projected implementation date of July 1, 2018. The strategies to achieve this expected readiness are the same strategies we would apply to reach full compliance in the provisional scenario:

- Network development:
    - *Intensive Outpatient:* PHC will work aggressively with current substance use outpatient and mild/moderate mental health or physical health providers to develop the necessary intensive outpatient capacity. As noted earlier in this document, several key physical health providers have been the recipients of grants and other resources to expand their substance use treatment capacity throughout the Regional Model area. PHC has a history of helping sites to address their critical needs, including help with recruitments, staff trainings and technical support.
    - *Withdrawal management:* PHC will work with the existing behavioral and physical health care networks to seek to expand the availability of

withdrawal management services.
    - *Note on transportation:* Recent State legislation and directives require that PHC be able to meet extensive transportation needs. This transportation system will help ensure that all mandatory services are available to ODS system beneficiaries.
    - *Contracting:* The Plan expects to start to develop contracts several months before the actual implementation date. These efforts will continue until the mandatory network is available.
- Policies and procedures:
    - The Plan and its partner counties will continue to work aggressively to develop and implement all necessary policies and procedures.
- Training:
    - Any outstanding trainings will be facilitated through all available resources.

Authorization on Behalf of PHC Counties
(resubmission with amendments)

	Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, Trinity	September 18, 2017
Elizabeth Gibboney, CEO Partnership HealthPlan of California	County	Date

Elizabeth Gibboney	Chief Executive Officer	707-781-4232
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

Appendix A

Services by Modality and Year of Availability in Regional Model

Summary

Care Level	Requirement	Initial Capacity Needed[1] (projected)	Description	Availability			
				At Implementation	By Yr 2	By Yr 3	By end of Yr 3
Screening and Brief Intervention ASAM Level 0.5							
0.5	Available throughout Regional Model	Up to 3000	Screening and Brief Intervention for substance use needs	Available at sites throughout all counties	N/A	N/A	N/A
Outpatient ASAM Level 1.0							
1.0	Available in all Regional Model counties at Implementation	Up to 9000	Up to 9 hours/week for adult and 6 for adolescents for recovery and motivational enhancement therapies/strategies	Available in all counties	Additional sites will be added	N/A	N/A
Intensive Outpatient Services ASAM Level 2.1							
2.1	Available in all counties at Implementation	Up to 3600	9 or more hours/week for adults and 6 for adolescents to treat multidimensional instability	Available in all counties except Modoc and Lassen	Available in all counties	Additional sites to be added	N/A
Withdrawal Management Services ASAM Levels WM – 1, 2, 3.2							
1.0	Available in key locations throughout Regional Model	Up to 5400	Mild withdrawal with daily or less than daily outpatient supervision. Outpatient facility with links to licensed prescriber.	Available in Shasta, Mendocino, Humboldt, Solano	Available at this level or higher in all counties	N/A	N/A

[1] Based upon up to 10% utilization by approximately 300,000 beneficiaries.

	Counties (all levels)			Counties as well as adjoining counties			
2.0		N/A	Moderate withdrawal with all-day management and support and supervision; supportive family or living situation at night. Outpatient facility with links to outside prescriber.		Additional sites to be added		
3.2		N/A	Moderate withdrawal with 24 hour support for withdrawal management and to increase likelihood of continuing treatment recovery; licensed inpatient facility.		Additional sites to be added		
Residential Services ASAM Levels 3.1 to 4.0							
3.1	One level required by Implementation Date.	60,000 (all levels)	24 hour structure with available trained personnel; at least 5 hours of clinical service/week with prep for outpatient	Available in Shasta, Humboldt, Mendocino, Lake (for Mendocino clients) and Contra Costa Counties (for Solano)	Additional capacity in Humboldt, Mendocino, Lake and Solano Counties		
3.3	Required within three years.		24 Hour care with trained counselors to stabilize multidimensional imminent danger. Less intensive milieu and group treatment for those with other impairments unable to use full active milieu or			Additional sites to be added	

			Therapeutic community and prepare for outpatient treatment.				
3.5	Required within three years.		24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu and therapeutic community.	In Shasta County		Additional sites to be added	
3.7			24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability. In hospital facility.			Available by end of year	
4.0			24 hour nursing care with daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment. In hospital facility.			Available by end of year	

Opioid Treatment Management							
NTP			Daily or several times a week opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Buprenorphine available in all counties; methadone available to all and located in Shasta and Solano Counties.	Additional buprenorphine sites and buprenorphine available via telehealth. Methadone may be available in Humboldt County.		

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Humboldt

Provider Name	Capacity	Address	Hours of Operation	Languages	Populations Served	DMC Certified/ Availability (If not at implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.partnershiphp.org/Members/Medi-Cal/Pages/default.aspx)	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
Humboldt County HHS; Alcohol and Drug Programs	Co-ed 80	720 Wood Street, Eureka, CA	8 to noon and 1 to 5, M-F	English	All	Yes
Healthy Moms Program, Humboldt County HHS: Alcohol and Drug Programs	Women (preg or with young children only) 24	2910 H Street, Eureka, CA	8 to noon and 1 to 5, M-F	English	All	Yes
United Indian Health Services	Co-ed; 50	1600 Weott Way, Arcata, CA	8 to noon and 1 to 5, M-F	English	All	N/A
Intensive Outpatient Services ASAM Level 2.1						
Healthy Moms Program; Humboldt County HHS: Alcohol and Drug Programs	Women (preg or with young children only) 12	2910 H St, Eureka CA	8 to noon and 1 to 5, M-F	English	Women	Yes
United Indian Health Services	Co-ed; 20	1600 Weott Way, Arcata, CA	8 to noon and 1 to 5, M-F	English	All	N/A
Withdrawal Management Services ASAM Level WM – 1						
Singing Trees Recovery Center	3; co-ed	2061 Highway 101, Garberville, CA	M-F	English	All	DMC certification expected by end of Implementation Year 1

Withdrawal Management Services ASAM Level WM-2						
Alcohol and Drug Care Services	4 (co-ed)	1321, 1335 C Street; 217 4th Street, Eureka, CA	24/7	English	All	DMC certification in process; expected by implementation
Withdrawal Management Services ASAM Level WM-3.2						
Waterfront Recovery Services	TBD	1321 C Street, Eureka, CA	24/7	English	All	By Year 2
Residential Services ASAM Level 3.1						
Humboldt Recovery Services	21 (men only)	1303 11st Street and 1024 N Street, Eureka, CA	Regular business hours	English	Men	DMC certification in process; expected by implementation
Humboldt Recovery Services	23 (men only)	905 L Street; 1116 and 1120 9th Street, Eureka, CA	Regular business hours	English	Men	DMC certification in process; expected by Implementation
Humboldt Recovery Services	18 (women only)	944 N Street and 1219 10th Street, Eureka, CA	Regular business hours	English	Women	DMC certification in process; expected by implementation
North Coast Substance Abuse Council; Crossroads	22 (men only)	1205 and 1210 Myrtle Avenue, Eureka, CA	Regular business hours	English	Men	DMC certification in process; expected by implementation
Alcohol Drug Care Services Residential Treatment Program	21 (co-ed)	1321, 1335 C Street, 217 4th Street, Eureka, CA	Regular business hours	English	All	DMC certification in process; expected by implementation
Singing Trees Recovery Center	20 (co-ed)	20-61 Highway 101, Garberville, CA	Regular business hours	English	All	DMC certification in process; expected by implementation
ADCS Women's Residential Treatment Program	8 (women only)	1742 J Street, Eureka, CA	Regular business hours	English	Women	DMC certification in process; expected by implementation
Residential Services ASAM Level 3.3-3.5						
Waterfront Recovery Services	56-co-ed	2413 2nd Street Eureka, CA 95501	24/7 care Admission 9-5 M-F	English (TBD)	All	By Year 2

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Lassen

Provider Name	Capacity	Address	Hours of Operation	Languages	Populations Served	DMC Certified/ Availability (If not at implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.partnershiphp.org/Members/Medi-Cal/Pages/default.aspx)	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
Lassen County Behavioral Health	25	1400 Chestnut Street Suite A Susanville CA 96130 Phone: 530-251-8112	8AM -5PM	English/ Spanish	All	Yes
Lassen County Behavioral Health	20	555 Hospital Lane Susanville Ca 96130 Phone: 530-251-8108	8AM – 5PM	English/ Spanish	All	Hoping to be certified in near future
Intensive Outpatient Services ASAM Level 2.1						
Lassen County Behavioral Health	10	1400 Chestnut Street Suite A Susanville CA 96130 Phone: 530-251-8112	8AM -5PM	English/ Spanish	All	Yes
Lassen County Behavioral Health	10	555 Hospital Lane Susanville Ca 96130 Phone: 530-251-8108	8AM – 5PM	English/Spanish	All	Hoping to be certified in near future
Withdrawal Management Services ASAM Level WM-2						
TBD	TBD	TBD; perhaps associated with Banner Lassen Clinic	TBD	TBD	All	Projected for Year 2
OTP Services						
Aegis Treatment Centers	TBD	TBD	TBD	TBD	All	Spoke linked to Chico Clinic

Services by Modality, Location, Language and Hours of Operation
And Year of Availability in Regional Model
County: Mendocino

Provider Name	Capacity	Address	Hours of Operation	Service Languages	Populations Served	DMC Certified/ Availability (if after implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.partnershiphp.org/Members/Medi-Cal/Pages/default.aspx	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
FORD STREET PROJECT	20	139 FORD STREET UKIAH, CA 95482 Phone: (707)462-1934 Fax: (707)468-9860	8AM-4PM	English	All	DMC Certification pending
MENDOCINO COUNTY HEALTH AND HUMAN SERVICES AGENCY, ALCOHOL AND OTHER DRUG PROGRAM	20	790 SOUTH FRANKLIN STREET, SUITE B FORT BRAGG, CA 95437 Phone: (707)472-2605 Fax: (707)472-2657	Regular business hours	English	All	Yes
MENDOCINO COUNTY HEALTH AND HUMAN SERVICES AGENCY BEHAVIORIAL HEALTH & RECOVERY	20	1120 SOUTH DORA STREET, UKIAH, CA 95482 Phone: (707)472-2637 Fax: (707)472-2768	Regular business hours	English	All	Yes
MENDOCINO COUNTY HHSA - CHILDREN'S AND FAMILY SERVICES	10	727 S. STATE STREET UKIAH, CA 95482 Phone: (707)472-2605 Fax: (707)472-2657	Regular business hours	English	Women	Yes

WILLITS INTEGRATED SERVICES CENTER (WISC)	10	221 B LENORE STREET WILLITS, CA 95490 Phone: (707)472-2605 Fax: (707)472-2657	7AM-5PM	English	All	Yes
YUKI TRAILS HUMAN SERVICE PROGRAM - A DEPARTMENT OF ROUND VALLEY INDIAN HEALTH	10	23000 HENDERSON ROAD COVELO, CA 95428 Phone: (707)983-6648 Fax: (707)983-6649	8AM-5PM	English	All	N/A
Intensive Outpatient Services ASAM Level 2.1						
MENDOCINO COUNTY HEALTH AND HUMAN SERVICES AGENCY, ALCOHOL AND OTHER DRUG PROGRAM	10	790 SOUTH FRANKLIN STREET, SUITE B FORT BRAGG, CA 95437 Phone: (707)472-2605 Fax: (707)472-2657	Regular business hours	English	All	By Year 2
MENDOCINO COUNTY HEALTH AND HUMAN SERVICES AGENCY BEHAVIORIAL HEALTH & RECOVERY	10	1120 SOUTH DORA STREET, UKIAH, CA 95482 Phone: (707)472-2637 Fax: (707)472-2768	Regular business hours	English	All	By Year 2
Withdrawal Management Services ASAM Level WM - 1						
Ford Street Project	5	139 FORD STREET UKIAH, CA 95482 Phone: (707)462-1934 Fax: (707)468-9860	8 a.m. to 4 p.m.	English	All	In process
Withdrawal Management Services ASAM Level WM-3.2						
UKIAH RECOVERY CENTER	16	201 BRUSH STREET, BUILDINGS 201A, 201B, AND 201CUKIAH, CA 95482 (707)462-6290	8AM-4PM	English	All	Pending
Residential Services ASAM Level 3.1						
UKIAH RECOVERY CENTER	40	201 BRUSH STREET, BUILDINGS 201A, 201B, AND 201CUKIAH, CA 95482 (707)462-6290	8AM-4PM	English	All	Pending

HILLTOP RECOVERY SERVICES	40	Clear Lake Oaks	Regular business hours	English	Men	Pending
Hilltop Recovery Services	10	Clear Lake Oaks	Regular business hours	English	Women	By Year 2
OTP Services						
Aegis Treatment Centers	TBD	TBD	TBD	English	All	By Implementation

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Modoc

Provider Name	Capacity	Address	Hours of Operation	Languages	Populations Served	DMC Certified/ Availability (if after implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.partnership.org/Members/Medi-Cal/Pages/default.aspx)	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
Modoc County HHS; Alcohol and Drug Programs	Various	441 N Main Street Alturas, CA 96101	Regular business hours	English	All	Yes
Intensive Outpatient Services ASAM Level 2.1						
Modoc County HHS; Alcohol and Drug Programs	Various	441 N Main Street Alturas, CA 96101	Regular business hours	English	All	Yes

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Shasta

Provider Name	Capacity	Address	Hours of Operation	Primary Language	Populations Served	DMC Certified/ Availability (if later than implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory); http://www.paartnershiphp.org/Members/Medi-Cal/Pages/default.aspx	Various	Spanish English	All	N/A; available at implementation
Outpatient ASAM Level 1.0						
EMPIRE OUTPATIENT SERVICES	Various	1616 WEST STREET REDDING, CA 96001 Phone: (530)244-7074 Fax: (530)244-7065	8AM-7PM	English Spanish	All	Yes
SHASTA COUNTY AOP	Various	2640 Breslauer Way Redding CA 96001 Phone: (530)225-5200 Fax: (530)245-6752	8AM-5PM	English	All	Yes
SHASTA COUNTY Youth Drug Court	Various	2640 Breslauer Way Redding CA 96001 (530)225-5200 Fax: (530)245-6752	8AM-5PM	English	Youth	Yes
VOTC, Inc.	Various	3617 Ricardo Avenue #1 Redding, CA 96002	8AM-8PM	English	All	Yes
VOTC, Inc.	Various	3617 Ricardo Avenue #1 Redding, CA 96002	8AM-8PM	English	Perinatal	Yes
ANDERSON OUTPATIENT PROGRAM	Various	2110 FERRY STREET ANDERSON, CA 96007 Phone: (530)365-8523	8AM-7PM	English	All	Yes

Intensive Outpatient Services ASAM Level 2.1						
SHASTA COUNTY PERINATAL PROGRAM	Various	1506 Market St. REDDING, CA 96001 Phone: (530)245-6411	8AM-5PM	English	Perinatal	Yes
VOTC, Inc.	Various	3617 Ricardo Avenue #1 Redding, CA 96002	8AM-8PM	English	All	Yes
VOTC, Inc.	Various	3617 Ricardo Avenue #1 Redding, CA 96002	8AM-8PM	English	Perinatal	Yes
Withdrawal Management Services ASAM Level WM - 1						
EMPIRE RECOVERY SERVICES	6	1237 California Street Redding, CA 96001	24/7	English	All	Yes
Withdrawal Management Services ASAM Level WM-2						
TBD	TBD	TBD	TBD	TBD	All	By Year 2
Withdrawal Management Services ASAM Level WM-3.2						
TBD	TBD	TBD	TBD	TBD	All	By Year 3; at either WM 2 or WM 3.2
Residential Services ASAM Level 3.1						
EMPIRE RECOVERY CENTER	36	1237 CALIFORNIA STREET REDDING, CA 96001 Phone: (530)243-7470 Fax: (530)243-7477	Open 24 hours	English	All	No
VOTC, INC.	24	3640, 3642, 3644, 3646, 3650, 3652 EL PORTAL DRIVE AND 3647 RICARDO AVENUE REDDING, CA 96002 Phone: (530)722-1114 Fax: (530)722-1115	Open 24 hours	English	All	Yes
VOTC, INC.	18	2066 Placer Street Redding, CA 96001	Open 24 hours	English	All	Yes; will be available by time of implementation

Residential Services, ASAM Level 3.5						
VOTC, INC.	10	3617 RICARDO AVENUE, #6, 7, 8 REDDING, CA 96002 Phone: (530)722-1114 Fax: (530)722-1115	Open 24 hours	English	Perinatal	Yes
NTP Services						
Aegis Treatment Services	150	1147 Hartnell AVE. REDDING, CA 96002 Phone: (530)345-3491	5:00- 9:30 AM	English	All	Yes

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Siskiyou

Provider Name	Capacity	Address	Hours of Operation	Languages	Populations Served	DMC Certified/ Availability (if after implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.patnershiphp.org/Members/Medi-Cal/Pages/default.aspx	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
KARUK HEALTH CLINIC	Various	1519 SOUTH OREGON STREET City, State Zip: YREKA, CA 96097 (530)842-9200 Fax: (530)841-5150	8AM-5PM/M-F	English,	Native and Non Native	By Year 1
Addictions Recovery Center, Inc.	Various	DAAP, EAP, DUII Flex 1003 E Main, Medford Oregon 97504	8AM – 5 PM M-F with evening and weekend groups	English	All	N/A; not in California
Addictions Recovery Center, Inc	120 total for all outpatient programs	1003 E Main, Medford OR 97504	8AM-5PM/M-F With evening groups	English	All	N/A – Not in the state of California
HealTherapy	30	805 Juvenile Lane, Yreka, CA 96097	8am-5pm/M-F	English and Spanish	Criminal Justice Population	By Year 2
Intensive Outpatient Services ASAM Level 2.1						
SISKIYOU COUNTY BEHAVIORAL HEALTH	92	2060 CAMPUS DRIVE City, State Zip: YREKA, CA 96097-9538 (530)841-4890 Fax: (530)841-4881	8AM-5PM/M-F	English	All	Applying for Certification

Addictions Recovery Center, Inc	200	1003 E Main, Medford OR 97504	8AM-5PM/M-F With evening groups	English	All	N/A – Not in the state of California
Withdrawal Management Services ASAM Level WM-3.2						
Addictions Recovery Center, Inc	4	1003 E Main, Medford OR 97504	8AM-5PM/M-F With evening groups	English	All	N/A – Not in the state of California
Medically Monitored Detox ASAM Level 3.7						
Addictions Recovery Center, Inc	12	338 N Front Street, Medford OR 97501	24 hours/7 days	English	All	N/A – Not in the state of California
Residential Services ASAM Level 3.5						
Addictions Recovery Center, Inc	28	1003 West Main, Medford OR 97501	24 hours/7 days	English	All	N/A – Not in the state of California
NTP						
AEGIS TREATMENT CENTERS	Tbd	TBD	TBD	English	All	By implementation date
Bright Heart Health	TBD	By Telehealth	TBD	English	All	By implementation date

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Solano

Provider Name	Capacity	Address	Hours of Operation	Languages	Populations Served	DMC Certified/ Availability (If not at implementation)
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.partnershiphp.org/Members/Medi-Cal/Pages/default.aspx)	Various	Various	All	N/A
Outpatient ASAM Level 1.0						
RECOVERY CONNECTION (BI-BETT CORP)	40	604 BROADWAY ST VALLEJO, CA 94590 Phone:707-643-2748 FAX: 707-558-8047	1:30PM - 10PM	English	All	DMC certified
ANKA BEHAVIORAL HEALTH	25	CORPORATE: 1850 GATEWAY BLVD, #900 CONCORD, CA 94520 PROGRAM: 201 Georgia St. VALLEJO, CA 94590 Phone: 707-558-8195 FAX: 707-558-8196	Regular business hours	English	All	DMC certified
HEALTHY PARTNERSHIPS (FAIRFIELD)	200	1735 ENTERPRISE DR., STE. 105A FAIRFIELD, CA 94533 Phone: 707-425-1799 FAX: 707-425-1081	9AM-6PM	English, Spanish	All	DMC Certified
HEALTHY PARTNERSHIPS (VACAVILLE)	150	1286 CALLEN ST. VACAVILLE, CA 95687 Phone: 707-447-8982 FAX: 707-447-3205	9AM-6PM	English, Spanish	All	DMC certified
TBD	25	TBD	TBD	English and Spanish	All	By Year 2

Intensive Outpatient Services ASAM Level 2.1						
HEALTHY PARTNERSHIPS (FAIRFIELD)	200	1735 ENTERPRISE DR., STE. 105A FAIRFIELD, CA 94533 Phone: 707-425-1799 FAX: 707-425-1081	9AM-6PM	English, Spanish	All	DMC Certified
HEALTHY PARTNERSHIPS (VACAVILLE)	150	1286 CALLEN ST. VACAVILLE, CA 95687 Phone: 707-447-8982 FAX: 707-447-3205	9AM-6PM	English, Spanish	All	DMC certified
ANKA BEHAVIORAL HEALTH	25	CORPORATE: 1850 GATEWAY BLVD, #900 CONCORD, CA 94520 PROGRAM: 201 Georgia St. VALLEJO, CA 94590 Phone: 707-558-8195 FAX: 707-558-8196	Regular business hours	English	All	DMC certified
Withdrawal Management Services ASAM Level WM - 1						
TBD	TBD	RFP for Vallejo based services pending	TBD	TBD	All	Targeted for Implementation
TBD	TBD	RFP for Fairfield based services pending	TBD	TBD	All	Targeted for Implementation
Withdrawal Management Services ASAM Level WM-3.2						
SOUTHERN SOLANO ALCOHOL DRUG COUNCIL (BI-BETT CORP)	9	419 PENNSYLVANIA ST. VALLEJO, CA 94590 Phone: 707-643-2715 FAX: 707-634-8536	24/7	A little Spanish, English	All	Certification pending; expected to be available by initial implementation date
Contra Costa Providers (e.g., Wollam House, Pueblos del Sol, Fred Ozanam)	TBD	TBD	24/7	English, Spanish	All	By end of Year 1

Residential Services ASAM Level 3.1						
GENESIS HOUSE	19	1149 WARREN AVE. VALLEJO, CA 94591 Phone: 707-552-5295 FAX: 707-552-3394	24/7	English	All	Certification pending; expected to be available by initial implementation date
J COLE RECOERY HOMES, INC	16	1408 A ST. ANTIOCH, CA 94509 Phone: 925-978-2873 FAX: 925-757-0411	24/7	English	Men	Certification pending; expected to be available by initial implementation date
THE RECTORY	16	12960 SAN PABLO AVE. RICHMOND, CA 94805 Phone: 510-236-3134 FAX: 510-236-3200	24/7	English, Spanish	Women	DMC certified
SHAMIA (BI-BETTCORP)	16	126 OHIO ST. ; 126 ½ and 128 VALLEJO, CA 94590 Phone: 707-644-2577 FAX: 707-644-5501	24/7	English,	Women	DMC certified
OZANAM HOUSE (BI-BETTCORP)	19 total; lesser number available to non-Contra Costas residents	2931 PROSPECT ST CONCORD, CA 94518 Phone: 925-676-4840 FAX: 925-676-1315	24/7	English	Women	Certification pending; expected to be available by initial implementation date
DIABLO VALLEY RANCH (BI-BETTCORP)	68	11540 MARSH RD. CLAYTON, CA 94517 Phone: 925-672-5700 FAX: 925-672-1374	24/7	English	Men	Certification pending; expected to be available by initial implementation date
GENESIS HOUSE	12	133 RENIDA STREET VALLEJO, CA 94591	24/7	English	All	Certification pending; expected

						to be available by initial implementation date
Residential Level 3.3						
TBD	TBD	TBD	TBD	TBD	TBD	By Year 2
Residential Level 3.5						
TBD	TBD	TBD	TBD	TBD	TBD	By Year 3
Narcotic Treatment Programs ASAM Level OTP						
MEDMARK TREATMENT CENTERS	400	1143 Missouri Street Fairfield, CA 94533	M-F: 5AM-130 PM, Sa-Sun: 7 AM-1030	English, Spanish	All	DMC certified
MEDMARK TREATMENT CENTERS	330	1628 N. Broadway Street, Suite B Vallejo, CA 94590	M-F: 5AM-130 PM, Sa-Sun: 7 AM-1030	English, Spanish	All	DMC certified

Services by Modality, Location, Language and Hours of Operation

And Year of Availability in Regional Model

County: Trinity

Provider Name	Capacity	Address	Hours of Operation	Primary Language	Populations Served	DMC Certified/ Availability
Early Intervention ASAM Level 0.5						
Various	Various	Various (see PHC provider directory; http://www.plartnershiphp.org/Members/Medi-Cal/Pages/default.aspx)	Various	Various	Various	N/A; available at Implementation
Outpatient ASAM Level 1.0						
TRINITY COUNTY ALCOHOL AND OTHER DRUG SERVICES	24	1450 MAIN STREET WEAVERVILLE, CA 96093 Phone: (530)623-1362 Fax: (530)623-5830	8AM-5PM	English	All	Yes
HAYFORK BEHAVIORAL HEALTH	12	154-B TULE CREEK ROAD HAYFORK, CA 96041 Phone: (530)628-4111 Fax: (530)628-1982	8AM-5PM	English	All	Yes
Intensive Outpatient Services ASAM Level 2.1						
TRINITY COUNTY ALCOHOL AND OTHER DRUG SERVICES	12 (Women only)	1450 MAIN STREET WEAVERVILLE, CA 96093 Phone: (530)623-1362 Fax: (530)623-5830	8AM-5PM	English	All	Yes; available within 6 months of implementation

NTP Services						
Aegis Treatment Centers (spoke)	TBD	TBD	TBD	TBD	All	DMC Certification to be available by time of implementation
Recovery Support						
TRINITY COUNTY ALCOHOL AND OTHER DRUG SERVICES	12	1450 MAIN STREET WEAVERVILLE, CA 96093 Phone: (530)623-1362 Fax: (530)623-5830	8AM-5PM	English	All	Yes; available within 6 months of implementation
HAYFORK BEHAVIORAL HEALTH	12	154-B TULE CREEK ROAD HAYFORK, CA 96041 Phone: (530)628-4111 Fax: (530)628-1982	8AM-5PM	TBD	All	TBD

Appendix B:
QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM DESCRIPTION

Draft for Proposed ODS Waiver Regional Model

Anticipate submission to PHC board for approval in early 2018

TABLE OF CONTENTS

PROGRAM PURPOSE AND GOALS

The Partnership HealthPlan of California (PHC) Quality and Performance Improvement QI/PI program provides a systematic process to monitor clinical and service aspects of health care delivery to all PHC members. It includes an organized framework to review activities to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and to improve health outcomes. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- ensure integration with current community health priorities, standards, and public health goals,
- identify and act on opportunities to improve care and service,
- identify overuse, misuse, and underuse of health care services,
- identify and act on opportunities to improve processes to ensure patient safety,
- address potential or tangible quality issues, and
- review trends that suggest variations in the process or outcomes of care.

The QI/PI program goal is to optimize the quality and cost effectiveness of clinical care and service to PHC members by:

- systematically monitoring and evaluating service and care provided,
- actively pursuing opportunities for improvement in areas that are relevant and important to our members' health, and
- implementing strong interventions when opportunities for improvement are identified.

This goal aligns with PHC's mission: To help our members and the communities we serve be healthy.

The QI/PI program provides a structured framework to consistently monitor and evaluate the care and service provided to our members. Evaluation is based on the measurement and trending of selected indicators and professionally recognized standards of practice. Objectives of the program are to:

- Identify opportunities for improvement and act on opportunities that have the greatest impact on patient care and that are aligned with PHC's mission, vision, and values.
- Monitor and ensure compliance with contractual quality requirements, state and federal quality regulations, evidence-based standards of care, and standards of selected accrediting bodies.
- Through PHC's Grievance Department, provide a process for receiving, analyzing, and responding to provider and member complaints, grievances, appeals, or suggestions relating to quality of care, service, and facility. This process is also followed for grievances related to substance use services.
- Support the credentialing/re-credentialing process with measurement and evaluation of PCP transfer requests, office site surveys and medical record reviews, and clinician quality issue investigation/peer review.
- Establish, maintain, and enforce confidentiality and conflict of interest policies regarding peer review activities and protection of confidential member and provider information.
- Accurately document quality improvement (QI) investigations and activities, including documentation of committee meetings and quantitative and qualitative evaluation reports.
- Ensure regular reporting of QI/PI activities, problem identification, risk management, resource management, network management and member satisfaction information to the plan's Internal Quality Improvement Committee (IQIC), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Board of Commissioners.
- Educate and inform PHC staff, members and contract practitioners regarding the philosophy, procedures, QI processes, practice, and expectations of the PHC QI/PI program.
- Provide relevant QI/PI information and tools to contracted providers to assist them in clinical decision-making processes in the provision of care and service.
- Administer PHC's financial incentive programs. This includes measure research and specification design, the provision of technical assistance to practice sites, management of supporting information systems, and calculation of performance scores for participating practices.

- Collaborate with the PHC Health Educators in development and implementation of a comprehensive health education and Cultural Linguistics Program.
- Effectively coordinate QI/PI activities with other health plan management functions including utilization management, care coordination, health education, behavioral health, pharmacy, provider relations and member services in an effort to promote continuous quality improvement in organization-wide performance.
- Assure that the objectives, scope, organization and mechanisms for overseeing effectiveness of monitoring, evaluation and problem solving activities in the QI/PI program are assessed and revised at least annually.

SCOPE OF QI/PI PROGRAM

The scope of the QI/PI program includes the quality of clinical care and the quality of service for all members. Partnership has a single product line – Medi-Cal – and this program covers that product line. The monitoring and evaluation of clinical issues reflects the population served by PHC without regard to age group, disease category, or risk status. In partnership with other PHC departments, the QI/PI program encompasses all aspects of medical care including:

- Potential quality issues and other patient safety indicators
- Diagnoses and procedures with a wide variation in cost or utilization patterns
- Identifying overuse, misuse, and underuse of health care services
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying and addressing access or quality issues related to behavioral health services through delegated contracts
- Promoting cultural and linguistic competence of PHC staff and network practice sites and providers
- Member experience outcomes
- Facility Site Review survey to assess compliance with patient safety standards
- Ambulatory Medical Records Review
- Part C Reviews that include an assessment of accessibility for seniors and persons with disabilities
- Preventive health care guideline compliance
- Clinical Practice Guideline (CPG) compliance, chronic and acute care
- Continuity and coordination of care between PCPs and Specialists, PCPs and other provider types, and PCPs and Behavioral Health Practitioners (through Care Coordination of Health Services department)
- Accessibility and quality of primary, specialty and behavioral health care
- Member grievances (through the Grievance/Complaint/Appeals department)
- Health promotion to educate members about preventive and chronic care (in collaboration with Health Educators in the Health Services Department)
- Provider satisfaction (through the Provider Relations Department)
- Provider credentialing (through the Provider Relations Department)
- Supporting clinics in achieving patient centered health homes

The QI/PI program encompasses monitoring and evaluation of care and service in the following settings:

- Acute hospital services
- Ambulatory care, including preventive health care, perinatal care, chronic disease management, and family planning
- Emergency and urgent care services
- Behavioral health services* (mental health and substance abuse)
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, medical supplies, Durable Medical Equipment (DME), therapy services, laboratory, vision, and radiology services
- Long-term care including Skilled Nursing Facility Care, Rehabilitation Facility Care, and Home Health Care
- Regional Drug Medi-Cal Model

*QI Program scope as it relates to behavioral health services:

Mental Health Services:

As a Managed Care Plan (MCP), PHC has been held responsible by DHCS since January 1, 2014 for the provision of mental health services for conditions deemed to be mild to moderate impairments of mental, emotional, or behavioral functioning. PHC delegates the provision of such services to Beacon Health Options in all fourteen counties served by PHC and to Kaiser Permanente in five counties where a portion of PHC Members are assigned to Kaiser Permanente. This mandate is detailed in DHCS All Plan Letter 13-018 issued November 27, 2013.

Specialty Mental Health Services for mental health conditions deemed to be moderate to severe in terms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) are assigned by DHCS to County Mental Health Plans (MHPs) and include all conditions that meet the medical necessity criteria pursuant to Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210)

All Mental Health QI management and improvement activities are delegated by PHC to Beacon Health Options and Kaiser Permanente. PHC oversight of these delegated QI functions is achieved through: 1) annual audits, 2) review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects (e.g., improved PCP referral forms, review of quality issues related to neuropsychological testing, requesting of additional reports related to QI, monitoring of access standards) through frequent meetings.

Regional Drug Medi-Cal Model:

Partnership HealthPlan of California (PHC) and 8 California Counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano and Trinity) have proposed development of a Regional Drug Medi-Cal Model, beginning in July, 2018. Just as PHC does for its other services, this program description includes the planned structure of quality and performance improvement activities PHC proposes to use for the overall Regional Model, as a whole.

The quality infrastructure of the Regional Drug Medi-Cal Model is designed to help achieve one of the key goals of the Regional Drug Medi-Cal Model: the integration of substance use services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the Other Drug Services (ODS) waiver requirements into the strong, foundational quality structure of Partnership HealthPlan of California.

AUTHORITY AND RESPONSIBILITY

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI/PI program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the program to the Physician Advisory Committee (PAC). The PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQIC), which are described in more detail below. Members of the Commission are appointed by the county Boards of Supervisors for each geographic area and include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMO's, local government, and County Health Departments. The Commission meets at least quarterly.

Chief Executive Officer

The PHC Chief Executive Officer's (CEO) primary roles in quality management and improvement are fourfold:

- maintain a working knowledge of clinical and service issues targeted for improvement,

- provide organizational leadership and direction,
- participate in prioritization and organizational oversight of quality improvement activities, and
- ensure availability of resources necessary to implement the approved QI/PI program.

Chief Medical Officer

The CMO, with the assistance of the members of the PAC, Q/UAC, and IQIC, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of the IQIC and Q/UAC and has significant involvement in all QI/PI, Pharmacy and Health Services activities as well as providing oversight to these programs on a day-to-day basis.

Mental Health Clinical Oversight

The Mental Health Clinical Director, with the assistance of other members of the PHC Behavioral Health Leadership Team (Senior Director, Health Services; Chief Operating Officer; Executive Director, Northern Region; Regional Director, Santa Rosa Regional Office; Team Supervisor, PHC Care Coordination), is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures, through oversight of PHC activities in these areas and through oversight of these activities as provided by PHC's delegated behavioral health providers. Annual audits by PHC of Beacon Health Options and Kaiser Permanente (mental health delegates) stipulate that the organizations produce evidence that Behavioral Health Specialists at the level of Ph.D. and/or M.D. are on their QI Committee or on teams that report to their QI Committee. Both organizations meet this standard.

Substance Use Services Clinical Oversight

The Medical Director of PHC Substance Use Services, and PHC's Substance Use Clinical Director, with the assistance of other members of the PHC Behavioral Health Leadership Team (Senior Director, Health Services; Chief Operating Officer; Behavioral Health Administrator; and other Plan leadership) are responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures, through oversight of PHC activities in these areas and through oversight of these activities as provided by any PHC delegated Substance Use providers. Annual audits by PHC and Kaiser Permanente (delegated for substance use services) stipulate that the organization produces evidence that a physician addiction specialist serves on their QI Committee or on teams that report to their QI Committee.

Program Staff

PHC QI/PI program staff and their titles are included in Attachments A and B.

Committee Functions

Substance Use Provider Advisory Group (SUPAG)

The SUPAG monitors PHC Substance Use treatment activities. The committee meets at least 4 times per year. Membership includes licensed and certified substance use providers and clinicians and others involved in substance use care and administrators of contracted SU provider organizations. The Committee also includes county substance use services administration representatives and client or family representatives. The SUPAG advises the Board of Commissioners on issues related to PHC's administration of the Substance Use benefit. It is a subcommittee of the Board of Commissioners and subject to Brown Act regulations.

Physician Advisory Committee (PAC)

The PAC monitors and evaluates all Health Services activities and is directly accountable to the Commission for the oversight of the QI/PI program. The PAC meets monthly at least ten times a year and voting membership includes external Primary Care Providers (PCPs) and board certified high-volume specialists, including at least one addiction medicine specialist. A voting physician member of the committee chairs the PAC. The PHC CMO, Associate Medical Director of Quality, the Medical Director of PHC Substance Use Services, and leadership from the QI/PI, Provider Relations, Member Services, Utilization Management, Care Coordination, Pharmacy, and Grievance Departments attend the PAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports QI/PI activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to PHC members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation and Work Plan. Q/UAC voting membership includes external physicians whose specialties are internal medicine, family medicine, pediatrics, OBGYN, nephrology, neonatologists, an addiction medicine specialist, among others and a consumer representative. The Q/UAC also includes a psychiatrist whose role is to monitor and advise on policy, procedures, and clinical behavioral health topics. The PHC CMO (chair of the committee), the Medical Director of PHC Substance Use Services, the Associate Medical Director of Quality, and leadership from the QI/PI, Provider Relations, Member Services, Utilization Management, Care Coordination, Pharmacy, and Grievance Departments attend the Q/UAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee usually meets monthly, but at least quarterly. Q/UAC activities and recommendations are reported to the PAC and to the Commission at least quarterly. The Q/UAC provides guidance and direction to PHC staff by coordinating all quality improvement activities. Coordination includes but is not limited to:

- Review and approve the QI/PI Program Description, the QI/PI Program Evaluation and Work Plan annually.
- Review and approval of standardized utilization review criteria and protocols.
- Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives.
- Analyze summary data and make recommendations for action plans for quality improvement activities.
- Assure that appropriate follow-up activities occur for all Corrective Action Plans (CAPs) and QI/PI activities.
- Provide oversight of delegated QI activities except for Credentialing activities, which are reviewed by the Credentialing Committee.

Peer Review Committee
The Peer Review Committee is a subcommittee of the Q/UAC and membership includes external practitioners representing PCPs and board certified specialists. The PHC CMO, the Regional and Associate Medical Directors, Performance Improvement Clinical Specialists (quality nurses), and the Manager of Patient Safety and Quality Assurance support the Committee. The committee usually meets monthly but at least quarterly. Peer review functions are:

- Review potential and actual quality issues and provider/member complaints and appeals related to quality of care.
- Make recommendations for Corrective Action Plans (CAP) and practitioner discipline or sanctions to the Credentialing Committee.
- Make recommendations on improvements to systems of care based on specific occurrences.

Substance Use Services Subcommittee of the Peer Review Committee
A subcommittee of the Peer Review Committee that reviews quality issues related to substance use services provided by substance use services providers and clinicians providing substance use services. The subcommittee reviews potential quality issues and makes recommendations on CAPs and practitioner discipline or sanctions to the full Peer Review Committee.

Credentialing Committee
The PHC CMO, or designee, chairs the Credentialing Committee. Committee members include the PHC Senior Provider Relations Director, Director of Provider Relations, Provider Relations Credentialing Supervisor, and Provider Relations Credentialing Specialists, QI/PI staff, and a minimum of five contracted PHC physicians/practitioners. The committee convenes as needed, but at least quarterly. The functions of the Credentialing Committee are to:

- Participate in and make recommendations regarding the structure and process for the credentialing and re-credentialing of providers and licensed practitioners.
- Participate in the development, implementation, and annual review of related policies and procedures.
- Review and approve PHC staff recommendations for routine credentialing of practitioners who do not meet exception criteria.

- Review qualifications and circumstantial details for contracted practitioners who meet exception criteria and make credentialing decisions.
- Review and evaluate the qualifications, utilization, and quality data of each practitioner seeking re-credentialing as a contracted provider at least every three years, and assure compliance with established criteria.
- Verify that credentialing requirements are met by each provider in the network, including implementation of and adherence to any CAPs to meet standards.
- Decisions regarding provider credentialing and re-credentialing.
- Develop and recommend disciplinary or sanction actions of practitioners.
- Provide oversight of any delegated credentialing activities.

Summary information of credentialing activities is presented to the PAC and to the PHC Board of Commissions at the regularly scheduled meetings.

Pharmacy and Therapeutics Committee (P&T)
The P&T Committee is chaired by the PHC CMO and is comprised of PHC staff and network practitioners including pharmacists, PCPs, and specialists including behavioral health. P&T makes decisions and recommendations on development and review of the drug formulary, pharmacy policies and procedures, new drugs, and drug approval criteria. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Provider Advisory Group (PAG)
The PAG is one of the Commission's advisory committees and acts as a liaison between practice site office staff and PHC. The committee has representatives from physician groups and individual offices, community clinics, ancillary providers, long-term care facilities, county health departments, and community advisory groups. The PAG reports to the Physician Advisory Committee (PAC) and provides feedback and recommendations on health care service issues, community health activities, and issues for special needs populations.

Consumer Advisory Committee (CAC)
The CAC is composed of PHC health care consumers who represent the diversity and geographic areas of PHC's membership. There are two CAC committees – one PHC's Northern seven counties and a second in PHC's Southern seven counties. Both groups meet quarterly. The CAC is a liaison group between members and PHC, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC provides important feedback pertinent to quality improvement issues directly to the Commission and a consumer serves on the Q/UAC to provide consumer input to the quality program and reports to the CAC.

Internal Quality Improvement Committee (IQIC)
An internal PHC committee comprised of appropriate PHC department directors and staff, the IQIC tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQIC meets ten times per year and reviews policies, procedures and QI activities. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQIC serves to integrate quality activities organization-wide. Activities and progress are reported to the Q/UAC and PAC.

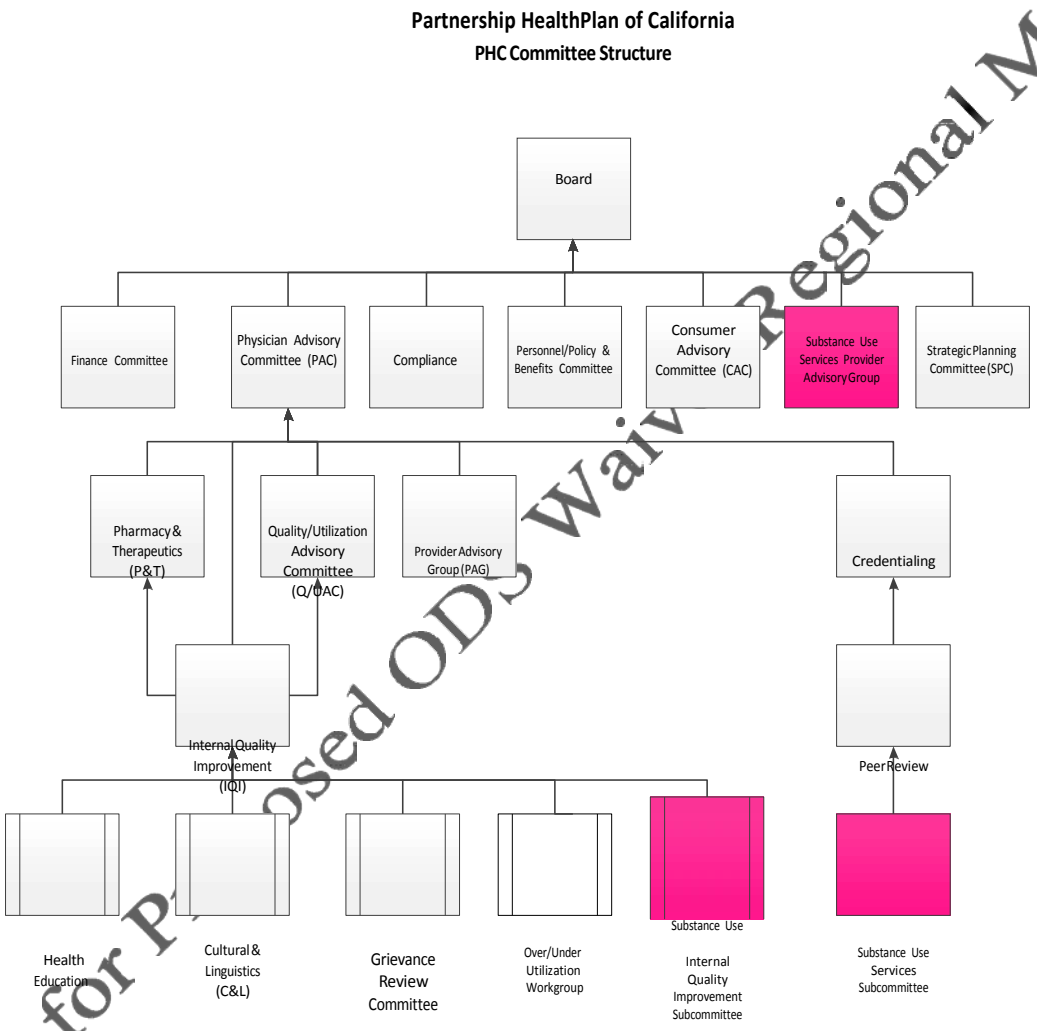
Substance Use Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use oversight. Activities and progress are reported 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 Medical Director of PHC Substance Use Services, the SU clinical director, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Departments.

Over/Under Utilization Committee

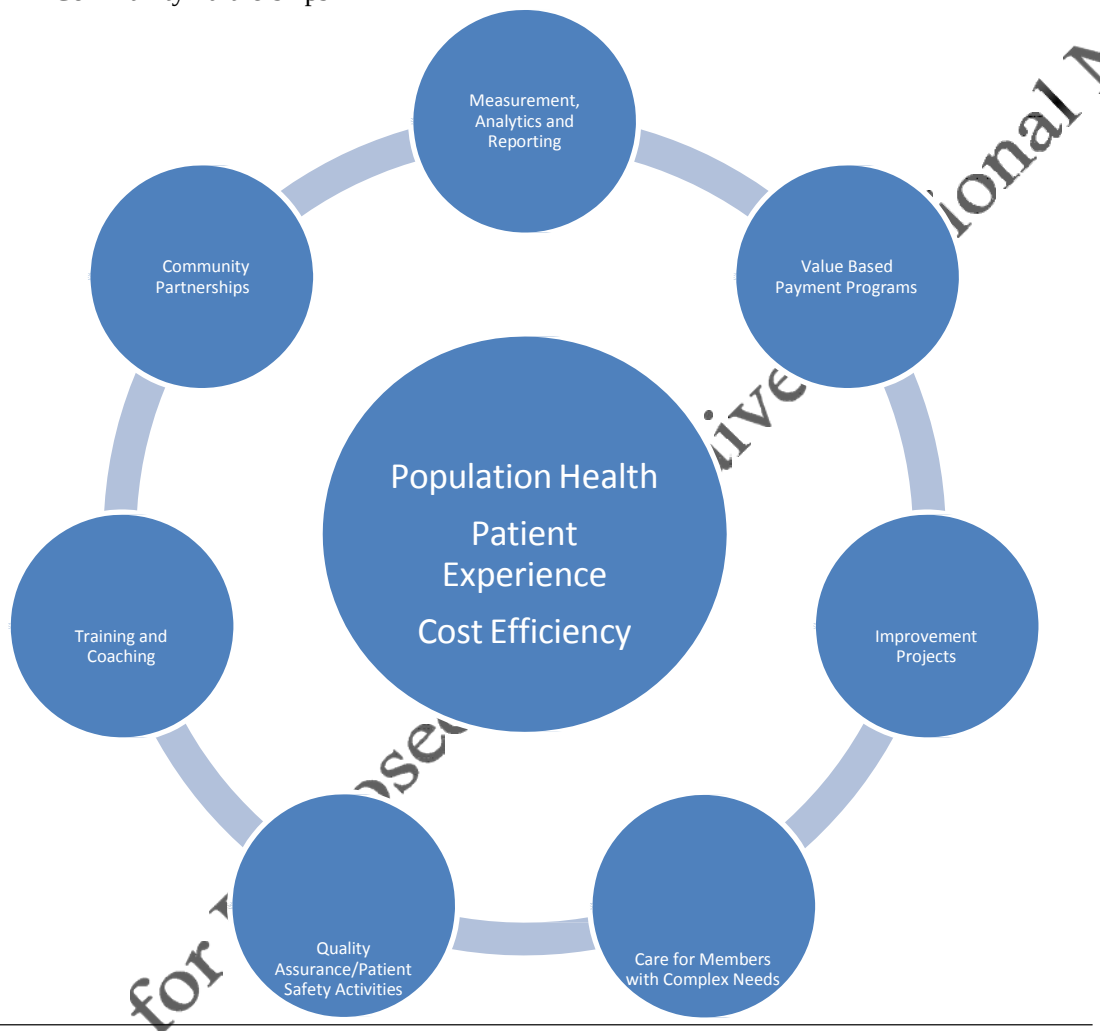
The Over/Under Utilization Committee is an internal PHC committee that evaluates services that may be over-utilized or under-utilized compared to optimal utilization. Its goals are to use the results of the analysis to drive quality improvement activities, accuracy of data collection and analysis, and the most cost-effective use of resources. The committee is chaired by PHC's CMO and supported by the Health Analytics department. Representatives from Health Services, Compliance, Member Services, Provider Relations and Claims also attend. A summary of activity from the committee is annually reported to IQI, QUAC and PHC's Compliance Committee.



APPROACH TO QUALITY AND PERFORMANCE IMPROVEMENT

PHC's QI/PI program focuses on simultaneous pursuit of the triple aim – population health, patient experience and cost efficiency – via seven primary levers:

- Measurement, Analytics and Reporting
- Value Based Payment Programs
- Improvement Projects
- Care for Members with Complex Needs
- Quality Assurance and Patient Safety Activities
- Training and Coaching
- Community Partnerships



Measurement, Analytics and Reporting

The QI/PI Department collects data annually on clinical indicators for Medi-Cal through the Health Effectiveness Data Information Set (HEDIS) initiative. Every three years, PHC analyzes data on CAHPS measures for both children and adults. Internally administered member experience surveys are conducted and analyzed annually. Summary results from access studies, grievances, Initial Health Assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and activities from the Partnership Improvement Academy are presented to the Internal Quality Improvement Committee (IQIC) and physician committees at least annually. Project measures are reviewed more regularly during improvement team meetings. We complete a robust, comprehensive evaluation annually for our major programs and quality improvement projects and initiatives.

At the organization level, the Executive Team and Board of Directors review a comprehensive dashboard including metrics across the organization at least quarterly. There are also four organization-wide goals set annually, of which there is always a quality-related goal.

Externally, feedback on performance is shared through data reports and data presentations given at Medical Director meetings, during academic detailing visits, provider site visits, webinars and community meetings.

Through PHC's value based programs, providers receive reports showing their performance against the PHC network average (and/or across a peer group) at least annually. The Primary Care Provider value based program (PCP QIP) provides reports on non-clinical measures bi-monthly and real time access to clinical measure data through an online tool called eReports that is updated weekly. The reports identify those members with gaps in preventive and chronic disease care.

In 2016 PHC began developing the Partnership Quality Dashboard. The tool will provide more data at the primary care practice level beyond the value based program measures. CAHPS site level data, IHA rates, HEDIS, and several utilization measures will be incorporated into a more comprehensive online data report. Further, comparative reporting (practice level comparisons to national and local benchmarks), drill down analysis, and ability to trend data over time will be built into the system. The Partnership Quality Dashboard will be released in 2018.

Drug Medi-Cal-focused Performance Improvement Projects will be managed by Partnership HealthPlan and administered centrally. The SUIQI will review data at least annually from eligibility, claims, encounter and provider data to analyze adherence to protocols and identification of those in need of services; timely access measures; initial and engagement of clients into treatment; fidelity to ASAM requirements; and outcome and recovery data.

In addition, review of the Drug Medi-Cal program will be incorporated into the ongoing PHC measurement and reporting programs including analysis of member satisfaction (CAHPS) measures for both children and adults; summary results from access studies, grievances, initial health assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and training activities. These are presented to the Substance Use Internal Quality Improvement Committee on an ongoing basis and reported up to the SUPAG, IQI, QUAC, and PAC at least annually.

Substance use services performance reports are also shared at various meetings, trainings, and webinars and community meetings.

MAJOR DATA COLLECTED TO SUPPORT QI EFFORTS FOR SUBSTANCE USE SERVICES

Calls from Members *(either to the Central Access Line or directly to Partnership HealthPlan)*

- Number of calls over the period
- Nature of the calls
- Abandoned call rate
- Average time to answer

Utilization Management *(for services requiring prior approval: residential placement; also methadone?)*

- #/percentage of placement requests denied
- Time to reach placement decision

Access

- Time for first appointment for ASAM-verified necessary services, by type of service by County

Adequacy of Facilities
- Percentage of contracted facilities (not programs) that are certified by DHCS
- Results of required Facility Site, Medical Record, and Physical Accessibility Reviews

Cultural and Linguistic Adequacy
- Language and ethnicity of members who use SUD services
- Language capabilities of contracted SUD facilities/sites.

Effectiveness of Care
- Periodic review of electronic and other health records for consistency with treatment plans; adequacy and timeliness of treatment plans
- Periodic review of electronic and other health records for adequacy of documentation

Satisfaction Surveys
- Member satisfaction (annually)
- Provider satisfaction (annually)

Value Based Payment Programs

Primary Care Provider Quality Improvement Program (PCP QIP)

This program provides financial incentives, data reports and technical assistance to primary care providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The Provider Advisory Committee (PAC) oversees the PCP QIP. A group of providers and administrators (QIP Advisory Group) across counties and practice types recommend measures for the PCP QIP each year. Following this group's recommendations, the draft measures are released to the PHC provider network during a "public comment period." Feedback from the public comment period is shared with the QIP Advisory Group at which time measure recommendations are forwarded to the PAC for review and approval. The measures and detailed specifications can be found on our website.

Hospital QIP (HQIP)

The Hospital Quality Improvement Program, established in 2012, is a pay-for-performance program for select PHC hospitals. Participants report on measures the following measurement domains: Readmissions, Palliative Care, Clinical Quality, Patient Safety, and Quality Improvement. Like the PCP QIP, the program is collaboratively designed with our hospital partners and formally overseen by the PAC. The measures and detailed specifications can be found on our website.

Pharmacy QIP

The Pharmacy QIP, established in 2013, is design to support and improve the access to and quality of community pharmacy services provided to our members. The Pharmacy QIP program was developed with measures that are simple, stable, meaningful and collaborative with participants. Only community pharmacies are eligible to participate in the Pharmacy QIP. The domains address clinical, patient experience, cost efficiency, and access measurement areas. Measures are: Comprehensive Medication Review for Customers, Chronic Pain Medication Oversight, Free Blood Pressure (BP) checks, Medication delivery, Generic fill rate, after hours**,** and Safe Medication Disposal.

Specialist QIP

The Specialist Quality Improvement Program was developed in 2014 to reward in-network specialists for actively accepting referrals and seeing PHC Medi-Cal members. In order to participate, a specialist must be contracted with PHC and be located within the PHC service region. Specialists who work primarily in an inpatient setting are excluded. The funding for the Specialist QIP is equal to 10% of the Plan's expenditures on specialty care during the measurement period. The funds are distributed to participating providers based on the number of unique members seen during the measurement year. In order to receive payment, the specialist must see a minimum of 24 unique members. Payments are issued annually in November for the prior fiscal year ending in June. The calculation for payment is: (Total Fund Amount / Total number of members seen by all qualified specialists) * number of members seen by individual physician.

Long Term Care QIP (LTC QIP)

The Long Term Care QIP launched in 2016. PHC designed the program to support and improve the access to and quality of long-term care provided by our contracted facilities. The program, overseen by the PAC, offers financial incentives for quality that are separate and distinct from the usual reimbursement for services. The measurement domains are Clinical, Functional Status, Resource Use, and Operations/Satisfaction. To participate, facilities must contract with PHC and sign a Letter of Agreement.

Improvement Projects

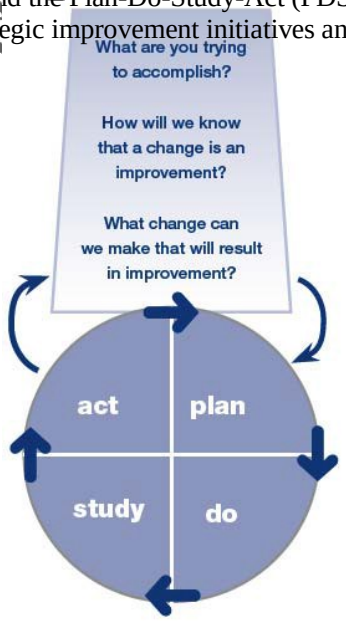
The first step is to define areas for focused improvement efforts. The drivers that help define areas include projects required by regulators (DHCS), areas where performance is lower than expected, the state or 1115 waiver priorities, and stakeholder feedback. Data sources used to determine focus areas include HEDIS, Consumer Assessment of Health Providers and Systems (CAHPS) survey, facility site and medical record review results, Initial Health Assessment rates, utilization data in areas shown to exhibit strong practice variation (i.e., pain medications), and county level/public health data. To ensure that rates are calculated in accordance with specifications, PHC participates in compliance audits with the state-contracted External Quality Review Organization (EQRO).

PHC analyzes data to identify priorities for improvement. Criteria for selection include:

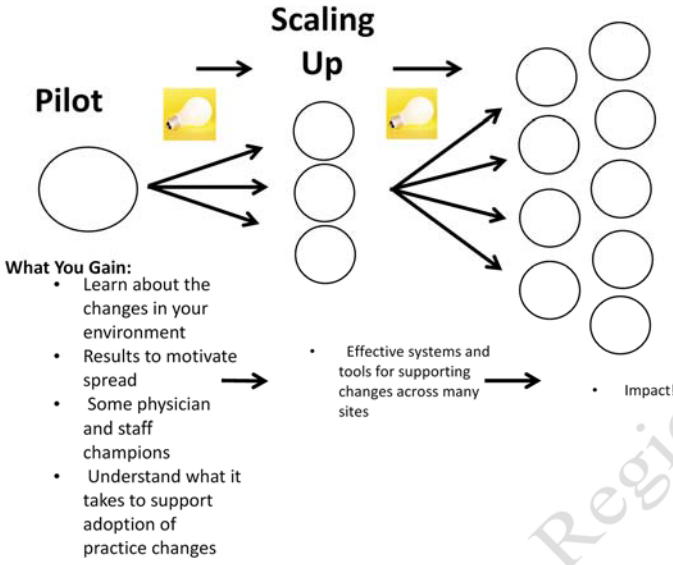
- Clinical or service areas where provider variation in practice is greatest
- Meaningful clinical or service areas to both providers and members
- Measures that align with other measures being evaluated in our regions (i.e. UDS, Meaningful Use, etc.)
- Evidence suggests interventions can improve outcomes
- Overuse or misuse results in high cost to the plan
- Measures that impact large populations of members
- Measures or areas that are mandated by regulatory agencies
- Measures not meeting or exceeding regulator and committee designated Minimum Performance Levels (MPL)

Using the criteria above, the QI/PI Department, members of the IQIC, and the Chief Medical Officer propose focus areas and projects. Once projects are approved, an improvement team is formed, usually across departments, and includes a project manager and individuals who are involved in the improvement effort. For 2017-18, improvement efforts include but are not limited to: Primary, Specialty and Mental Health Access, Managing Pain Safely (appropriate and safe prescribing of opioid medications), addressing Social Determinants of Health, Offering and Honoring Choices (advance care planning and palliative care), Blood Pressure Control, Diabetic Retinopathy Screening, Annual Monitoring for Patients on Persistent Medications, Timeliness of Prenatal and Post-Partum Care, Childhood Immunizations and Immunizations for Adolescents

PHC uses the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle, LEAN methods, and robust project management infrastructure to guide strategic improvement initiatives and targeted improvement projects.



Small tests of change (PDSA) are used with pilot populations (i.e. testing with a few patients or providers) to test changes to see what works and how changes need to be adapted to make improvements on a larger scale. Changes are then spread to more sites and patients as more is known about the change and the resources and infrastructure needed to support the change on a larger scale. Figure 2 outlines this approach.



Examples of 2017-2018 Improvement Projects

Improving Primary Care Access
PHC has a number of projects aimed at improving primary care access. One of the largest projects is the Provider Recruitment Program (PRP), which includes advertising and recruitment assistance to primary care clinics, incentives for provider candidates to enhance packages that clinics offer, and assistance developing training programs to rotate students through the communities PHC ser es.

Managing Pain Safely
The goal of Managing Pain Safely (MPS) is to optimize different uses of medication and other modalities, so that pain is treated appropriately depending on the needs of the patient, informed by current medical science. The problem of over-use of opioids can be addressed at three levels:

1. Opioids should only be initiated when indicated, and only for the time period that is appropriate. Non-opioid medications should be given priority preceding to the use of opioids for mild to moderate pain.
2. Opioid medications should only be escalated if medically appropriate.
3. Patients on harmful, high doses should have their opioid dose tapered.

Diabetic Retinopathy
To improve retinopathy screening rates and decrease rates of diabetes-associated vision loss among diabetic members, PHC allocated funding to purchase digital retinopathy screening equipment from EyePACS, LLC, for distribution to six primary care clinics. The use of digital retinopathy screening technology in primary care clinics is an evidence-based intervention that increases access and utilization of preventative retinopathy screening services, and increases the likelihood of early detection and treatment of sight-threatening eye disease.

Offering and Honoring Choices (Advance Care Planning and Palliative Care)
The Offering and Honoring Choices™ initiative seeks to ensure that PHC members and their families are knowledgeable about health care treatment options, empowered to define their treatment goals, and able to make informed choices about the interventions they choose during the last years of life. The three main areas under Offering and Honoring Choices™ are: 1) Advance Care Planning, 2) Palliative Care, and 3) Policy and Public Education and Engagement.

Social Determinants of Health (SDH)

The SDH project at Partnership works in collaboration with key partners throughout the health system and within the community to target social determinants of health. Examples of social determinants of health include: employment, housing, food security, literacy, access to transportation, and education level. Our aim is to increase the opportunity for PHC members to be born, live, grow-up, work, and age in a healthy environment by increasing the number of health centers in our network who are actively working to address social determinants of health.

HEDIS Improvement Projects
PHC has a number of projects underway to improve performance on our annual HEDIS project. Measures of focus for 2017-2018 include Annual Monitoring for Patients on Persistent Medications, Childhood and Adolescent Immunization, Diabetic Nephropathy Screening, Breast Cancer Screening and Asthma Medication Ratio.

A complete list of 2017-2018 improvement projects is available in PHC's 17-18 QI Program Work Plan.

Care for Members with Complex Needs
PHC provides telephonic intervention and care coordination for those members with complex or multiple chronic conditions who have modifiable risk factors. The following is a summary; please see the Care Coordination Program Description for additional details. Care Managers and Health Care Guides work closely with members to educate them regarding their health condition and assist them in modifying habits or lifestyles that put them at risk for exacerbation of their condition. Cases are identified by diagnosis using high-risk screening criteria. The nurse coordinating care uses a team approach; involved care team members may include the attending physician, specialist provider, home health agencies, discharge planners, physical therapists, social workers, and other providers as appropriate. PHC will apply specific tailored interventions to PHC's population.

In addition to telephonic care coordination for members with complex needs, PHC offers complex case management via the health plan's Intensive Outpatient Care Management Program (IOPCM). In this model, an Intensive Care Case Manager (ICCM) may be assigned to individual physician practice sites to assist with care management for their high risk members, or the member's assigned Primary Care Clinic may provide intensive outpatient care services, which are sponsored by PHC. This varies from other programs offered by PHC because this is a face-to-face model. The member is met in the physician's office, in their home, or at a mutually agreed upon site and the ICCM also follows that member face-to-face in any setting the member encounters. An Individualized Care Plan addressing both clinical and non-clinical components is developed in collaboration with the member, primary care physician and other caregivers.

Other activities related to Care for Members with Complex Needs include:

- Disease Management Programs for members with Asthma and Diabetes are in development.
- Offering and Honoring Choices program (described above) – program to promote Advance Care Planning and Palliative Care.
- Social Determinants of Health program (described above) – program to address the social determinants of health that influence member health outcomes.

Quality Assurance and Patient Safety Activities
Quality Assurance and Patient Safety activities include identifying and responding to Potential Quality Issues (PQIs), pharmacy patient safety initiatives, facility site and medical record reviews, monitoring initial health assessment (IHA) rates.

<u>Potential Quality Issues</u>
The Performance Improvement Clinical Specialists (PICS nurse) under direction of the Chief Medical Officer (CMO) and Associate Medical Director of Quality oversee the Peer Review Process, which provides a systematic method for identification, reporting, and processing potential quality issues (PQIs). A PQI is defined as a suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care problems. A quality issue is defined as a confirmed deviation from expected provider performance, clinical care, or outcome of care, which has been determined to be inconsistent with professionally recognized standards of care.
PQIs involving substance use services are tracked and processed by the patient safety team in the Quality Department, and reviewed with the PHC Medical Director of Substance Use Services for evaluation and

recommendation to the SUS of Peer Review. Potential quality issues related to mental health and substance use services that are identified by our delegated providers (Beacon and Kaiser), are investigated and followed up by those providers. These issues are tracked by the delegates and monitored by PHC's Mental Health Clinical Director and the Medical Director for Substance Use Services, through the delegation agreement with each organization.

PHC identifies PQIs through:

- information gathered through concurrent, prospective, and retrospective utilization review
- referrals by health plan staff or providers
- facility site reviews
- focused studies
- pharmacy utilization data
- member/provider satisfaction surveys
- claims/encounter data
- medical records audits, including HEDIS medical record reviews
- phone log detail
- member appeals/grievances
- member calls through the Member Services Department
- ancillary providers/vendors/delegates such as Beacon, VSP, etc.
- provider sentinel or "never" events such as adverse events that are serious and possibly preventable via review of Provider Preventable Condition Reporting as required by the State.

The PICS nurse reviews the case in accordance with Policy MPQP1016. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern is given an opportunity to respond. Peer Reviewers are engaged and in some cases, the Peer Review Committee. Cases with significant concerns are communicated to the Credentialing Committee at the recommendation of the Peer Review Committee. Annual reports are presented to IQIC and Q/UAC showing trends related to referral patterns and quality of care concerns.

Pharmacy Department Patient Safety Initiatives

PHC has a number of activities in place to ensure medication safety and adherence for our members. These activities include:

- *Managing Pain Safely*. Pharmacy utilization management to promote the safe use of opioids. Development of the MPS Pharmacy and Naloxone tool kit to increase knowledge, share best practices and support community pharmacies' effort in preventing opioid misuse.
- *Medication Adherence Program* (diabetes, high blood pressure, dyslipidemia). Identify high-risk members with suboptimal medication adherence and provide interventions that include but are not limited to patient education, therapeutic recommendation to prescriber, and support to dispensing pharmacy.
- *Hepatitis C Treatment Monitoring*. Tracking and monitoring Hep C medication adherence to help ensure optimal compliance with therapy. Collaborate externally with Walgreens Specialty Pharmacy and internally with PHC internal resources to find resolutions when potential access or gap in care issues are identified.
- *IOPCM*. Provide patients enrolled in the IOPCM program with a comprehensive medication review (CMR) and consult with the PCP with therapeutic recommendations based on the medication review with the patient. Functions include thorough analysis of medical chart notes and medication history, in person interaction with the member and PCP, documentation of CMR and therapeutic recommendations provided to PCP, monitor patient pharmacotherapy and consult with Care Coordination if additional intervention is required.
- *Beacon Grand Rounds*. Provide analysis and recommendation on pharmacotherapy to help ensure optimal therapeutic outcome for members accessing behavioral health services.
- *Smoking Cessation*. Smoking cessation program targets high-risk tobacco users based on patient's underlying chronic condition and suboptimal use of tobacco cessation therapies. Functions include provider outreach, educating members on medication adherence to tobacco cessation products, and assist with enrollment in the CA Smokers Helpline program.

- *Latent Tuberculosis Therapy (LTBI) Monitoring*. LTBI monitoring to ensure patients receive appropriate therapy and interact with providers and public health officer to ensure completion of therapy and identify patients that may have fallen out of therapy.

Facility Site and Medical Record Reviews

PHC also conducts facility site and medical record reviews that include a review of the physical site, medical records, and a review that evaluates accessibility for Seniors and Persons with Disabilities (SPDs) – Part C review. Facility Site and Medical Record Reviews are conducted for Primary Care Providers, OB/GYN providers, Palliative Care Providers, Urgent Care providers and Substance Use Services Providers. The internal and external quality improvement committees review the results from the sites reviews, initial health assessments, and Part C reviews least annually. Results from these assessments are reported to the Credentialing Committee.

Initial Health Assessments (IHAs)

It is a requirement of the California Department of Health Care Services that all newly enrolled health plan members receive an initial health assessment (IHA) with a primary care physician within 120 calendar days of enrollment to the health plan. PHC monitors these rates quarterly and works with low performing providers to increase compliance.

In addition to the above, PHC collaborates with network practitioners and providers to improve patient safety by:

- Identifying areas where training is needed
- Identifying and sharing best practices
- Seeking input from network practitioners about systems PHC can put in place to improve patient safety (i.e. pharmacy data on-line)
- Providing technical assistance, resource materials, and training in areas where indicated
- Collaborating with network practitioners, including behavioral health specialists, to improve processes in the area of communication and coordination of care

Training and Coaching

The Partnership Improvement Academy provides a space for clinicians, administrators and staff to gain quality improvement expertise from industry leaders and peers. Each of the Academy's initiatives prepares provider sites to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

ADVANCE, a 12-month Improvement Advisor training program that prepares participants to lead and sustain health care quality improvement initiatives. Learning objectives for the course are:

- Learn from quality improvement leaders
- Apply learning in real time to a practice-selected quality improvement project
- Receive 1:1 coaching from Partnership HealthPlan QI staff
- Gain quality improvement and change management knowledge, tools, and skills
- Establish infrastructure and affect practice culture to advance future improvement endeavors

Quality improvement experts guide participants in practical, participatory learning sessions. The topics covered are grounded in the Model for Improvement framework and include basics of improvement, PDSAs in action, understanding variation, relating data to improvement, change management, spread and sustainability.

ABCs of QI is a one-day in-person training designed to teach healthcare organizations the basic principles of quality improvement, including, how to create an Aim (goal) statement, how to use data to drive their work, and how to identify change ideas and test them on a small scale.

Substance Use Services Support and Training

The PHC Drug Medi-Cal Regional Model training program will provide a space for clinicians, administrators and staff to gain quality improvement expertise from industry leaders and peers. Sites will be supported in a manner to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. Trainings provided on a regular basis include ASAM criteria and application; documentation; and key evidence-based practices.

PHC provides a range of support and services to contracted Regional Model Drug Medi-Cal Providers. These include:

- Training and technical assistance to help providers improve services and clinical documentation and regulatory compliance.
- Conduct of regularly scheduled chart compliance reviews, offering guidance and written feedback focused on quality improvement of services.
- Provision of resources such as sample forms, audit instruments and other tools that would help providers develop effective systems of quality records management.
- Assistance in the submission of Drug Medi-Cal certification applications to the State. This includes on site consultations, trainings and referral to outside trainings; peer support and others.
- Responding to technical questions related to regulations or practices
- Communication with providers and other agencies in order to better understand and interpret program regulations and to address treatment needs
- Responding to complaints and/or grievances from consumers or other concerned individuals in the areas of access, quality, billing, critical incidents or client rights.

Community Partnerships

In general, the quality improvement efforts that have the biggest impacts on the health of our members usually involve significant community collaboration and coalitions with community partners. This is also true at Partnership HealthPlan. Our community partners include county health departments (including the public health officers), the five consortia that serve the Community Health Centers in our community, law enforcement, and various community not-for-profit organizations. Most fundamentally, our network of providers not only provide health care services to our members, most are also partners in larger community-level interventions. This includes primary care physicians, Community Health Centers, Rural Health Centers, Indian Health Service Health Centers, Hospitals, Long-term Care facilities, specialist physicians, hospice agencies and community pharmacies, to name a few.

Partnership's participation in community partnerships can be in one of five roles: Leader, Convener, Participant, Funder and Advocate.

Some current major initiatives involving community partnerships include:

1. Managing Pain Safely
2. Offering and Honoring Choices
3. Mental Health Integration
4. Improving Specialty Access
5. Supporting breastfeeding
6. Testing interventions for addressing Social Determinants of Health
7. Developing a regional approach to treating substance use disorder

Member Input

Member input is obtained from member experience surveys, member focus groups, member complaint/grievance data, Consumer Advisory Committee feedback, PCP/Specialist access and availability data, Member Services telephone access reports, member suggestions, and member requests for PCP transfers. Consumers are also represented on the Q/UAC. Various workgroups meet to review the data collected at least quarterly and the workgroups recommend areas for improvement and action plans. These are presented and monitored by the Internal Quality Improvement Committee (IQI). Performance in HEDIS measures and progress made in other QI activities is shared with our members through the Q/UAC, CAC and through the member newsletter.

Clients of Substance Use Services may also attend and give feedback at the SUPAG.

Physician Input

Through PHC's committee structure, clinicians provide input on the quality improvement program including focus areas, strategies to improve care and service, and effective ways for measuring performance in projects. In addition, clinician input is provided on various projects such as the pay-for-performance programs for primary care, specialty care, and hospitals. PHC holds "provider comment periods" where physicians and their staff can provide input on priorities for these programs. Across all of our work, PHC solicits input on priorities and interventions through Committee meetings and other meetings with provider practices and clinic consortiums.

CULTURAL COMPETENCY

PHC is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. The Cultural and Linguistic Program regularly assesses and documents member cultural and linguistic needs to determine whether all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

PHC's Health Services, Provider Relations and Members Services Departments are responsible for the operations of the Cultural and Linguistic Services Program. Additionally, the Consumer Advisory Committee provides advice on the development and implementation of cultural and linguistic accessibility standards and procedures.

PHC's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. PHC has systems and processes to:

- Assess, identify, and track linguistic capability of interpreters, bilingual employees and contracted staff in medical and non-medical settings.
- Conduct a Health Education and Cultural and Linguistic Group Needs Assessment (GNA) every 5 years to: identify member health education and cultural and linguistic needs and continuously develop and improve contractually required health education, cultural and linguistic services, and educational materials.
- Provide cultural competence, sensitivity, or diversity training for staff, providers or subcontractors.

PHC monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to:

- Member satisfaction surveys
- Member complaints and grievances
- Reports of utilization of interpreter services by language
- Provider satisfaction surveys
- Provider assessments and site reviews
- Disparities in HEDIS data

In addition to the Cultural and Linguistic Program Description, PHC maintains a Health Education and Cultural and Linguistic Work Plan documenting the activities, evaluation and status of service areas and goals. Service areas and goals include:

- Identify Health Equity/Disparities
- Consumer Advisory Committee
- Analyze Member Grievances
- Standards of Care
- Assess & Track Language Capability of Providers & Staff
- Monitor Provider Compliance with Language Assistance Requirements
- Inform Limited English Members of Free Language Assistance Services
- Health Education and Quality Improvement activities

More details about PHC's Cultural and Linguistic Program can be found in the Cultural & Linguistic Program Description, MPLD7001 and the Cultural & Linguistic Work Plan.

COMMUNICATION SYSTEMS

PHC communicates its QI/PI program activities internally and externally through the following mechanisms:

- Solicit input regularly from our members through the Consumer Advisory Committee to assist in program design and evaluation.
- Solicit input regularly from providers by leveraging committees, consortia meetings, the Provider Advisory Group, regional medical director/quality meetings, and offering "provider comment periods" to share feedback on the QIP measures.
- Bi-weekly QI/PI Department meetings to provide project updates and identify critical issues and a plan of action that involve two or more team members.

- PHC Website: maintain current information on the website related to all QI project and programs. Content is reviewed and updated at least quarterly.
- Provider Relations: meet at least twice annually with PR and member services to provide information on key QI/PI projects and identify strategies for getting information out to the network and members where appropriate (member newsletters and provider newsletters). Northern region meeting monthly with PR department.
- Webinars/teleconferences/Onsite meetings: provide overviews of the QIP and key QI/PI projects at least annually.
- QI/PI Department monthly newsletter that describes all activities and training resources related to improving quality of care.
- Conferences, trainings and webinars to share best practices across regions.
- Share information regarding improvement activities within the Health Services Department through monthly HS Leadership Committee meetings.

DELEGATION

Activities that are delegated to contracted providers are reviewed and approved at least annually by the Delegation, IQIC and Q/UAC committees. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and PHC.

- Reporting quality improvement activities and analyses to PHC on a quarterly or annual basis is done for delegated QI activities. Reports are summarized for review and evaluation by the Delegation, IQIC and Q/UAC.
- Evaluation includes a review of both the processes applied in carrying out delegated activities, and the outcome achieved toward quality improvement in accordance with the respective policy (ies) and agreement governing the delegated responsibility.
- The Delegation, IQIC and Q/UAC review evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.
- PHC QI/PI staff communicates feedback from the Delegation, IQIC and Q/UAC to contract providers, and incorporates improvement activities initiated in the annual QI/PI work plan.

REVIEW BY OUTSIDE LICENSING AGENCIES OR ACCREDITING BODIES

Medi-Cal is a federal/state-funded program and CMS has delegated administration of the state program to the California DHCS. CMS permission is required in order for the state to delegate program administration to PHC. The state must document the cost effectiveness of the program, and provide assurance that program beneficiaries are not negatively impacted by this delegation. PHC operations, including the QI/PI program, are audited annually by DHCS. PHC submits periodic compliance reports to DMHC and undergoes periodic compliance audits. Opportunities for improvement identified through all compliance or regulatory audits are addressed by multidisciplinary teams and corrective action plan development and implementation are reported to the IQIC and Q/UAC. PHC maintains a compliance plan that includes monitoring and reporting of fraud, waste, and abuse. The PHC Compliance Committee consists of representatives of each department including QI/PI.

SANCTIONS

Should any sanctions be imposed on PHC, or if PHC fails to meet minimum performance levels established by regulatory agencies or purchasers, a quality review team is initiated to develop and implement a corrective action plan. This team at a minimum includes the PHC CEO, CMO, Compliance Officer, Director of Quality & Performance Improvement, Health Services Senior Director, and Pharmacy Director. Action plans and progress reports are shared with the Q/UAC.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the QI/PI program is evaluated in writing annually by the IQIC and Q/UAC and is approved by the Q/UAC, PAC, and the Commission. The evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care

and quality of service.

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices.

The following are not included in the QI evaluation but rather as separate evaluations:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of UM and Care Coordination Activities
- A comprehensive evaluation of member complaints and grievances

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. When the evaluation is complete, an announcement indicating the availability of QI information is published in the member and provider newsletters.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of QI/PI Program activities through enforcement of the following:

- All members of the Q/UAC, PAC, and Credentialing Committee are required to sign a confidentiality statement that is maintained in the QI files.
- All QI/PI and UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, PRC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Peer Review and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, PQI and QI files, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential peer review documents that are protected by California Evidence Code §1157 are designated "Confidential – Protected by CA Evidence Code 1157."
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only.
- Confidential documents are destroyed by shredding.
- PHC has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- PHC maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC and Credentialing Committee are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

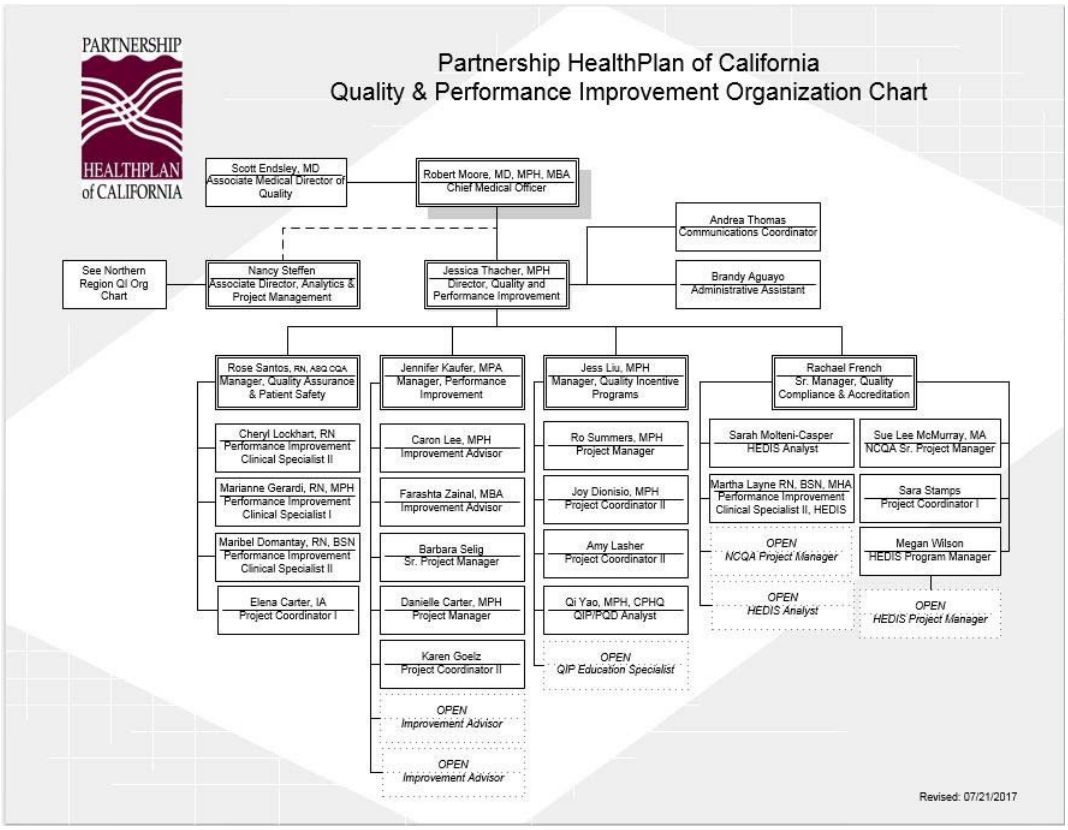
PROGRAM APPROVAL

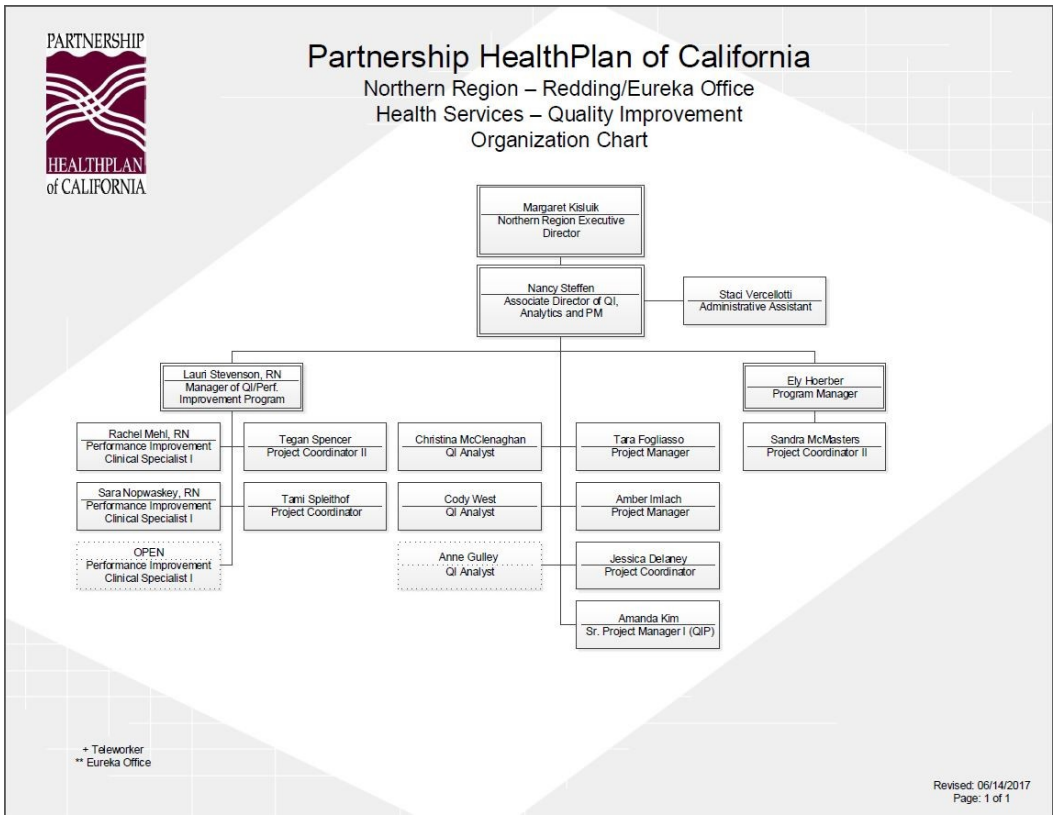
Robert Moore, M.D.	**3/15/17**
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Jeff Gaborko, M.D.	**4/12/17**
Physician Advisory Committee Chairperson	*Date Approved*

Mich Riccioni	**4/26/17**
Board of Commissioners Chairperson	*Date Approved*

Attachment A: PHC QI/PI Department Organizational Charts





Attachment B: Standing Staff Members of PHC QI Committees – PAC, Q/UAC and IQI
(Does not include external physician or consumer membership)

PAC PHC Standing Members
Chief Executive Officer
Chief Medical Officer
Chief Financial Officer
Northern Region Executive Director
Senior Director, Health Services
Senior Director, Provider Relations
Director, Quality & Performance Improvement
Director of Utilization Mgmt
Director, Pharmacy Services
Director, Member Services
Regional Medical Directors
Associate Medical Director of Quality

QUAC PHC Standing Members
Chief Medical Officer
Regional Medical Directors
Associate Medical Director of Quality
Northern Region Executive Director
Sr. Director, Health Services
Sr. Director, Provider Relations
Director, Quality & Performance Improvement
Director, Pharmacy Services
Director of Utilization Mgmt
Director, Care Coordination
Director, Northern Region Health Services
Director, Northern Region MS & PR
Director of Government and Public Affairs
HS Mental Health Director
Regional Director, Southwest
Associate Director, Care Coordination
Associate Director, Provider Relations
Associate Director, Northern Region Quality
Sr. Manager, Provider Relations
Manager of Quality Improvement Programs
Manager of Quality Assurance/Patient Safety
Manager of Health Analytics
Grievance System Manager
Regional Manager, Northwest
Senior Health Educator
Credentialing Supervisor, Provider Relations
QI Project Coordinator

IQI PHC Standing Members
Chief Executive Officer
Chief Operating Officer
Chief Medical Officer
Regional Medical Directors
Associate Medical Director of Quality
Sr. Director, Health Services
Sr. Director, Provider Relations
Sr. Director, Claims
Sr. Director, Policy/Program Development
Director, Quality & Performance Improvement
Director, Pharmacy Services
Director of Utilization Mgmt
Director, Northern Region Health Services
Director, Northern Region MS & PR
Director of Operations Excellence & PMO
Regional Director, Southwest
Associate Director, Care Coordination
Associate Director, Pharmacy Operations
Associate Director, Northern Region Quality
Sr Manager of Provider Education
Manager of Quality Improvement Programs
Manager of Quality Assurance/Patient Safety
Manager of Northern Region QI Performance Improvement
Quality Manager, Health Services
Grievance System Manager
Regional Manager, Northwest
Team Manager, Utilization Management
Senior Health Educator
QI Project Coordinator

Other PHC staff members attend the quality committee meetings on an ad hoc basis.

Compliance Plan

Calendar Year 2017

Table of Contents

SUMMARY

Partnership HealthPlan of California (PHC) is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules pertaining to PHC Medi-Cal line of business.

As part of that commitment, PHC has appointed a Compliance Officer and formalized its compliance activities by developing a compliance program that incorporates the elements of an effective compliance program as identified by the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), and the California Department of Health Care Services (DHCS) requirements based on contractual obligations, statutes, and regulations. PHC also has a designated Chief Information Officer (CIO), whose role is to actively assess and manage security risks. The CIO provides regular updates to the PHC Board of Commission (Commission) and Executive Staff. Additionally, PHC's Privacy Officer actively participates in completing the risk analysis, and oversees the audits and Fraud, Waste, and Abuse (FWA) reporting. This comprehensive approach is intended to prevent and detect any violations of ethical standards, contractual obligations, and applicable laws within PHC's operations, senior leadership or Commission. The Compliance Program is a continually evolving process that is modified annually, based on the completed risk analysis, ongoing compliance monitoring, and newly identified areas of risk. The Compliance Program applies to Commission, employees, and providers.

PHC prioritizes its commitments by completing an annual risk analysis. The Compliance Plan reflects the application of this risk analysis by focusing PHC's limited resources in a manner that most effectively protects PHC from FWA, and other risks to PHC, its employees, and members.

This plan is reviewed and approved annually by PHC's Board of Commission.

THE COMPLIANCE PLAN

This Compliance Plan sets forth PHC's commitment to legal and ethical conduct by establishing principles, standards, and policies and procedures in order to efficiently monitor PHC's compliance with applicable laws and regulations. The Compliance Plan is designed to ensure that PHC's operations and the practices of its employees, commissioners, and providers comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is reviewed and adopted by the PHC Commission. The first part of the Compliance Plan addresses the review and implementation of contractual, legal, and regulatory obligations for PHC's operations. PHC maintains policies and procedures relating to its business operations and compliance efforts. The balance of the Compliance Plan addresses the other elements of an effective Compliance Program including the structure and operational aspects of the program, such as delegation of authority, training and education processes, monitoring and auditing activities, enforcement/discipline, and corrective action.

If a PHC employee or provider has any question about the application of this Compliance Plan**,** PHC values, or PHC policies and procedures, he or she can seek guidance from the Compliance Officer, or another member of the Compliance Committee. Employees, providers and commissioners should be generally familiar with the contractual, legal, and regulatory requirements pertinent to their job duties. All PHC employees receive annual evaluations which include measurements of job-specific knowledge and knowledge of departmental and company policies and procedures.

This Compliance Plan does not address all of PHC's activities and the applicable legal issues they may entail. Employees, providers, and commissioners should seek the guidance of their supervisor, the Compliance Officer, or PHC Senior Management as applicable with respect to any other issues that may arise.

WRITTEN STANDARDS

Code of Conduct

The Code of Conduct is PHC's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to PHC, its employees and commissioners. The Code of Conduct is provided to new employees and commissioners. Employees and commissioners are required to review and submit an attestation annually that they have reviewed and understand the Code of Conduct. When standards are updated, employees and commissioners are provided with updates. Commitment to the Code of Conduct is a required condition of employment. A copy of the Code of Conduct is attached to the Compliance Plan as Attachment A.

Policies and Procedures

PHC regularly and systematically reviews and updates its policies and procedures to ensure business operations are compliant with new and existing contractual, legal, and regulatory requirements. This decentralized process is managed through PHC Senior Management and committees meeting regularly to review and approve proposed changes and additions to PHC's Policies and Procedures.

Policies and procedures are required to be reviewed annually to ensure that PHC, its commissioners, employees and providers operate under and comply with changing standards. Policies and procedures are developed to respond to changing standards and potential risk areas identified by PHC, federal and state agencies. These activities include internal reviews; external reviews of PHC's operations by regulatory agencies; and review of PHC's participating providers and sub-contracted full-service and specialized plans.

Policies and procedures are written to assure that employees have clear guidance to perform their responsibilities in compliance with their positions and applicable law. Employees are responsible for ensuring that they comply with policies and procedures relevant to their job description. Providers are responsible for complying with their contractual obligations and government regulations. Policies and procedures are accessible to employees internally through SharePoint. Relevant policies and procedures are available to PHC providers on PHC's website.

OVERSIGHT

Commission

PHC's Commission has the duty to assure that PHC implements and monitors a Compliance Program governing PHC's operations. The Commission receives and reviews reports from the Compliance Officer periodically, but no less than annually. The commission delegates the Compliance Program oversight and day-to-day activities to the Chief Executive Officer (CEO). The Director of Government and Public Affairs/Compliance Officer has been designated, by the CEO, to manage the oversight and activities of the Compliance Program. The Commission remains accountable for ensuring the effectiveness of the Compliance Program within PHC and monitoring the status of the Compliance Program to ensure efficient and successful implementation. The commissioners are responsible for:

- Understanding the content and operations of PHC's Compliance Program;
- Approve the Compliance Plan, including the Code of Conduct;
- Review and Approve semi-annual Compliance Reports, including, but not limited to, summaries of overall compliance activities, and any changes that are recommended;
- Receive annual compliance training; and
- Annually attest to the performance and effectiveness of the Compliance Program.

Compliance Officer

The Senior Director of External and Regulatory Affairs serves as the Compliance Officer and is responsible for developing and implementing compliance activities and programs, as well as, overseeing implementation of compliance policies and procedures and practices designed to ensure compliance with federal and state health care program regulations. The Senior Director of External and Regulatory Affairs reports directly to the CEO. As the Compliance Officer, the Senior Director of External and Regulatory Affairs has authority to report matters directly to the Commission at any time.

The Compliance Officer will receive periodic training in compliance procedures and has the authority to oversee and direct compliance efforts. Proper execution of compliance responsibilities and promotion of adherence to the Compliance Program are factors in the Compliance Officer's annual work evaluation.

Compliance Committee

Purpose

The Compliance Committee has general responsibility to oversee PHC's compliance and ethics programs. The purpose of the Committee is to: (i) oversee PHC's implementation of compliance programs, policies and procedures that are designed to respond to the various compliance and regulatory risks facing the company; (ii) provide an avenue of communication among management,

those persons responsible for the internal compliance function, and the Commission; and (iii) perform any other duties as directed by the Commission.

The Compliance Committee is composed of Senior Management and operational staff, as designated by the CEO. The Compliance Committee Charter is included as Attachment B. Individuals selected for the Compliance Committee are department heads or their designees and other staff as appropriate based upon their job function. A complete list of Compliance Committee members is included in the Compliance Charter, reference above. The Compliance Committee meets a minimum of four times per year. PHC maintains minutes of Compliance Committee meetings that includes the reports made and the decisions made on issues discussed (subject to the attorney/client privilege, etc.).

Delegation Oversight Review Subcommittee (DORS)

The Delegation Oversight Review Subcommittee (DORS) is a subcommittee of the Compliance Committee and is chaired by the Compliance Oversight Manager. The DORS is responsible for overseeing agreements and responsibilities between PHC and its delegated entities. The DORS ensures that delegates are compliant with all applicable laws and regulations. The DORS has overall responsibility for PHC's compliance with delegation requirements as set forth by PHC's internal policies and procedures, NCQA standards and any regulatory and contractual requirements.

The Delegation Oversight Review Subcommittee charter is included as Attachment C. DORS members include representatives from PHC's departments as outlined in the DORS charter. The DORS meets no less than four times a year. The Compliance unit sets a delegation audit calendar that is reviewed by the CEO and approved by the DORS.

The Physical, Technical, Administrative Safeguard Group (PTAS)

The PTAS is comprised of key stakeholder from multiple departments. This workgroup implements

and reviews reasonable and appropriate security measures to safeguard protected health information and implements procedures to identify and prepare for potential or actual privacy incidents. The PTAS meets quarterly and is chaired by the Regulatory Affairs Manager. All privacy and security policies are reviewed by PTAS, prior to being forwarded to the Compliance Committee.

Executive Leadership Team

The CEO and Executive Leadership Team at PHC shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the authority, and resources necessary to operate a robust and effective compliance program;
- Through the Compliance Committee, receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, formal enforcement actions, and participate in corrective actions and responses, as appropriate.

Project Management Office

The Project Management Office is responsible for ensuring that all PHC's non-provider contracts are compliant with state and federal regulations and adhere to current business associate agreement requirements.

Provider Relations Department

The Provider Relations Department is responsible for ensuring that all provider contracts are in compliance with associated state and federal regulatory requirements.

TRAINING

PHC provides general and specialized trainings and education to employees to assist them in understanding the Compliance Program, including the Compliance Plan and policies and procedures relevant to all-staff. As a part of this process, employees are apprised of applicable state and federal laws, regulations, and standards of ethical conduct. Employees are also informed of the consequences of any violation of those rules.

PHC provides training to commissioners, employees, and providers as follows:

Initial and Continuing Education and Training

New employees receive copies of PHC's Statement of Values, Compliance Primer and policies and procedures pertinent to that individual's job responsibilities upon commencement of their employment. The Human Resources Department in coordination with the Regulatory Affairs and Compliance Unit ensure that new employees are trained on the Compliance Plan during their new hire orientation.

Ongoing Compliance Training

At least annually, PHC staff will be trained on three main Compliance Program topics: The PHC Compliance Program; HIPAA/Privacy Compliance; and FWA. PHC contracts with an outside vendor to provide updated Privacy and FWA Training. The Regulatory Affairs and Compliance units coordinate with the Human Resources Department to manage the implementation of this training through PHC's Learning Management System (LMS).

Specialized Training

Employees may receive additional compliance training as is reasonable and necessary based on the scope of their job function and duties. PHC makes the Compliance Plan and Compliance policies and procedures available to all employees through PHC4Me. All employees are trained annually as outlined below. The Regulatory Affairs and Compliance units complete a minimum of ten one-hour computer based training sessions annually.

The Commission and providers may be trained as necessary on how to respond appropriately to compliance inquiries and reports of potential non-compliance.

Commissioner Compliance Training

The Clerk to the Board provides new commissioners with a copy of the Compliance Plan and Code of Conduct upon their appointment. PHC's Compliance Unit provides a general overview of the Compliance Program to all commissioners on an annual basis.

Provider Compliance Training

Under the Direction of the Sr. Provider Relations Director, providers shall receive a copy of the Code of Conduct and Provider Manual. This information is available on the Provider section of the PHC website. Providers are encouraged to disseminate copies of the Code of Conduct and the Provider Manual to their employees, agents, and subcontractors that furnish items or

services to PHC or its members. Individual and group providers are encouraged to provide compliance training to their employees using these tools.

In compliance with the Deficit Reduction Act of 2006, Providers are given a copy of PHC's False Claims Act through the Provider Manual.

Failure to Participate In Annual Training

The Compliance & Human Resources Departments will make a good faith effort to ensure all employees participate in the annual training. Employee participation is tracked. If an employees is identified as having failed to participate in the annual training, the employee manager's is contacted. Failure to complete annual training within a reasonable amount of time will be reported at the Compliance Committee. The Compliance Office will discuss employee non-compliance with the employee's department director. Continued non-compliance with training requirements will be reported to the Chief Administration Officer.

Documentation

The following details the documentation requirements related to the training and education program:

- All employees must show completion of training through either an online tool, or the submission of a signed attestation
- All employees must sign the Code of Conduct after receiving training and reviewing the document. This signature may be electronic or on paper.

Coordination of Training

The Regulatory Affairs and Compliance Unit coordinates compliance education and training programs with the Human Resources Department. The Administration Department, unless otherwise specified by the Compliance Officer conducts Compliance Education and Training.

Other Education Program Communications

- When appropriate, PHC informs commissioners, employees and providers of any relevant federal and state fraud alerts and policy letters, pending/new legislation reports, updates, and advisory bulletins through regular operations meetings and ad hoc APL workgroups.
- PHC uses electronic communication and/or other forms of communication (as appropriate) to inform employees and providers of changes in applicable federal and state laws and regulations.
- PHC informs commissioners and employees that they can obtain additional information from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

COMMUNICATION

The Compliance Program, including provisions of the Compliance Plan, is implemented and maintained on behalf of PHC by the Compliance Officer and Compliance Committee.

Initial Distribution of Compliance Plan

Employees and Commissioners
The Compliance Plan, Code of Conduct, and policies and procedures are made available through PHC4Me and SharePoint. New employees receive the Compliance Plan and Code of Conduct during the New Hire Orientation.

A copy of this Compliance Plan and Code of Conduct are distributed to commissioners upon their appointment, and annually thereafter for review and approval. PHC's Compliance Officer, or Clerk of the commission, shall have responsibility to distribute and obtain a signed Code of Conduct from commissioners annually.

Regular Reaffirmation

PHC requires that endorsement of the Code of Conduct and applicable policies and procedures be affirmed each calendar year as follows:

- The Code of Conduct shall be reviewed with employees and commissioners. Employees and commissioners shall be advised of any changes from the prior year. Each commissioner and employee shall sign a Code of Conduct to acknowledge they completed the annual review. Original signature sheets are maintained by the Compliance Unit.
- The Administration Department directly receives employee training attestations and Code of Conduct signatures either electronically or on paper. The Clerk of the Commission receives and forwards commissioner Code of Conduct signature pages.

Additional Communication

The Administration Department will:

- Inform commissioners and employees of any relevant fraud alerts, policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary through:
    - New Staff Orientation trainings
    - Annual compliance trainings
    - PHC4Me
    - Other venues as requested by the Compliance Officer or Compliance Committee members
- Use electronic communications and/or other forms of communication (as appropriate) to inform employees and providers of changes in applicable federal and state laws and regulations through:

  - Employee Bulletins (email)
  - PHC4Me
  - Provider Newsletters
  - Provider Bulletins
  - The Provider Manual
  - The PHC Website (www.partnershiphp.org)
- Inform commissioners and employees that they can obtain additional compliance information from the Compliance Officer. Any questions which cannot be answered by the Compliance Officer will be referred to the Compliance Committee.
- The Regulatory Affairs and Compliance Units organize educational opportunities for PHC employees through the venue of a nationally recognized Compliance Week.
- The Regulatory Affairs and Compliant Unit periodically release new educational articles covering privacy and FWA issues on PHC4ME.

REPORTING

Disclosure, Confidentiality and Non-Retaliation Establishment, and Publication of Reporting System

PHC has established various avenues for the reporting of FWA and other misconduct. This reporting system provides several lines of "upstream" communication to ensure an effective collection of possible misconduct. Confidentiality, when requested, will be honored to the extent allowed by law. Commissioners and PHC employees have an affirmative duty and are directed in the Code of Conduct and policies and procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Government agencies have identified individual accountability of board members and senior staff for reporting known or reasonably should have known misconduct as a priority.

The various means of reporting are described below:

Open Door Policy

All PHC employees are notified upon hire, and annually thereafter of PHC's open door policy. This is incorporated into new hiring onboarding and training. All employees may approach their supervisor, manager, or director with any issue. PHC employees are encouraged to check with their supervisor, manager, or director with compliance issues, complaints, or questions. Management staff is trained to handle these situations and forward any necessary information to the Compliance Officer and/or the Regulatory Affairs and Compliance units for review or investigation. A dedicated staff member is assigned to forward reports of privacy and FWA to the state.

Compliance Hotline

PHC has a Compliance telephone hotline (Compliance Hotline) for PHC commissioners, employees, providers and members, and other interested persons to report all violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, without limitation.

The compliance hotline is a toll-free number: **(800) 601-2146**

Commissioners, employees, and providers have an affirmative duty under the Compliance Program to report all violations, suspected violations, questionable conduct or practices by a verbal or written report to PHC via the Compliance Hotline, to a supervisor, or the Compliance Officer.

PHC publicizes the Compliance Hotline through multiple means to commissioners, employees, and providers including, but not limited to, PHC4ME, e-newsletters, and/or posting hotline posters in prominent common areas.

The Compliance Hotline is accessible 24 hours a day, 7 days a week, excluding designated holidays (when callers are routed to a voice mail message alerting them to call back during

established hours of operation).

Notification of hotline reports are sent directly to the Compliance Officer, the Privacy Officer and the Regulatory Affairs Reporting inbox. Reconciliation of hotline reporting occurs monthly.

Dedicated Reporting Inbox

The Regulatory Affairs unit has a dedicated email address to receive and manage reports of any compliance, privacy or FWA issues. This dedicated email address is RAC_Reporting@partnershiphp.org.

Confidentiality, Anonymous Reporting and Non-Retaliation/Non-Intimidation

PHC takes all reports of violations, suspected violations, questionable conduct or practices seriously.

Reports of compliance issues are treated confidentially to the extent permitted by applicable law and circumstances. For hotline reports the caller and/or author need not provide his or her name.

Communications via the Compliance Hotline or in writing are treated as privileged to the extent permitted by applicable law.

PHC's policy prohibits any retaliatory action against a commissioner, employee, or provider for making any verbal or written communication in good faith. In addition, PHC policy prohibits any attempt to intimidate an individual reporting a compliance issue, for any reason.

Voluntary Disclosure and Prohibition Against Insulation

PHC employees are notified annually during compliance training of PHC's policy of voluntary disclosure. PHC employees are encouraged to disclose mistakes and misconduct to their supervisors, managers, directors or the Compliance Officer to prevent or deter FWA.

Although commissioners, employees, and providers are encouraged to report their own wrongdoing, they may not use any voluntary disclosure in an effort to insulate themselves from consequences of their own violations or misconduct. PHC takes violations of this reporting policy seriously and the Compliance Officer will review disciplinary and/or other corrective action for violations, as appropriate, with the Compliance Committee or Human Resources Director.

MONITORING

Each PHC Department is tasked with periodically monitoring and auditing their functions as the result of contractual requirements, policies and procedures, corrective actions as a result of prior audits, determinations or risk on a department or plan wide basis, or at the request of the CEO, CFO, or COO.

The Administration Department, in coordination with the Compliance Committee, is responsible for assisting in the development and maintenance of regular auditing and monitoring activities, through the use of a risk assessment approved by the Compliance Committee. The Administration Department will be responsible for maintaining global monitoring and auditing policies and procedures as approved by the Compliance Committee.

Monitoring Systems

Organizational Monitoring
Verbal and/or Written Compliance Reports

Reports of suspected or actual compliance violations, unethical conduct, privacy, FWA, and/or questionable conduct made by employees in writing or verbally, formally or informally, are subject to review and investigation as provided below, in consultation with legal counsel, by PHC's Compliance Officer and/or their designee.

The Compliance Officer will work under the supervision of the CEO to investigate reports and initiate follow-up actions as appropriate.

Internal Monitoring
Department directors regularly review internal status/progress reports to ensure compliance and efficiency in departmental activities. "Red flags" that are identified in these reports are reviewed by the department director and/or specially trained staff to determine if misconduct has occurred. Instances of FWA or other misconduct are investigated by the department director and reported to the Regulatory Affairs and Compliance Unit. A report is prepared and brought before the Compliance Committee. Corrective actions may be applied by the reviewing department director under the direction of the Compliance Committee. Resolution of cases identified for possible or actual FWA are reported to the Compliance Committee at the next quarterly meeting.

Oversight of Delegated Activities
PHC delegates certain functions and/or processes to contracted medical groups and sub-contracted full-service or specialty plans who are required to meet all contractual, legal, and regulatory requirements of PHC's policies and procedures and other guidelines applicable to the delegated functions. Detailed delegation agreements are executed with those delegated providers. Delegates are required to submit quarterly reporting to PHC. Reports are reviewed by PHC subject matter experts and reported on at the quarterly DORS.

PHC maintains oversight over all delegated providers, including but not limited to, the following delegated activities:

- Provider credentialing and re-credentialing at select facilities
- Pharmaceutical benefits and claims processing to MedImpact
- Utilization Management
- Grievances and Appeals
- Claims payment

Availability of Records

PHC and its provider records are available for review by regulatory agencies, or their designee. Records are maintained according to the contractual obligations specified between PHC and the provider, and are not kept for a period of time any shorter than mandated by applicable federal and/or state law.

Records under the Medi-Cal and Healthy Kids lines of business are maintained for 7 years.

Minimum Use

PHC has policies and procedures that regulate minimum use within the plan. Compliance by staff is regularly discussed during the Physical, Technical, Administrative Safeguard Group and Compliance Committee meetings.

Audit Systems

Internal Audits

In order to comply with its regulatory and contractual requirements, PHC conducts periodic internal audits of its operations. An internal audit calendar is published annually at the fourth quarter Compliance Committee meeting. The audit calendar may be adjusted throughout the year, based on new or changing risk areas. Audits may be routine or ad hoc, depending on the needs of PHC, the department conducting the monitoring, or pursuant to a regulatory agency request, notification or alert. Audits are based on contractual or regulatory obligations, or PHC policies and procedures.

External Audits

Compliance with Contractual Requirements

PHC maintains a contract with the Department of Health Care Services (DHCS). PHC undergoes an annual audit by DHCS to ensure compliance with contractual and regulatory requirements. The Compliance Unit is responsible for coordinating the annual onsite audit. Results from the audit conducted by DHCS will be reviewed and used to develop and modify systems to audit and monitor operations on a regular basis. DHCS 2016 Medical Audit Report included as Attachment D.

PHC undergoes an annual Financial Audit that is conducted by an outside Certified Public Accounting Firm. The results of the 2016 financial audit were reported directly to the Commission.

Government-Identified Risk Areas

The Compliance Officer or designee monitors for specific compliance issues identified by health care agencies. This includes, but is not limited to areas of risk identified in the OIG's Annual Work Plan, specifically the OIG's Medicaid Managed Care and State Management of Medicaid work plan, the results of audits of PHC operations by health care oversight agencies, and compliance issues identified and reported to PHC's Compliance Unit.

Annual PHC Monitoring and Auditing Work Plan

PHC maintains a monitoring and auditing work plan that includes:

- Summary of internal monitoring processes
- Internal audit calendar
- Audit narrative, including:
  - Audit objectives
  - Scope and methodology
- Staff responsible for specific audits
- Strategy to monitor and audit PHC's sub-contracted full-service and specialty plans
- Process for developing follow up and corrective action

The monitoring and auditing plan is modified based on a risk assessment. The risk assessment is used to determine which areas of PHC's business may be susceptible to FWA or non-compliance. Audit guides, experiences of other COHS plans, other resources developed by regulatory agencies and the health care industry standards may be used to identify high risk areas. The Compliance Unit with input of the Compliance Committee prioritizes the monitoring and auditing strategy based on available resources.

Areas in PHC's business that are found to be non-compliant will be reviewed to determine how the deficiencies should be addressed. Recommendations or corrective actions may be required depending on the severity of the findings.

Actions taken as a result of the work plan are tracked to evaluate the success of implementation efforts. A report on monitoring and auditing results is presented to the Compliance Committee in the quarter following the finalization of the audit report.

Compliance Program Annual Review

The Compliance Committee reviews the Compliance Program, including this Compliance Plan annually.

The Compliance Plan's functionality will be reviewed to ensure that best efforts are made to protect PHC from FWA, and other misconduct that could endanger PHC, delivery of services, members, providers, and other affiliated parties.

External Auditing for Delegated Entities

As part of its work plan PHC monitors and audits delegated entities that are involved in the

administration or delivery of services to PHC members. PHC audits its delegated entities using the same auditing tools provided by regulatory agencies to ensure compliance with each program's standards. Recommendations or corrective actions are provided to the delegated entity upon the conclusion of each audit. Audit findings are reported out at the DORS. Corrective actions are monitored and reported on at the DORS until the corrective action plan is closed. DORS committee minutes are reported up to the Compliance Committee for further review and determination if further action is needed.

Participation Status Review and Background Checks

PHC does not knowingly hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in federal and/or state health care programs; and/or has ever been excluded from participation in federal and/or state health care programs based on a mandatory exclusion.

Under the direction of the CAO, PHC conducts participation status reviews upon hiring of new, temporary or contract employees and monthly thereafter, to ensure employees are not excluded or do not become excluded from participating in federal and state health programs.

Under the direction of the Sr. Provider Relations Director, verification of a provider's eligibility to contract with PHC is covered in credentialing and re-credentialing policies maintained by the Provider Relations Department. Payments made by PHC (i) to excluded persons or entities; or (ii) for items or services furnished at the medical direction; or (iii) on the prescription of an excluded or suspended physician are subject to repayment/recoupment.

The Board Clerk conducts participation status reviews upon appointment of members to the Commission, and monthly thereafter, to ensure commissioners are not excluded or do not become excluded from participating in federal and state health programs.

Employees are required to notify the Human Resources Department if, after hiring their ability to participate in federal and/or state health care programs changes. In the event PHC discovers the status of any employee, volunteer or temporary employee no longer permits them to work for PHC, corrective actions will be taken.

ENFORCEMENT

Conduct Subject to Enforcement and Discipline

Commissioners may be subject to removal; employees to discipline, up to and including termination; and providers to contract termination for non-compliance behavior, including but not limited:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws, or failure to seek recoupment of known overpayment of a claim involving federal or state Medicaid funds
- Conduct that results in a violation or violations of any other federal or state laws or contractual requirements relating to participation in federal and/or state health care programs
- Failure to report violations or suspected violations of the Compliance Program or applicable laws or to report suspected or actual FWA issues to an appropriate person
- Failing to disclose a conflict of interest

Enforcement and Discipline

PHC maintains a "zero tolerance" policy towards any illegal conduct that impacts the operation, mission, or image of PHC. Any employee or provider engaging in a violation of laws or regulations (depending on the magnitude of the violation) may be terminated from employment or their contract. PHC will accord no weight to a claim that any improper conduct was undertaken for the benefit of PHC. Such conduct is not for PHC's benefit and is expressly prohibited.

PHC maintains a policy on employee Conduct and Work Rules which specifies unacceptable employee behavior. Employee discipline is determined by the Human Resources Director.

In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, PHC will not take into consideration a particular persons or entities economic benefit to the organization.

Employees and providers should also be aware that violations of applicable laws and regulations, even unintentional, could potentially subject them or PHC to civil, criminal, or administrative sanctions and penalties. Further, violations could lead to suspension or exclusion from participation in federal and/or state health care programs.

REMEDIATION

Notice of Violation or Suspected Violation

If a commissioner, employee or provider becomes aware of a violation, suspected violation, or questionable or unethical conduct in violation of the Compliance Plan or applicable law, that commissioner, employee or provider must notify PHC immediately. The commissioner, employee, or provider may report any violation, suspected violation, or questionable conduct to their immediate supervisor or director, including the Compliance Officer or the Regulatory Affairs or Compliance unit, by direct verbal or written report. Such reports may also be made to the Compliance Hotline.

Response to Notice of Violation or Suspected Violation

Upon receipt of a report of non-compliance (whether a general compliance issue, HIPAA or FWA), the Regulatory Affairs and Compliance Unit is responsible for review and investigation. Issues with high severity, including but not limited to employee misconduct, may be reported directly to the Compliance Officer or Human Resources Director for investigation as appropriate.

The Regulatory Affairs and Compliance Unit will work with the appropriate PHC staff, vendors, and our outside contacts to correct any compliance issue.

Reported issues are tracked by the Regulatory Affairs and Compliance Unit for routine reporting on a quarterly basis to the Compliance Committee. Statistics on compliance issue reporting are provided to the Commission for regular review.

It is the responsibility of the Compliance Officer, or their designee to review and implement any appropriate corrective action after considering such recommendations. It is the responsibility of the Human Resources Director or their designee to implement any disciplinary action with regard to employee misconduct.

FRAUD

PHC must comply with certain regulatory requirements pertaining to FWA prevention. Such regulations dictate the investigative, reporting and monitoring activities related to FWA prevention. PHC's approach to identifying and monitoring potential fraud activity is multi-faceted.

Fraud, Waste, and Abuse Program (FWA)

The Compliance Committee, along with the Compliance Officer is responsible for maintaining a FWA program. This program is decentralized. The structure of this program is maintained in the Regulatory Affairs unit of the Administration Department and its job function is currently assigned to a Regulatory Affairs Specialist. The Regulatory Affairs FWA program was established to receive reports of suspected fraud, and conduct an initial investigation. The Regulatory Affairs unit logs all reported allegation of fraud into the Fraud Reporting Tracking system. Each report is assigned a case number. All documents reviewed in the course of the initial investigation are scanned and saved into an electronic case file. Suspected incidents of fraud will be reported timely to DHCS and/or other enforcement agencies. If an initial investigation is inconclusive, the Regulatory Affairs unit may, when appropriate, refer the matter to the Claims audit unit or to the Finance Cost Avoidance unit. Additionally, FWA may be identified through the Health Service Over/Under Utilization workgroup.

Compliance Committee Training/Expertise in FWA

At least one committee member should have training in fraud prevention and investigation.

Fraud Detection

Fraud detection involves knowing what can go wrong, and who could do it. It also involves knowing what opportunities exist and understanding the systems and controls designed to minimize the opportunities. Additionally, fraud detection involves knowing the symptoms or patterns of the occurrence, being on the lookout for such patterns and building programs to look for the patterns.

PHC believes that knowing what can go wrong consists of identifying fraud indicators that warrant closer scrutiny, including the types of fraud, common fraud schemes and trends, "red-flags" and situations leading to potential fraud.

PHC also routinely identifies trends or "global" schemes in Medicaid (Medi-Cal), Medicare or health care fraud and abuse reported in newspapers, journals, through CMS Fraud Alerts, or other means.

Departmental Monitoring Activities

Fraud detection requires that fraud be proactively sought through a variety of means. Each department is responsible for taking proactive steps to detect fraud. PHC exercises diligence and actively searches for possible fraudulent behavior through the course of regular business, and as a result of fraud alerts provided by regulatory agencies via the Regulatory Affairs and Compliance Unit. PHC is required to conduct certain monitoring activities as a result of contractual or regulatory obligation. Once a symptom or pattern has been identified, further research is warranted to determine whether or not there is reasonable suspicion of fraudulent behavior.

FILING SYSTEMS

The Compliance Officer will establish and maintain a filing system (or systems) for all compliance-related documents. Records retention is handled according to PHC's contractual and regulatory obligations. Records related to the Compliance Program, including edits to the Compliance Plan, minutes of Committee meetings, documentation of education, and similar documentation is maintained for no less than 10 years, pursuant to CMS requirements.

Appendix C:
GRIEVANCE POLICY

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)</td><td colspan="3">Lead Department: Administration</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medi-Cal Member Grievance System</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/11/99 (MS 300)</td><td colspan="4">Next Review Date: 6/21/2018
Last Review Date: 6/21/2017</td></tr>
<tr><td>Applies to:</td><td>☒ Medi-Cal</td><td></td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH</td><td colspan="3">Approval Date: 6/21/2017</td></tr>
</table>

I. RELATED POLICIES:

A. MCLP7002 Cultural and Linguistic Services
B. MPQP1016 Potential Quality Issue Investigation and Resolution
MCUP3037 Appeals/Expedited Appeals of UM Decisions for Medical Necessity Determination (Non-Administrative)

II. IMPACTED DEPTS:

A. Member Services
B. Grievance
C. Provider Relations
D. Health Services
E. Claims
F. Quality
G. Pharmacy

III. DEFINITIONS:

A. Acknowledgement Letter is a written notification of receipt of a grievance or appeal that is sent to the member or member's authorized representative.
B. Appeal is a member's request to Partnership HealthPlan of California (PHC) for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.
C. Adverse Benefit Determination encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability which includes the following:
    1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    2. The reduction, suspension, or termination of a previously authorized service.
    3. The denial, in whole or in part, of payment for a service.
    4. The failure to provide services in a timely manner.
    5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    6. For a resident of a rural area, the denial of the member's request to obtain services outside the network.
    7. The denial of a member's request to dispute financial liability.

D. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent him/her in matters regarding his/her healthcare.
E. Complaint is the same as a Grievance. Where PHC is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
F. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are received over the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.
G. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.
H. Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
I. Grievance Clinical Lead (GCL) is the clinical staff member responsible for initiating and coordinating a multidisciplinary team approach to handling of grievances with members, providers, plan Medical Director, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to non-clinical staff as needed. The clinical lead may also provide input or participate in state hearings.
J. Grievance Coordinator is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgements and resolutions to member grievances and appeals. The Grievance Coordinator also represents PHC during state hearings.
K. Grievance system is the computer system that PHC uses to log and track member grievances, appeals, and state hearing requests which are logged by specific grievance types.
L. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to; questions pertaining to eligibility, benefits, or other PHC processes.
M. Member is the Medi-Cal eligible individual receiving health care through PHC to whom reference will be made as "member" in all protocols. For the substance use benefit, members include any individual enrolled in Medi-Cal in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano or Trinity Counties.
N. Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representatives from Grievances, Member Services, Provider Relations, Care Coordination, Quality, Pharmacy, Utilization, and Compliance.
O. Member Services Representatives (MSR's) are the PHC staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through PHC, including the grievance, appeal and hearing procedures, and assist members in obtaining resolution to their issues.
P. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with PHC, but may do business with PHC for specific reasons, e.g., provision of emergency, out-of-area or one-time member care.
Q. Notice of Action is a formal letter informing a member of an Adverse Benefit Determination.
R. Practitioner is a licensed individual who provides medical care.
S. Primary Care Provider (PCP) is a physician who has executed an agreement with PHC to provide the services of a primary care physician.
T. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.
U. Remark System (RS) is the AMISYS computer system that PHC uses to log and track specific grievance

types that are resolved by the end of the following business day. This system is also used by staff to make notes and document other issues relating to a grievance, appeal or state hearings.

V. Resolution Letter is written notice of the outcome of a grievance or an appeal. This letter will include information regarding any applicable next steps and appeal rights.

W. Standard Grievance is a grievance that cannot be resolved by the end of the following business day. These grievances are handled by the designated grievance staff.

X. State Hearing is a grievance or appeal filed by the member or member's representative to the California Department of Social Services to be heard by an Administrative Law Judge (ALJ).

Y. Substance Use Benefits are the range of services addressing drug or alcohol addiction provided in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano or Trinity Counties.

Z. Acknowledgement Letter is a written notification of receipt of a grievance or appeal that is sent to the member or member's authorized representative.

AA. Appeal is a member's request to Partnership HealthPlan of California (PHC) for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.

BB. Adverse Benefit Determination encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability which includes the following:

8. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
9. The reduction, suspension, or termination of a previously authorized service.
10. The denial, in whole or in part, of payment for a service.
11. The failure to provide services in a timely manner.
12. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
13. For a resident of a rural area, the denial of the member's request to obtain services outside the network.
14. The denial of a member's request to dispute financial liability.

CC. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent him/her in matters regarding his/her healthcare.

DD. Complaint is the same as a Grievance. Where PHC is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

EE. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are received over the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.

FF. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.

GG. Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

HH. Grievance Clinical Lead (GCL) is the clinical staff member responsible for initiating and coordinating a multidisciplinary team approach to handling of grievances with members, providers, plan Medical Director, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to

non-clinical staff as needed. The clinical lead may also provide input or participate in state hearings.

II. Grievance Coordinator is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgements and resolutions to member grievances and appeals. The Grievance Coordinator also represents PHC during state hearings.

JJ. Grievance system is the computer system that PHC uses to log and track member grievances, appeals, and state hearing requests which are logged by specific grievance types.

KK. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to; questions pertaining to eligibility, benefits, or other PHC processes.

LL. Member is the Medi-Cal eligible individual receiving health care through PHC to whom reference will be made as "member" in all protocols. For the substance use benefit, members include any individual enrolled in Medi-Cal in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano or Trinity Counties.

MM. Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representatives from Grievances, Member Services, Provider Relations, Care Coordination, Quality, Pharmacy, Utilization, and Compliance.

NN. Member Services Representatives (MSR's) are the PHC staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through PHC, including the grievance, appeal and hearing procedures, and assist members in obtaining resolution to their issues.

OO. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with PHC, but may do business with PHC for specific reasons, e.g., provision of emergency, out-of-area or one-time member care.

PP. Notice of Action is a formal letter informing a member of an Adverse Benefit Determination.

QQ. Practitioner is a licensed individual who provides medical care.

RR. Primary Care Provider (PCP) is a physician who has executed an agreement with PHC to provide the services of a primary care physician.

SS. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.

TT. Remark System (RS) is the AMISYS computer system that PHC uses to log and track specific grievance types that are resolved by the end of the following business day. This system is also used by staff to make notes and document other issues relating to a grievance, appeal or state hearings.

UU. Resolution Letter is written notice of the outcome of a grievance or an appeal. This letter will include information regarding any applicable next steps and appeal rights.

VV. Standard Grievance is a grievance that cannot be resolved by the end of the following business day. These grievances are handled by the designated grievance staff.

WW. State Hearing is a grievance or appeal filed by the member or member's representative to the California Department of Social Services to be heard by an Administrative Law Judge (ALJ).

IV. ATTACHMENTS:

A. Appeal Acknowledgement Letter
B. Grievance Acknowledgment Letter
C. Appeal Extension Letter
D. Appeal Modify Letter
E. Appeal Overturned Letter
F. Your Rights Under Medi-Cal Managed Care Letter
G. Resolution Letter
H. Appeal Decision Upheld Letter

Policy/Procedure Number: CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)			**Lead Department: Administration**
Policy/Procedure Title: CGA-003 Medi-Cal Member Grievance System			☒**External Policy** ☐**Internal Policy**
Original Date: 2/11/99 (MS 300)		**Next Review Date: 6/21/2018** **Last Review Date: 6/21/2017**	
Applies to:	☒ **Medi-Cal**		☐ **Employees**

I. Appeal Withdrawn Letter
J. Grievance Withdrawn Letter
K. Member Grievance Form

V. PURPOSE:

To ensure the thorough, appropriate, and timely resolution to member grievances, appeals, and state hearing requests as well as to ensure PHC's responsiveness to issues raised by PHC members. The sections below outlines the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with PHC's contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 17-006, Title 28 §1300.68 [except Subdivision §1300.68(c) g) and (h)], §1300.68.01[except Subdivision §1300.68.01(b) and (c)], Title 22 §53858, 42 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY/PROCEDURE:

A. Member Rights

PHC takes member grievances, appeals and state hearings seriously and strives to reach a fair resolution after a thorough evaluation of each issue. PHC will address all grievances, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present in writing or in person before the individual(s) resolving the grievance, evidence, facts and law, in support of their grievance. The objectives of the grievance resolution process are as follows:

1. To protect the rights of members.
2. To ensure that there is no discrimination by PHC against a member on the grounds that the member filed a grievance, appeal or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically-related issues by the Medical Director and Health Services staff.
6. Any member whose grievance is resolved or unresolved has the right to request a state hearing. Submissions of a grievance are not constructed as a waiver of the member's right to request a state hearing.
7. To report and evaluate aggregate data on member grievances to determine areas requiring corrective action and/or opportunities for improvement. To develop and implement necessary corrective actions with the intent of achieving increased member satisfaction.
8. To ensure that all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to; translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.
9. Ensure members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 14 calendar days to submit the documentation.

B. Cultural and Linguistic Requirements

1. A member has the right to language translation during any part of the grievance process, within a reasonable timeframe, including standard documents and correspondence. PHC's policy MCLP7002 Cultural & Linguistic Services details PHC's system for addressing cultural and linguistic requirements. The procedure for review of member grievances ensures that all grievances are reviewed by grievance coordinators for any cultural and linguistic issues. Training is provided on a yearly basis.

D. How grievance processes are communicated to PHC members
Members will be advised of their rights and access to grievance processes by the following means:
1. Written Materials - The PHC member grievance process explaining how to file a grievance is printed in the PHC Evidence of Coverage/Disclosure Form. It is included in the PHC Member Newsletter at least once each year, mailed with all grievance and appeal acknowledgement and resolution letters and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication - Telephone calls with PHC staff and PHC Providers and/or Practitioners.
3. Contracting Provider – Member Grievance forms and a description of the grievance process is available at each contracting provider's office.
4. PHC Website - PHC maintains a Website on the Internet which provides member grievance forms and information to members on how to file a grievance with PHC and the expedited medical review process.
5. Items 1, 3 & 4 above all include the toll-free phone number, Internet address, and the toll-free phone number for the hearing and speech impaired for PHC. PHC address is also included.

E. Member Grievance Process
Grievances may be filed at any time following any incident or action that is the subject of the member's dissatisfaction. Grievances may address, but are not limited to, the following issues:
1. Difficulty obtaining an appointment
2. Customer service at the provider or practitioner office
3. Billing issues
4. Appointment waiting times
5. Facility Conditions
6. Confidentiality issues
7. Appeals of denied Treatment Authorization Requests (TAR)
8. Appeals of level-of-care determinations
9. Appeals of PHC claims payment denials
10. Appeals of primary care provider (PCP) request for disenrollment
11. Refusals of PCP to refer the member for care

F. Grievances Filed
Members can receive assistance in filing a grievance or appeal from a patient advocate, a provider filing on behalf of the member, an ombudsperson or any other persons chosen by the member. There are five methods members or a member's authorized representative may use to file a grievance:
1. By Telephone
The member can contact PHC's Member Services Department to file a verbal grievance. PHC uses both bilingual staff and interpreter services for members who speak other languages (in accordance with Title 22 CCR 53858). A Member Services Representative (MSR) will record the grievance into PHC's grievance system.
2. In Writing
The member may also submit his/her grievance in writing to PHC. Upon request, members can request a member grievance form from PHC or from a contracted provider office. The member grievance form contains information regarding the PHC member grievance system as well as an authorized representative form.
3. In Person
Members may also visit PHC's offices in Fairfield and Redding and request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a grievance from the MSR or grievance staff. If the member is under the age of 18, a parent or guardian may file a grievance on their behalf. Members may also fill out an Authorized

Representative Form to authorize someone of their choice to represent them.

4. Contracted Provider
   Members may file a grievance at one of PHC's contracting providers' offices. The form titled "Member Grievance Form" is available at all contracted provider offices (in accordance with Title 22 CCR 53858).
5. PHC website
   Members can file a grievance by visiting PHC's website at: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspxh and select "Online Grievance Form" to file their grievance electronically through PHC's secure server.

G. Delegation
   1. PHC delegates the grievance process, or portions thereof, to Kaiser Health Plan and Beacon Health Strategies (Beacon).
   2. PHC oversees the delegation of the grievance process conducted by these entities through quarterly reviews of the grievance logs and annual audits.
   3. PHC requires corrective action plans whenever PHC designated staff identifies a problem in any of these entities process and assigns a deadline for receiving evidence that the problem has been resolved.

H. Resolving Member Grievances
   The steps to resolve a member's grievance will occur as outlined below, which is established by the date PHC receives the grievance.
   1. The following documents are sent to the member by the grievance staff within five (5) calendar days of receipt of the member's grievance:
      a. Acknowledgement Letter- acknowledges the date the grievance was received and the name, address and phone number of the Grievance Coordinator who may be contacted about the grievance or the appeal and the toll-free phone number for hearing and speech impaired members.
   2. "Frequently Asked Questions about the Grievance Process," which describes PHC's procedures for filing and resolving grievances and the telephone number and address for presenting a grievance. As appropriate, the Grievance Coordinator will conduct a preliminary investigation by contacting medical staff, PHC's medical staff or other appropriate individuals to gather information.
      a. If the grievance is about quality of care, denial of care, diagnosis or treatment, or other medical quality issues, the Grievance Coordinator will consult with the Grievance Clinical Lead Nurse.
      b. The Grievance Clinical Lead reviews all grievances for potential quality issues and forwards them to the Nurse in the Quality Department for review. PHC's responses to grievances involving a decision that the requested service is not a covered benefit shall specify the provision in the contract, and Evidence of Coverage/Disclosure that excludes the service. The Grievance Resolution Letter shall either identify the document and page number where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision that explains in a clear concise language how the exclusion applied to the specific health care service or benefit requested by the member.

I. Expedited Grievance Process
   If a member or a treating physician requests an expedited review or if the MSR or other PHC staff determines expedited review is needed, the issue will be immediately forwarded to PHC's Medical Directors to render a determination as to whether an expedited review is appropriate. Resolutions on expedited reviews include an oral and written notification. The process is as follows:
   1. Presentation of evidence, facts and law in support of member's grievance.
      Members are advised of their rights to submit evidence, facts and law in support of their grievance.

Members are also informed by the grievance coordinators of the limited time available to present evidence due to the nature of the expedited review request.

2. Expedited Review/Grievance Request Approved
   If PHC's Medical Director determines that the grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function, the grievance will be handled as an expedited grievance.
3. When expedited review is necessary and the Medical Director determines that he/she will not reverse the decision (if a decision was previously made by him/her), the Medical Director will facilitate a review of the grievance by another medical professional, including at least one practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment at issue.
   a. Decisions
      1) The Medical Director will render the expedited decision and the grievance staff will notify the member as expeditiously as the medical condition requires, but no later than 72 hours from when expedited review was requested. PHC will provide oral and written notification of the decision to the member.
4. Expedited Request Denied
   If PHC's Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by grievance staff that their request for an expedited review has been denied within 72 hours of their request and the grievance will be processed using standard timeframe (30 calendar days).

J. Incoming Grievances
1. When a grievance is received into the grievance unit, the Grievance Resolution Specialist (or designee) will assign the grievance to a grievance coordinator using the Grievance Rotation Tracker.
2. Upon assigning the case, an email is generated to all grievance staff, including the Grievance Clinical Lead (GCL). The GCL will log into the grievance system to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in the grievance system under the "Clinical vs Non-Clinical" action by the GCL. Grievance staff will utilize the grievance categories worksheet to assess the grievance for other referrals to PHC departments and will proceed as directed in the worksheet.
3. All clinical cases are reviewed by the GCL or designee to evaluate the need to forward the case to the Quality Improvement (QI) Department for a PQI and/or order records for further evaluation. The GCL or designee will direct grievance staff if a PQI referral is needed. The GCL or designee will also make recommendations for case work on any clinical cases.

K. Clinical Grievance
A clinical grievance is defined as any issue concerning the services provided by a clinic, hospital, provider or pharmacy. The types of grievances considered to be clinical in nature include:
1. Quality of Service (by clinic/hospital/provider/dental provider)
2. Access
3. Pharmacy issues
4. Quality of Medical Care
5. Denials, Refusals (formulary, denial of service/treatment)
6. Cultural, Linguistic, and Health Education (by clinic/hospital/provider/dental provider)

L. Non-Clinical Grievance
A non-clinical grievance is defined as any issue concerning the services provided by PHC and its non-clinical components. The types of grievances considered to be non-clinical in nature include:
1. Billing

2. Benefits/Coverage (benefits)
3. Cultural, Linguistic, and Health Education (by PHC staff, PHC materials)
4. Quality of Service (by PHC staff)
5. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
6. Cab grievances

M. Quality of Medical Care Grievances
1. All quality of medical care grievances are reviewed by PHC clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel his/her treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound). Or they feel they were denied care, where the medical records show that the service is not necessary and an alternative treatment option was provided.
2. The designated PHC clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history.
3. All quality of care grievances are reviewed by a GCL and submitted to the CMO or his/her physician designee for review within a timeframe which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the GCL or Quality Improvement RN, documentation of the issue will be reviewed by the QI Department.

N. Inter-Rater Reliability (IRR)
1. To ensure that grievances are appropriately designated by the GCL as clinical versus non-clinical and referrals for PQIs are accurately being referred to the QI department, inter-rater reliability studies will be conducted every quarter.
2. Sample will be prepared by the Grievance System Manager or designee.
   a. PQI Referral Sample - A random selection of a minimum of 10 grievances will be pulled for review by the CMO or his/her designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
   b. Clinical vs Non-Clinical Sample- A random selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the categorization of a grievance, clinical or non-clinical was appropriate.
3. Time frame – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
4. Results - A 90% inter-rater reliability is required. Where a 90% score is not achieved, additional training will be provided to the GCL by the QI designated staff member and subsequent inter-rater reliability studies will be conducted until the passing score is achieved.

O. Grievances Involving Coverage For Terminally Ill Members

A member who has a terminal illness (incurable or irreversible condition that has a high probability of causing death within one year or less) requires the following procedure for addressing a coverage denial.
1. Within five (5) business days of a denial of a benefit for treatment, services, or supplies deemed experimental as recommended by a participating plan provider, PHC will provide to the member the following information.
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment services or supplies covered by the plan, if any. Compliance with this subdivision Section 1368.1 of the Act, by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
   c. Copies of the plan's grievance procedures or grievance form. The grievance form shall provide an opportunity for the member to request a conference as part of the plan's grievance system provided under Section 1368.1.

2. If the member requests a conference, the conference will be held within five (5) business days if the treating participating physician determines, after consultation with the health plan Medical Director, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies, or any alternative treatment, services, or supplies covered by the plan, would be materially reduced, if not provided at the earliest possible date. The member will also be given the option to extend the timeframe to request to participate in the conference up to 30 calendar days.

P. Contacting providers regarding grievances filed against them
   1. Members are notified at the time of the filing that their grievance may be sent to the provider they are grieving about to receive a response regarding their grievance. Members may request that any notification to their provider or practitioner regarding the grievance be delayed until a relationship with a new provider or practitioner is effective. Such a request is noted when the grievance is filed by the PHC staff member. PHC staff will assure the member that there will be no discrimination against them by PHC or its providers or practitioners on the grounds that they have filed a grievance.

Q. Member Grievance Correspondence
   1. There are two (2) types of member correspondence that are issued by grievance staff. Of note, each member correspondence includes PHC's notice "Member Complaint, Appeal and Hearing Information". This notice provides the member information regarding PHC's grievance process including the member's rights to file for a state hearing.
      a. Acknowledgement Letter
         1) An acknowledgement letter is issued within 5 calendar days of receipt of a grievance. This letter will include the name, address and phone number of the PHC grievance coordinator who has been assigned to their case and the phone number for the California Relay Service.
         2) Exception to sending the acknowledgement letter
            a) If a grievance is resolved within 5 calendar days of receipt, the grievance coordinator will issue only the Grievance Response/Resolution.
      b. Resolution Letter
         1) The grievance coordinator mails a Grievance Response/Resolution within 30 calendar days of the date the grievance was received. The letter summarizes the grievance and describes the resolution.

R. Timeframe - Grievance
   1. Standard:
      a. Resolution – member grievances are resolved within 30 calendar days of the member's request for a grievance [Title 22 CCR 53858 (f) (1)].
   2. Expedited:
      a. Grievance staff will process the case within 72 hours from the date of receipt of the grievance/appeal.
   3. Grievance Acknowledgement will be sent to the member within 5 calendar days of receiving the grievance.

S. Grievance File Maintenance

   Documentation for each grievance is maintained by the Grievance Coordinator. Documentation may include, but is not limited to the following:
   1. Memo outlining the grievance and the steps taken to resolve the issue;
      a. The date of the call
      b. The name of the complainant
      c. The complainant's member identification number
      d. The nature of the grievance
      e. The nature of the resolution

f. The name of the plan representative who took the call and resolved the grievance
g. Request for an Appeal or Grievance Form
h. Acknowledgement Letter and Frequently Asked Questions about the Grievance Process
i. Additional written correspondence between PHC, the member, providers and/or practitioners
j. Billing and claims information (if appropriate)
k. Medical Records Release Form (if appropriate)
l. Medical records (if appropriate)
m. Grievance Resolution Letter
n. Notice of Unresolved Grievance, if appropriate

2. Copies of grievances and responses shall be maintained by PHC for ten (10) years. They are maintained on-site for two (2) years, and include a copy of all medical records, documents, evidence of coverage and other relevant information upon which PHC relied in reaching its decision.

VII. MEMBER APPEAL PROCESS

A. Time Frame – Appeal

Appeals must be filed within 60 calendar days following any denial action that is the subject of the member's dissatisfaction. Appeals can be filed by the member, his/her authorized representative (AR), or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the member service representative (MSR) or grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal. There is only one level of appeal for members per 42 CFR 438.402(b).

B. Resolving Member Appeals

1. Confirmation of member appeal
   a. Upon receipt of an appeal, grievance staff conducts a preliminary investigation of the request by contacting the treating provider, PHC staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the appeal and to also provide the member an opportunity to submit a statement for the reason for the appeal.
2. Presentation of evidence, facts and law in support of member's grievance
   a. Members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 14 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medical records and any other documents before and during the appeal process.
3. Continuation of benefits (also known as aid paid pending)
   a. Upon request, the member's benefit/service can continue pending the outcome of the appeal decision.
      1) The criteria for continuation of benefits is listed below per 42 CFR 438.420
         a) Requests must occur within 10 calendar days from the date the notice of action was mailed to the member.
         b) The appeal must be filed timely.
         c) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
         d) The service was ordered by an authorized provider.
         e) The original period covered by the original authorization has not expired.
         f) The member requests extension of benefits.
   b. Duration of continued or reinstated benefits
      1) If, at the member's request, PHC continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

a) The member withdraws from the appeal
b) 10 days pass after PHC mails the notice, providing resolution of the appeal against the member, unless the member, within the 10 day time frame has requested a state hearing with continuation of benefits until a state hearing decision is reached.
c) The state hearing office issues a hearing decision adverse to the member.
d) The time period or service limits of a previously authorized service has been met.

C. Examples of Member Appeals
1. An appeal is a member's request for reconsideration of an initial decision resulting in the denial of service, benefit or claim. Appeals may address, but are not limited to, the following issues:
   a. Appeals of denied Treatment Authorization Requests (TAR)
   b. Appeals of level-of-care determinations
   c. Appeals of PHC claims payment denials
   d. Appeals of primary care physician request for disenrollment
2. Members filing grievance regarding their Medi-Cal eligibility are referred to their local county Health and Social Services Department or the Social Security Administration office for assistance.

D. Review of Appeals
   a. Medically-Related Appeals
      1) Grievance staff will refer medically-related appeals and all documentation to the Medical Director for review who was not part of the original decision to deny unless the final decision is in favor of the member (Contract Exhibit A, Attachment 14, 2, F). The "health care professional with appropriate expertise" is not determined by specialty, but by expertise and experience which varies with the career and experience of the particular Medical Director. In general, if the appeal is about a child, then a pediatrician or family physician Medical Director would be consulted. If the appeal is about an adult, then one of the internal medicine physicians or family physicians would be consulted. If the Medical Director reviewing the appeals feels that the particular clinical issue in question is outside his/her expertise or experience, he/she may refer the case to another Medical Director for review (who was not part of the original decision to deny) or to an outside physician consultant with expertise in this area (Contract Exhibit A Attachment 14, 2, C).
         a) Ordering Medical Records
            The Medical Director will direct grievance staff to order medical records from primary care providers and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within 5 working days.
   b. Other Appeals
      1) Appeals regarding claims, billing issues, special cases status and other non-medically-related cases will be presented to the Member Grievance Review Committee for direction on which department/personnel should review the appeal. Grievance staff will work with other appropriate PHC staff to develop a resolution for non-medically related appeals as needed. The staff reviewing the appeal will be individuals who were not involved in the initial determination unless the final decision is in favor of the member.
   c. Expedited Appeals
      1) Requests for expedited appeals will be immediately forwarded to a Medical Director for review. If the expedited review is deemed medically necessary, the appeal resolution will be provided within 72 hours. The grievance coordinator will make reasonable efforts to notify the member orally and provide written notice within 72 hours.

2. Member Correspondence

a. There are 3 types of member correspondence that are issued by grievance staff. Of note, each member correspondence includes PHC's notice, "Member Complaint, Appeal and Hearing Information". This notice provides the member information regarding PHC's grievance process including the member's rights to file for a state hearing.
   1) Acknowledgement Letter
      a) An acknowledgement letter is issued within 5 calendar days of receipt of an appeal.
      b) This letter will include the receipt date, name, address and phone number of the PHC grievance coordinator who has been assigned to their case and the phone number for the California Relay Service.
      c) Exception to sending the acknowledgement letter
         i. If an appeal decision is rendered within 5 calendar days of receipt, the grievance coordinator will issue only the appeal decision letter.
      d) Denial of Expedited Review
         i. If a request for an expedited review has been denied by a Medical Director, grievance staff will also include in the acknowledgment notice that the request for an expedited review has been denied and the reason why the request was denied.

b. Appeal Resolution Letter
   1) The grievance coordinator mails an appeal resolution letter within 30 calendar days from the date the appeal was received. The letter summarizes the appeal and describes the appeal decision. If any appeal resolution timeframe is not met (i.e., standard, expedited, extension), the member is considered to have exhausted PHC's appeals process and may proceed to State Hearing.
   2) PHC will authorize or provide services for overturned adverse benefit determinations (as the result of an appeal determination) as expeditiously as the member's health condition requires, but no later than 72 hours of the decision.

c. Extension Letter
   1) In the event an appeal decision cannot be resolved within the 30 calendar days, an extension letter may be mailed to the member before the thirtieth day. The request for the extension may be granted upon request from the member or if PHC demonstrates that there is a need for additional information and the delay is in the member's best interest. PHC will inform the member that PHC will take up to 14 additional calendar days to render a decision and a notice will be sent once the appeal decision is rendered. Reasons for the delay will be clearly documented in the extension letter. The grievance coordinator will make reasonable efforts to notify the member orally and provide written notice within two (2) calendar days.

d. Notification
   1) Each written notification sent to the member will also include the member's right to file a grievance if the member disagrees with the extension as well a state hearing (Title 22 CCR 53858 (f) (3)].
   2) Each notification template (i.e., Notice of Action, Notice of Appeal Resolution, "Your Rights" attachments) when informing members of a denial or appeal resolution will either be DHCS templates or be submitted to DHCS for review and approval prior to use.

VIII. MEMBER STATE HEARING PROCESS

A. Member State Hearing Timeframe

State Hearings must be filed within 120 calendar days following the date of the Notice of Appeal Resolution (NAR) that is subject of the member's dissatisfaction. State Hearings can be filed by the member or his/her authorized representative (AR). For the purpose of this policy, member will be used to

refer to the member and the AR unless otherwise noted.

B. Filing a State Hearing
   1. Members have the right to file for a state hearing after exhausting PHC's appeal process.
   2. Members can file for a State Hearing with the California Department of Social Services. There are four ways to request a state hearing.
      a. By Phone
         Members can call the State Hearing Office at 1-800-952-5253. Hearing impaired members may use TTY by calling 1-800-952-8349.
      b. By Mail
         Members can send a hearing request form or their own written request directly to:
         California Department of Social Services
         State Hearings Division
         P.O. Box 944243, Mail Station 9-17-37
         Sacramento, CA 94244-2430
      c. By Fax
         Members can fax their hearing request form or their own written request directly to the state at 916-651-5210 or 916-651-2789.
      d. In Person
         Members can also turn in their hearing request form or their own written request at one of the local county offices.

C. Responding to State Hearing Requests
   1. Notification of Hearing Request
      PHC receives a notice of the member's request for a state hearing from the SCOPE unit in the California State Department of Social Services and from the Office of the Ombudsman. Notifications include the case name, the request for hearing and filing date.
   2. Review of Hearing Request
      Upon receipt, grievance staff conducts a preliminary investigation of the request by contacting the treating provider, PHC staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the state hearing and to also provide the member an opportunity to submit a statement for the reason for the hearing. If the member has not opened an appeal with PHC, staff will offer to open an appeal as well.
   3. Parties to State Hearings
      The parties to the state hearings include PHC, the member and their representative or the representative of a deceased member's estate.
   4. Continuation of benefit
      a. Upon request, the member's benefit/service can continue pending the outcome of the state hearing decision.
      b. The criteria for continuation of benefits is listed below per 42 CFR 438.420.
         1) Request must occur within 10 calendar days from the date the notice of action was mailed to the member.
         2) The state hearing must be filed timely.
         3) The state hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
         4) The service was ordered by an authorized provider.
         5) The original period covered by the original authorization has not expired.
         6) The member requests extension of benefits.
      c. Duration of continued or reinstated benefits

If, at the member's request, PHC continues or reinstates the member's benefit while the state hearing is pending, the benefits will be continued until one of the following occurs:

1) The member withdraws from the state hearing
2) The state hearing office issues a hearing decision adverse to the member
3) The time period or service limits of a previously authorized service have been met

d. Disputes regarding continuation or reinstated benefits
In the event grievance staff finds that the member does not meet criteria for continuation or reinstated benefits, the member will be referred back to the Office of the Ombudsman to review and render a decision if aid paid pending applies.

D. Statement of Position
1. Creation of Statement of Position
Grievance staff, while working with clinical PHC staff, will prepare the Statement of Position (SOP). The SOP will state the following information:
a. The Issue
b. The Background
c. Pertinent Facts
d. Guidelines
e. History of TAR
f. Applicable Law
g. Conclusion
2. Submission of Statement of Position
Statements of Positions are submitted directly to the state hearing SCOPE office, the Office of the Ombudsman, and to the member, at least 2 working days prior to the scheduled hearing. To ensure receipt prior to the hearing, PHC will email the statement of position via secure email to scopeofbenefits@dss.ca.gov and the Office of the Ombudsman. Grievance staff will send the Statement of Position via FedEx to the member. FedEx envelops will require direct signature for delivery. In the event a physical address cannot be obtained or is not available, Statement of Positions will be mailed via certified mail to the member's PO Box.

E. Representation during the State Hearing
1. Grievance staff will appear at the state hearings to represent PHC and explain PHC's position. Appropriate PHC staff and/or other representatives may be asked to appear at the state hearings as determined necessary by the Medical Director.

F. Expedited State Hearings
1. Within 2 working days of being notified by the Department of Social Services (DSS) or the Office of the Ombudsman that a member has filed a request for a state hearing which meets the criteria for expedited resolution, PHC will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which PHC considered in connection with, the action which is the subject of the expedited state hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request (TAR) and Notice of Action (NOA), plus any pertinent grievance resolution notices. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and grievance resolution notices. One or more plan representatives with knowledge of the member's condition and the reason(s) for the action, which is the subject of the expedited state hearing, shall be available by phone during the scheduled state hearing.

G. State Hearing Decisions
1. The notice of the Administrative Law Judge's decision will provide members with information on

how to request a rehearing of their issue if they disagree with the decision. A member may obtain judicial review of the decision by filing a petition in Superior Court under Code of Civil Procedure §1094.5 within one year after the date of the decision.

a. Upheld Decisions
   Decisions favorable to PHC will be noted in the grievance system case file and closed. A copy of the decision is forwarded to the department that rendered the adverse decision to the member.
b. Overturned Decisions
   Adverse decisions to PHC will be noted in the grievance system case file. A copy of the decision is forwarded to the department that rendered the adverse decision to the member and will be given 72 hours to overturn the decision; expedited hearings will require the denial be overturned within 24 hours. Once confirmation is received that the decision is overturned, grievance staff will contact the member and the Office of the Ombudsman and verbally notify that the denial has been overturned. Interactions with the member and the Office of the Ombudsman are documented in the grievance system case file and the case is closed once a copy of the overturned decision is available.

H. State Hearing File Maintenance
   1. All documentation relating to a state hearing is scanned and uploaded into the grievance system under the member's case number. Documentation includes but is not limited to the following:
      a. Case Summary (produced out of grievance system) outlining the state hearing and the steps taken to resolve the issue
      b. Notification of State Hearing
      c. All written correspondence between PHC, the member, providers and/or practitioners
      d. Billing and claims information (if applicable)
      e. Statement of Position
      f. Administrative Law Judge's decision on the hearing

I. Monitoring of Timeliness of Grievances
   1. All grievances, appeals and state hearing requests with their resolutions are documented in the grievance system.
   2. At the end of each month, the grievance system manager or his/her designee will review the grievance staff cases as part of his/her performance review. In addition, all grievances and appeals that are pending and unresolved for 30 days or more are reviewed
   3. Weekly one-on-one meetings are conducted with staff to ensure that member grievances and appeals are resolved within established time frames as well as to review open member grievances and appeals and determine appropriate resolutions.

J. Reporting Grievances to HealthPlan Committees for Review
   1. Under the direction and oversight of the Chief Medical Officer (CMO), individual and aggregate data on member grievances and appeals is reviewed by the Member Grievance Review Committee (MGRC), Internal Quality Improvement (IQI), and Quality/Utilization Advisory Committee (Q/UAC) no less than 4 times per year. Each committee reviews the data for possible actions as determined appropriate according to PHC Quality Assurance Protocol. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be reviewed and analyzed by committee to remedy any problems identified. On an annual basis, PHC's Consumer Advisory Committee (CAC) will review the written record of Grievance and Appeals.

IX. – EXEMPT GRIEVANCE PROCESS

A. Each night the Information Technology (IT) Department generates the grievance report of all grievances resolved by the end of the business day in the Member Services (MS) Department.

B. The assigned grievance staff member will review each log on the report to check for the following:
   1. Resolution is clearly listed
   2. Only one (1) issue is listed per log on the report
   3. The remark code category matches the content of the log
C. Logs that have resolutions which are not clear, severe grammar issues that prevent the log from being read clearly, the remark code category does not match the content of the log, and/or if more than one issue is listed on the log will be sent to the MS representative's supervisor for review.
D. The designated MS supervisor will review and respond to the designated grievance staff member regarding the outcome of his/her review.
E. All exempt grievances will be reviewed by GSL to assess the member's concern and screen for potential quality of medical care issues.
F. The designated GSL will base his/her determination on the review of information submitted by the member or his/her authorized representative. The review will also consist of review of medical records and claims history.
G. All exempt grievances that are identified by the GSL as potential quality of care grievances are submitted to the Chief Medical Officer or his/her physician designee for review within a timeframe which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the GSL or Chief Medical Officer or physician designee, documentation of the issue will be reviewed by the Quality Improvement Department.
H. The Member Grievance Review Committee will review the aggregate data on a quarterly basis. The committee is responsible for identifying trends and any potential issues that require action.

X. REPORTING REQUIREMENTS

1. PHC maintains an inquiry log of all requests for information that do not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other PHC processes.
2. PHC maintains and has available for DHCS' review, PHC's grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances and the PHC exempt grievance log. Grievance logs are maintained based on the requirements set forth in Title 22 CCR Section 53858 (e).
   a. Date and time the grievance was filed
   b. The name of the member filing the grievance
   c. Member identification number
   d. The name of the person receiving the grievance
   e. A description of the grievance
   f. A description of the action taken to resolve the grievance
   g. The proposed resolution by the plan
   h. The name of the person responsible for resolution
   i. The date of notification to the member
3. The information contained in this log shall be periodically reviewed by PHC. PHC also submits quarterly grievance reports based on Title 28 CCR Section 1300.68(f).

XI. MEDICAL RECORDS/DOCUMENT REQUESTS

A. Members and providers may call to request materials and/or letters to be sent to them by mail or by fax (upon request).
B. Members can request materials/documents/records free of charge by calling PHC's member services department or by filling out the Grievance Records Request form.

Policy/Procedure Number: CGA-024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)			**Lead Department: Administration**
Policy/Procedure Title: CGA-003 Medi-Cal Member Grievance System			☒**External Policy** ☐**Internal Policy**
Original Date: 2/11/99 (MS 300)		**Next Review Date: 6/21/2018** **Last Review Date: 6/21/2017**	
Applies to:	☒ **Medi-Cal**		☐ **Employees**

XII. REFERENCES:

B. PHC Contract 08-85215 A19
C. 22 CCR §53858
D. 28 CCR §1300.68 [except subdivision §1300.68(c),(g) and (h)]
E. 28 CCR §1300.68.01[except subdivision §1300.68.01(b)and (c)]
F. 42 CFR 438.420(a)(b) and (c)
G. 42 CFR 438.406(b)(3)
H. APL 17-006 May 9, 2017 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments

XIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

XIV. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance System Manager

XV. REVISION DATES:

Medi-Cal
MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06; 01/16/08; 03/18/09; 07/21/10; 03/20/13; 11/18/15; 06/21/17

PREVIOUSLY APPLIED TO: N/A