DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

IMPLEMENTATION PLAN

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PART I

PLAN QUESTIONS

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

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

   ☒ County Behavioral Health Agency
   ☒ County Substance Use Disorder Agency
   ☒ Providers of drug/alcohol treatment services in the community
   ☒ Representatives of drug/alcohol treatment associations in the community
   ☒ Physical Health Care Providers
   ☒ Medi-Cal Managed Care Plans
   ☒ Federally Qualified Health Centers (FQHCs)
   ☒ Clients/ Client Advocate Groups
   ☒ County Executive Office
   ☒ County Public Health
   ☒ County Social Services
   ☒ Foster Care Agencies
   ☒ Law Enforcement
   ☒ Court
   ☒ Probation Department
   ☒ Education
   ☒ Recovery Support Service Providers (including recovery residences)
   ☒ Health Information technology stakeholders
   ☐ Other (specify): _____

2. How was community input collected?

   ☒ Community Meetings
   ☒ County Advisory Groups
   ☐ Focus Groups
   ☐ Other method(s) (explain briefly): _____

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
   ☐ Bi-Monthly
   ☐ Quarterly

☐ Other: _____

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

   ☐ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to 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 county plan?

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

   How will these required services be provided?

   ☐ All county operated
   ☒ Some county and some contracted
   ☐ All Contracted

   OPTIONAL
   ☒ Additional Medication Assisted Treatment
   ☐ Partial Hospitalization
   ☒ Recovery Residences
   ☐ Other (specify)

6. Has the county established a toll free number for perspective clients to call to access DMC-ODS services?

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

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

   ☒ Yes (required)
   ☐ No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.

   ☒ Yes (required)
   ☐ No

9. Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:

   - Number of days to first DMC-ODS service/ follow-up appointments at appropriate level of care after referral and assessment
   - Existence of a 24/7 telephone access line with prevalent non-English language(s)
   - Access to DMC-ODS services with translation services in the prevalent non-English language(s)
   - Number, percentage of denied and time period of authorization requests approved or denied

   ☒ Yes (required)
   ☐ No

PART II
PLAN DECRIPTION

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

Kings County Behavioral Health (KCBH) has a long history of collaborating with other county agencies and other contracted providers in an effort to provide comprehensive behavioral health services within Kings County. The collaborative process utilized to develop this Implementation Plan included ongoing multidisciplinary meetings, and coordination meetings. These meetings included the following:

- Wellness Bridge Project meetings Monthly
- Behavioral Health Advisory Board Monthly
- Proposition 47 Steering Committee Quarterly
- Kings Partnership for Prevention Monthly
- Kings Provider Network Monthly

As outlined above, KCBH participated in a number of ongoing community planning and coordination meetings that include criminal justice, community, mental health advocates, substance use disorders advocates, substance use disorders providers, and health centers. At each of these ongoing meetings, participants were given an orientation to the DMC-ODS waiver, updates to the process and engaged in discussion about implementation of the waiver in Kings County.

KCBH invited members from the public health, local health centers, probation and health and human services to attend the Kings Provider Network (KPN) meeting. The KPN meeting serves as a forum in which the county provides Department of Healthcare Services (DHCS) updates, informational notices updates, capacity building, technical assistance, CalOMS/DATAR updates, and contract updates. The KPN meeting is a collaborative environment in which providers and partners may ask questions, raise concerns, offer feedback, provide updates and work together to improve services. The KPN served as the primary advisory committee for the development of the DMC-ODS implementation plan.

KPN met to determine the current capacity of providers to participate in the DMC-ODS development. We also discussed ideas about the expansion of services, availability of services, case management, Medication Assisted Treatment (MAT), increased care coordination with mental and physical health, client flow, beneficiary notification, access line, and evidence based practices.

KCBH and SUD treatment providers also met with the local Managed Care Plans to discuss their existing benefits and services and to develop processes for comprehensive screening, SBIRT training, care coordination, case management delineation and update the required memorandum of understanding to improve services where consumers are shared between mental health, substance use, and primary care.

KCBH and our SUD treatment providers have developed working relationships involving coordination of care and bi-directional referral with the local health centers in the area. It is our intention to continue and build on these existing procedures to facilitate access to care for beneficiaries with substance use disorders. We met with representatives of the local health centers to get input for this plan.

To ensure ongoing involvement and effective communication will occur, KPN will serve as the steering committee for the implementation of the plan. During the first year of implementation, the KPN will focus on implementation review, client flow review, care coordination and continued improvement opportunities. KCBH will also continue to use existing meetings, forums, workgroups, and committees to discuss the implementation of the plan.

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

Kings County has a "no wrong door" philosophy to treatment. Any individual or family member who has the courage to seek treatment may contact KCBH or any community SUD treatment provider to learn about the available services. Referrals to DMC-ODS services will come through multiple access points including 1) Beneficiaries may be referred or walk-in directly from inter-agency partners to any SUD treatment provider and KCBH for American Society of Addition Medicine (ASAM) screening, 2) Beneficiaries may call the 24-hour toll free phone line, 3) Beneficiaries may be referred or walk-in from Crisis and/or NTP programs 3) Beneficiaries can direct contact by members of the public with SUD treatment providers within the community for ASAM screening. Referral sources may call to schedule an appointment for the beneficiary or may accompany the beneficiary to request an appointment. Referral sources are encouraged to provide transportation to the SUD provider for screening and/or assessment and SUD providers will also provide transportation as needed. In a high risk or crisis situation, consumers may access necessary services immediately in order to mitigate any potential for harm.

Screening and Referral
All individuals will be triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/ eligibility verification and/ or enrollment, and are advised of the benefits to which they are entitled to per the DMC-ODS. KCBH has created a uniform screening tool based on the American Society of Addition Medicine (ASAM) dimensions. All screening staff will be trained with this screening tool prior to implementation of

services. The screening usually occurs in a clinical setting but may also occur over the phone or an offsite location such as a hospital or in custody setting. Once screened, the beneficiary will be referred to the appropriate ASAM level of care as determined by the standardized ASAM screening tool.

Once the screening is complete, the screener will connect the beneficiary to the appropriate treatment provider. For ASAM level 0.5, a SUD Counselor at the screening agency will complete a one on one session the same day in order to explore, identify and address risk factors associated with substance use disorders. 0.5 services engage the beneficiary in conversation to educate and prevent substance use disorders which include how personal conflict, legal, and financial issues arise from the use of alcohol and other drugs. When outpatient ASAM level 1.0 and 2.1 services are recommended, the assessing SUD Counselor will schedule an appointment for the consumer. The consumer will know where, when, and with whom their first treatment appointment will take place. For urgent conditions or if an immediate intervention is required, the consumer will be linked to services immediately. For ASAM levels 3.1 3.3 & 3.5, the SUD counselor will contact the treatment provider, schedule an appointment with the provider on behalf of the consumer and assist the consumer in getting to the appointment in the event they exhibit barriers in keeping the appointment. For residential treatment that has a bed available, the consumer will be connected to the treatment provider immediately. Should a bed be unavailable, the consumer will be referred to outpatient interim services until a bed is available. However, this does not apply to intravenous and/or pregnant individuals who will be referred to any available bed that same day. These consumers always take precedence in regard to placement. In the event there is a delay in connecting individuals to immediate services, the assessing SUD Counselor will stay in contact with the consumer daily to ensure their entry into treatment. In regard to any recommended level of care, if it is determined that Medication Assisted Treatment (MAT) is needed, a release of information is completed and a referral is made to MAT in addition to other services. Other placement considerations from the screening include geographic accessibility, threshold language needs and beneficiary preferences. .

Assessment

A comprehensive ASAM assessment will be conducted at the referred treatment provider site. The LPHA will determine if the consumer meets the medical necessity requirements for the recommended services in accordance with ASAM and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) and will approve or deny the recommended treatment plan. Additionally, in an effort to provide an appropriate continuum of care, the consumer will be referred to any/all necessary ancillary services including: primary care, financial assistance, housing, and mental health treatment. Case managers will assure that consumers receive the recovery and ancillary treatment services they require. This may include facilitating appointments and travel to primary care, public assistance programs, Social Security appointments, job training, or any other services they might require.

Each service provider will complete standardized progress notes. Medical necessity will be evaluated on an ongoing basis to determine improvement, treatment plan compliance, relapse, or decompensation. The consumer will be reassessed at a minimum of 30 days for residential treatment and at a minimum every 90 days for outpatient treatment. Additionally,

consumers will be reassessed at the conclusion of every treatment level to determine the next level of services needed or no later than 6 months after entry into any determined level of care. Treatment plans will be reviewed during any significant change in consumer functioning to determine if an increased or decreased level of care is required. Should it be determined that a consumer requires an alternative level of care, the treating provider will complete a new assessment based on ASAM and medical necessity criteria. This process will allow consumers to navigate through the levels of care they require while maintaining engagement and access to all other integrated services.

As consumers progress through the continuum of care, their attendance, progress, and treatment episodes are tracked. SUD Providers will be required to track and monitor beneficiary progress, ensuring all components of treatment are tracked including: the number of referrals, completed assessments, and number of consumers entering treatment. M

Transitions and Case Management
As beneficiaries progress with their treatment plan, case management services will be utilized to assure the beneficiaries successfully transition from one level of care to another. Additionally, in an effort to provide an appropriate continuum of care, the consumer will be referred to any/all necessary ancillary services including: primary care, financial assistance, housing, and mental health treatment. Case managers will assure that consumers receive the recovery and ancillary treatment services they require. Case Managers may assist beneficiaries with transitioning to higher or lower levels of care, developing or revising their treatment plans, assisting with any necessary advocacy and linkage to treatment providers. This may include facilitating appointments and travel to primary care, assistance programs, social security appointments, job training, or any other services they may require. A multidisciplinary team will be utilized to identify and address the needs of beneficiaries with complex conditions who are high utilizers. It is expected that case management for high utilizers will focus on engagement, monitoring and care transitions and will occur outside of a formal treatment episode.

As beneficiaries progress within the continuum of care, their attendance, progress, and treatment episodes will be tracked by the Quality Improvement staff. The Quality Management (QM) staff will also review the number of referrals, completed assessments, and numbers of beneficiaries entering treatment.

3. Beneficiary Notification and 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)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).*

KCBH will operate a 24-hour toll free number, 7 days a week for beneficiaries to acquire general information about services, locations and phone numbers to clinic locations. The Toll

free number is available on the KCBH website and distributed widely to referring professionals. Access line services are available in Spanish (the county's only non-English threshold language) and are ADA TTY compliant.

During the initial stage of the implementation of the waiver, beneficiaries who call the toll free number will be given referral numbers to call to seek substance use services. However, later implementation of this plan will include trained crisis services workers and a licensed therapist to answer these calls and provide the ASAM standardized screening to callers. This new service will be implemented once these employees have been trained to administer the ASAM standardized screening tool.

Each call answered is logged and the following data is collected:

- Call time
- Call duration
- Caller's name
- Call type
- Disposition
- Person who answered the call

Other data collected includes:

- Insurance type
- Disposition type (Specialty, Network, SUD, 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

Individuals will be able to locate the access number at all Behavioral Health, SUD and Physical Health care sites throughout Kings County, as well as through 211 and websites for KCBH and SUD providers. Information describing the expanded functions of the Access line (to encompass all Behavioral Health, Mental Health and Substance Use Disorders) will be available in written postings in Kings County's threshold languages. KCBH will review Access Line records to ensure that beneficiaries receive appropriate services in a timely manner and to gather data for ongoing quality improvement efforts. Additionally, KCBH will conduct random test calls to the Access Line to assist in improving the quality and overall experience of connecting beneficiaries to services.

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 county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.*

KCBH maintains and monitors a network of providers under Board of Supervisors approved contracts, ensuring adequate access to services for beneficiaries. Services are individualized for beneficiaries when determined medically necessary and based on the level of care indicated utilizing the ASAM multidimensional assessment criteria. It is an expectation that all providers connect beneficiaries to services to meet other physical health, mental health, and ancillary service's needs based on the ASAM multidimensional assessment. All DMC network providers are required to meet established timely access standards.

Contracted DMC provider facilities are required to maintain DMC certification. Perinatal Services Network Guidelines are followed by the appropriate providers. Facility staff are licensed or certified and are in compliance with certification requirements. All contracted providers are required to comply with Federal, State, and local requirements, including KCBH standards and evidence-based practices that meet the DMC- ODS quality requirements.

Kings County is neighbored by counties who have chosen to opt-in to the DMC-ODS demonstration project. For that reason, we do not foresee many beneficiaries seeking services from opt-out counties. However, should KCBH receive a request for services from a beneficiary from another California county, services will be provided. A release of information will be obtained from the beneficiary in order to coordinate care and discuss Medi-Cal eligibility processes with other counties. Please see Table 1 below for a list of services that King's County will provide as part of the DMC-ODS.

Table 1: List of King's County's Proposed DMC-ODS Services

Service Type	ASAM Level	Required or optional
Early Intervention / Screening, Brief Intervention, and Referral to Treatment (SBIRT)	.05	Provided in partnership with existing primary care providers.
Outpatient Services /Outpatient Treatment Services	1	Required
Intensive Outpatient Treatment Services (IOT)	2.1	Required
Withdrawal Management Services (WM)	1-WM, 3.2-WM	1 level required
Residential Treatment Services (RTS)	3.1, 3.3, 3.5	1 level required in Year 1, all 3 by Year 3
Opioid/Narcotic Treatment Program (NTP)	1	Required
Additional Medication Assisted Treatment Services	1	Optional
Recovery Services		Required
Case Management		Required
Physician Consultation		Required
Recovery Residence		Optional

Service Descriptions

Early Intervention (ASAM Level 0.5)

A collaboration to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) will be made for the adult and adolescent populations. This collaboration will be with the existing managed care plans through Memorandums of Understanding. Managed care plan providers will ensure a substance use, physical, and mental health screening, including ASAM level 0.5 SBIRT services for all its members within primary care clinics, specialty care clinics, and the Emergency Department. Beneficiaries at risk of developing a SUD or those with an existing SUD are identified and offered: screening for adults, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage. Driving Under the Influence that qualify under the early intervention definition will be provided in accordance with the individuals assessed needs.

School sites will be utilized to offer early intervention services to adolescents. KCBH collaborates with selected school districts around the County to provide early intervention prevention services, to individuals identified by the school district. Students are screened in a neutral setting, usually the district office, by Prevention Coordinators to determine if students could benefit from an educational intervention. Those that are deemed appropriate for this type of intervention are maintained in the prevention program. Those who present a need for a higher level of care are referred to KCBH Access.

Outpatient Services (ASAM Level 1.0)

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

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 beneficiaries. Adolescents are provided a minimum of six (6) and a maximum of 19 hours 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.

Withdrawal Management Services (ASAM Level 1-WM, 3.2-WM)

Withdrawal Management services are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination. Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process. KCBH will offer ASAM Levels 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring by the end of implementation year 1. KCBH will offer ASAM Level 3.2-WM: Clinically-Management Residential Withdrawal Management by year 3 of implementation.

At this time, KCBH will not offer ASAM Level 2-WM; however we will review utilization and ASAM data and make a determination by the end of implementation year 2 whether there is a demonstrated need for this level of care within our continuum. Should a need be substantiated an RFP would be released for ASAM L 2-WM. KCBH will work with Adventist Health and other area service providers to assist beneficiaries to access ASAM Levels 3.7-WM (Medically-Monitored Inpatient Withdrawal Management) and 4.0-WM

(Medically-Managed Inpatient Withdrawal Management) when medically necessary. KCBH will coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care available within the DMC- ODS.

Residential Treatment Services (ASAM Levels 3.1, 3.3, 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 identified by the ASAM assessment.

The length of stay for residential services may range from 1-90 days, unless a re-assessment of medical necessity justifies a one-time services reauthorization/extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice involved beneficiaries may receive a longer length of stay based on medical necessity.

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

KCBH currently offers ASAM designation 3.1 for males and females, as well as perinatal residential services. It is anticipated that current providers will be able to acquire ASAM residential levels 3.3 and these services will be available at implementation of DMC- ODS provided, timely DMC Certification can be secured from the DHCS Provider Enrollment Division. KCBH will ensure ASAM level 3.5 is available within 3 years of final approval of the County's implementation plan and will follow the County policy and process for selecting new providers.

KCBH does not currently have any Residential treatment facilities for adolescents or Residential Level 3.7 (Medically Monitored Intensive Inpatient Services) and Level 4.0 (Medically Managed Intensive Inpatient Services) facilities. For Residential Levels 3.7 and 4.0, KCBH will coordinate care with the managed care plans. For adolescent residential services, KCBH will provide referrals to out-of-county facilities and will enter into a contract agreement for these services.

Although, KCBH will not offer in county adolescent residential services, we will review utilization and ASAM data and make a determination by the end of implementation year 2 whether there is a demonstrated need for this service within our county. KCBH will provide referrals to out-of-county facilities and will enter into a contract agreement for Residential treatment services. In all instances, KCBH will ensure 42 CFR compliant releases are in place in order to coordinate care with inpatient and out-of-county facilities

accepting Drug/Medi-Cal beneficiaries that are Kings

County residents. For beneficiaries in any residential treatment program, case management services will be provided to facilitate "step down" to lower levels of care and support.

Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1)
These services are medically necessary and are provided in NTP licensed facilities in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber. Beneficiaries may be simultaneously participating in OTP services and other ASAM levels of care.

NTP treatment components include intake, individual and some group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services. An opioid maintenance criterion is a two-year history of addiction, two treatment failures, and one year of episodic or continued use, pursuant to Title 9 CCR §10270(d). NTP treatment involves the direct administration of medications on a routine basis as determined by the NTP prescribing physician.

Beneficiaries will receive a minimum of 50 minutes of counseling with a therapist or counselor for up to 200 minutes per calendar month. Additional services may be provided based on medical necessity. Services will be provided based on information gathered during the initial needs assessment. Treatment plans will be updated within regulatory timeframes or as new treatment issues manifest during the treatment episode.

NTP programs will be required to offer and prescribe as needed, Methadone, Buprenorphine, Naloxone, and Disulfiram. In addition, proof of consumer understanding on choices of medications and treatment without medication will be documented in the patient record.

Currently residents of Kings County seek NTP treatment from the neighboring counties of Fresno, Tulare and Kern. Kings County will continue to fund NTP services provided to its residents out of county until a provider is selected within the county. Kings County will work to ensure rural areas of the county have access to NTP services.

Additional Medication Assisted Treatment (MAT) Services
These services include the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Licensed prescribers determine medically necessary services and develop individualized treatment plans for beneficiaries.

At this time Kings County has one FQHC provider that offers Suboxone. This is the only additional MAT services that Kings County anticipates in year 1. Kings County will continue to review data collected throughout implementation, and work to expand this level of service if need is indicated through these ongoing reviews.

Recovery Services
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 rely on community resources for ongoing support.

Recovery services may be provided face-to face, by telephone, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the beneficiary or re-assess the need for further care, recovery monitoring and/or recovery coaching, 12-step, peer-to-peer services and relapse prevention, education and job skills, family support, support groups and linkages to various ancillary services. Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries. These services may be provided by a Licensed Practitioner of the Healing Arts (LPHA), counselor, or Peers.

Case Management Services

Case management services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. Case management services are provided for beneficiaries who may be pre-contemplative and challenging to engage, and/or those needing assistance connecting to treatment services, and/or those beneficiaries stepping down to lower levels of care and support.

Case management services may include: comprehensive assessment, level of care identification, beneficiary plan development, coordination of care with mental health and physical health, monitoring access to SUD treatment, beneficiary advocacy and linkages to other supports including but not limited to mental health, housing, transportation, food, and benefits enrollment. Case managers will be trained in and utilize evidence-based practices such as trauma-informed care, cultural competency, Motivational Interviewing (MI), harm reduction strategies, and strength based approaches. Case management services can be provided at DMC provider sites, county locations, hospitals, health centers and other community-based sites appropriate for providing these services to the beneficiary.

Services may also be home-based, if deemed clinically appropriate. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary by a Licensed Practitioner of the Healing Arts or certified counselor. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law. Case management will be provided anywhere in the continuum of care with a special focus on assuring that the beneficiary is assisted in the transition between levels of care and linked to all necessary ancillary services as outlined in their treatment plan.

Physician Consultation

Physician Consultation includes DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians with seeking expert advice on designing treatment plans and supporting DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. KCBH intends to contract with at least one physician consultation services will only be billed by and reimbursed to DMC providers.

Recovery Residences
Recovery Residences, transitional living, and sober living homes are affordable, alcohol and drug free environments that provide a positive place for peer group recovery support. Sober housing promotes individual recovery by providing an environment that allows the residents to develop individual recovery programs and become self-supporting. While meant to be a transitional living situation, there is no maximum length of stay. KCBH is developing standards for contracted RR providers and will monitor to these standards. RRs are not reimbursable through Medi-Cal.

Optional Service Levels Pending ASAM Utilization Review
KCBH will consider whether to offer additional, optional DMC services once baseline data on beneficiary ASAM service need and utilizations has been collected and analyzed after year 1. If an unmet need for a service is determined, KCBH will amend its implementation plan to incorporate the additional service(s) and will initiate an RFP process to identify qualified providers.

Barriers
Remaining barriers to the required service levels will be expansion of all levels of Residential treatment for adolescents. Given the costs associated with opening new facilities, coupled with the local challenges related to obtaining zoning approvals for substance use treatment services, the most feasible solution to addressing these barriers will most likely involve seeking contracts with out-of-county providers. We also anticipate DMC certification delays.

Another challenge might be recruitment and retention of qualified bilingual (English and Spanish) staff. Potential strategies to address this barrier include offering recruitment incentives, such as higher salaries for bilingual staff, opportunities for providing supervision for intern hours, and offering partial reimbursement of related tuition expenses.

An additional barrier is geographic location and related beneficiary transportation barriers in the even we need to utilize out-of-county contracted providers.

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

KCBH consists of substance use and mental health services consolidated into a single department within Kings County. The SUD program manager reports to the County Mental Health Director who is responsible for all mental health and substance use services. Specialty MH services, for adults with serious and persistent mental illness and youth with sever emotional disturbances, are managed and delivered through a combination of County-operated and community based providers, some of whom also provide SUD services.

We are looking to expand integration with mental health care by co-locating substance use disorder services and/or mental health care clinics and locations. To support the integrated approach to behavioral health care beneficiaries receiving treatment services with a SUD provider that provides both mental health and substance use services and who is in need of mental health treatment will receive treatment in house.

Beneficiaries who are receiving treatment services from a SUD provider who does not provide mental health services and is in need of mental health treatment will be linked to the Kings County Mental Health Plan Same Day Access unit for specialty mental health services or other non-specialty mental health community providers. Outpatient and residential contracted providers will collaborate with case management staff to assist beneficiaries with linkage to the Mental Health service system.

Beneficiaries who are currently receiving mental health services through Kings County Mental Health Plan or its contracted providers and need substance use services can be linked directly through the Beneficiary Access Line, County Access unit, or be directed to any of the SUD contracted provider locations. The beneficiary will receive a screening and a referral to the appropriate level of care.

KCBH maintains a case management system for both mental health and substance use disorders. As such, case management staff will discuss confidentiality requirements in Code of Federal Regulations, Title 42, Part 2 (42 CFR, Part 2), and will ensure that beneficiaries are given sufficient information to allow them to give informed consent to authorize communication with mental health case management staff. Through this communication, staff will coordinate with the beneficiary to determine the role of each staff connected with the case to avoid duplication of services and ensure that the individual's needs are met. Mental Health and SUD Case management staff will maintain contact through the course of the beneficiary's treatment episode. KCBH wills seek to provide technical assistance to all SUD network providers and mental health staff to ensure inter-agency care coordination for beneficiaries.

The MOU with Medi-Cal Managed Care Plans will outline the screening, referral and care coordination procedures that he department will follow for beneficiaries eligible for services provided through other health plan entities.

SUD treatment providers, at a minimum, are required to coordinate with the appropriate Mental Health provider to seek treatment for beneficiaries with co-occurring disorders when such services are not part of their own menu of services. For any beneficiary who screens positive for mental health disorders, the KCBH will require DMC-ODS providers to include in the beneficiary's treatment plan an objective to obtain further assessment of the mental health disorder, and a coordinated referral to mental health treatment and/or direct provision of mental health services by the SUD treatment provider. Coordination with mental health care will be monitored during internal and contract audits by Quality Improvement staff on an annual basis.

6. **Coordination with Physical Health.** *Describe how the counties 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?*

Physical health care for Medi-Cal beneficiaries in Kings County is provided by Family Health Care Network, United Health Centers, Aria Community Health Center, and Adventist Health. While each provider has its own model of coordinating with KCBH mental health and substance use disorders services, all organizations highly value collaboration and coordination of care. We are looking to expand integration with primary care by co-locating substance use disorder services and/or physical health care clinics and locations.

Managed care plan providers will ensure a substance use, physical, and mental health screening, including ASAM level 0.5 SBIRT services for all its members within primary care clinics, specialty care clinics, and the Emergency Department. Beneficiaries at risk of developing a SUD or those with an existing SUD are identified and offered: screening for adults, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

KCBH will continue to require that all beneficiaries receiving SUD treatment services attend to their physical health needs by requiring documentation of a physical exam. A large proportion of individuals in outpatient and residential treatment settings report they have not had a physical exam in an extended period of time due to their drug use, and have not attended to their physical health needs.

The minimum initial coordination goals that we will ask the providers to adhere to will include listing any biomedical conditions and complications on the individualized treatment plan to allow progress in this area to be evaluated. Authorization will be obtained from beneficiaries with medical concerns (ASAM Dimension 2) to communicate with relevant medical providers to coordinate care and create shared treatment plans to address beneficiary goals regarding physical health. If the beneficiary has had a physical exam within the last 12 months, providers will obtain documentation of this exam. If the beneficiary has not had a physical exam during this timeframe, this will be listed on the individualized treatment plan and staff will review progress in this area.

Case management staff will assist providers in ensuring that beneficiaries have appropriate resources to address physical health needs. Case management staff may assist the beneficiary with navigation of managed care plans, selecting a physician, and/or scheduling an appointment Communication with the SUD treatment provider will be essential in ensuring follow up while the beneficiary continues in treatment.

Coordination with physical health care will be monitored during internal and contract audits by Quality Improvement staff on an annual basis.

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.*

The challenges currently anticipated are ensuring that all physical and mental health partners and beneficiaries understand the requirements related to 42 CFR, Part 2 and that procedures and forms are updated to effectively enable the communication necessary for effective care coordination, shared plan development and collaborative treatment planning, particularly as mental health, physical health and substance use are using separate electronic health records.

While partners are committed to participating in integrated and collaborative services—and substance use treatment providers already have 42 CFR, Part 2 protections in place—the infrastructure is currently not in place for all partners, and may require technical assistance during the initial implementation period.

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

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

Anticipated Medi-Cal Beneficiaries
KCBH analyzed data from several different public sites in order to estimate the number of individuals that would seek SUD services. Table 1 shows the trend in Kings County's overall population as well as the number of Medi-Cal beneficiaries (MCB). The data illustrates the impact of Medi-Cal expansion on the number of Medi-Cal beneficiaries in Kings County. According to 2017 DHCS Medi-Cal enrollment data, approximately 39% (58,121) of Kings County residents were eligible Medi-Cal beneficiaries.

According to the 2008-2010 National Survey of Drug Use and Health, 2013 American Community Survey, up to 14.2% of the Medicaid population meets the diagnostic criteria for a substance use disorder, while the California Department of Health Care Services Behavioral Health Needs Assessment, Vol. 2 2013, page 30, estimates 10.3% of the population meets criteria for a SUD. For the purpose of determining prevalence rates and projecting utilization moving forward, KCBH will use the mean average of both the federal and state estimates, which equates to 12.25%. Applying this prevalence rate to Kings County's Medi-Cal Beneficiary pool, KCBH projects approximately 7,085 have a SUD and could benefit from treatment. However, 2015 SAMHSA data indicates that only 10.8% of those who needed treatment received treatment in a specialty SUD treatment program. Given this data, (See Table 2 below) KCBH projects approximately 748-754 beneficiaries will access treatment services under the waiver expansion.

Table 2: Estimated Growth in Medi-Cal Beneficiaries

Data Points	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Kings County Population	149,702	149,407	150,441	151,675
Estimated Medi-Cal Beneficiaries	57,835	57,722	58,121	58,598
Mean Estimated SUD Prevalence	12.25%	12.25%	12.25%	12.25%
Estimated Beneficiaries Needing SUD Services	7,085	7,071	7,120	7,178
Estimated Penetration Rate	10.8%	10.8%	10.8%	10.8%
Estimated Medi-Cal Beneficiaries Accessing SUD Services	744	742	748	754

Current Provider Capacity and Expected Utilization of Services by Service Type
KCBH used historic data gathered from the CalOMS database to establish the baseline data used to calculate its post DMC-ODS estimates. Kings County will analyze utilization for all levels of services ongoing during the waiver implementation, and will work accordingly with providers to increase capacity as needed to properly serve the Kings County DMC SUD population.

Table 3: Current Provider Capacity and Expected Utilization of services by service type				
ASAM Level of Care	FY 15/16	FY 16/17	FY 17/18 (Projecte	FY 18/19 (Projecte
Outpatient	203	350	400	500
Intensive Outpatient	0	48	48	60
Residential*	15	20	20	69
Withdrawal Management	0	0	0	96
NTP	55	57	59	90

**beds*

Number and Types of Providers
KCBH currently has an established network of treatment providers. Please see Table 4 below.

Table 4: Providers, location, language capability, hours of operation and ASAM Level				
Providers	Location	Language Capability	Hours of Operation	ASAM Levels
Champions Recovery Programs	Hanford, Lemoore, Avenal	English, Spanish	24/7, M-S 8:30am-5:30pm, M-F 11:00am-8:00pm	1.0, 2.1, 1-WM, 3.2 WM, 3.1, 3.5
Kings View Counseling Services	Hanford, Corcoran, Tulare	English, Spanish	M-F 8:00am-7:00pm	1.0, OTP 1
WestCare, Inc.	Hanford, Corcoran	English, Spanish	M-F 7:00am-5:00pm	1.0
Eminence, Inc.	Hanford, Lemoore, Corcoran, Avenal	English, Spanish	M-F 7:00am-5:00pm	1.0

Hours of operation of providers
In addition to 24-hour, 7-day/week residential services, providers of other ASAM level of care services will be required to offer services at hours that meet the needs of beneficiaries, including varying evening and weekend options across the continuum of providers in the County.

Projected Language Needs
The threshold languages in Kings County are currently English and Spanish. KCBH ensures that all contracted providers provide all written information in Spanish. KCBH will also have access available to language lines for translation purposes when necessary. Kings County's current ODF and Perinatal providers have programs specifically for Spanish speaking beneficiaries and have bilingual staff.

Access Standards and Timeliness Requirements
KCBH and its providers are dedicated to providing timely access to services for all beneficiaries. Clear standards are required for access, timeliness of services, and after-hours

availability as outlined in the Quality Improvement Plan. These standards will be utilized in

quality review monitoring. The measurement tools for these service areas consider data extracted from the county's electronic health record based on dates of service provision.

These standards will be embedded in provider contracts, and will be measured by determining the number of days from initial screening to first appointment with the appropriate treatment provider.

Table 5: Access Standards and Timeliness Requirements	
Type of service	Access standard
Length of time from first request for service to first clinical assessment	Within 14 calendar days
Length of time from first request of service to first clinical assessment for priority populations	48 hours
Access to after-hours care: percentage of services provided outside of regular working hours (evening, early morning, weekends)	4%
Frequency of follow up	In accordance with individualized treatment plans
Average length of time for urgent appointment/service	Within 48 hours
Length of time from first request for service to initial medication service in Medication Assisted Treatment Setting	Within 14 calendar days

Kings County has an existing 24-hour access line on the mental health side and staff operating this access line will be trained regarding the SUD continuum and ASAM standardized screening tool so services can be screened for 24 hours per day, 7 days per week, including holidays.

Location of Providers and Medi-Cal Beneficiaries
In consideration of distance, travel time, transportation, and access for beneficiaries with disabilities, KCBH has established a network of providers in various cities in the county, as listed in Table 3. These locations are accessible by public transportation as well as transportation services specifically identified for persons with disabilities. KCMH also has providers in the outlying areas of the county in order to make treatment available to residents in rural communities. All provider contracts include required compliance with the Americans with Disabilities Act (ADA) to ensure access to people with disabilities.

Addressing Service Gaps, including assess to MAT services
A primary service gap for Kings County beneficiaries is transportation. As a rural County, with many services close to the County seat of Hanford, other areas throughout Kings County often lack regularly available Behavioral Health services. We have begun to increase services to Avenal but will need to continue to grow and expand services into Corcoran. As DMC-ODS implementation gets underway, we will be able to define and understand service gaps specific to SUD programs. Additionally, site reviews and ongoing KPN meetings will

maintain the topic of 'Addressing Service Gaps' on standing agendas/reviews. As gaps are clearly identified, system review of resources to address the need will be engaged, along with pursuit of collaborations, additional funding, etc., to minimize/eliminate service gaps ongoing. Currently residents of Kings County seek NTP treatment from the neighboring counties of Fresno, Tulare and Kern. Kings County will continue to fund NTP services provided to its residents out of county until a provider is selected within the county. Kings County will work to ensure rural areas of the county have access to NTP services.

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

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

KCBH will assure compliance with applicable access to care requirements outlined in 42 CFR 438.206 through the following:

Contracts for DMC-ODS Services: KCBH will include language in DMC-ODS contracts 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 currently 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 waiting times and appointments.

Monitoring Quality and Compliance of DMC-ODS Services: In addition to the in-depth annual monitoring process, which includes issuing a Self-Audit for providers to complete, reviewing applicable policies and procedures, and conducting an onsite review, KCBH will perform ongoing compliance monitoring and quality assurance activities, including, but not limited to: reviewing County-operated and network provider systems for documenting timely access to care; collecting and analyzing timely access to care data via monthly utilization reviews, and review of KCBH Access Log data; and performing test calls at least quarterly to the KCBH Access Line.

In the event of non-compliance with timely access to care requirements, KCBH will offer technical assistance to adhere to the requirements. KCBH will also issue a written report documenting the non-compliance and require a Corrective Action Plan be submitted to the County.

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

KCBH SUD trainings are determined through our KPN meetings on an annual basis and offered to staff and community-based providers throughout the year. These trainings are held to the National CLAS Standards, Department of Health Care Services' guidelines as well as specific professional association standards (such as APA, CAADE/CAADAC, BBS, etc.) related to effective service provision including clinical and counseling care as well as responsiveness to working with diverse communities. Training identified as evidenced-based, community-defined as well as promising practices will be highlighted in the training curriculum.

Table 6: Standard Trainings

Training Title/Subject	Mandatory/Optional	**Frequency**
Title 22/DMC regulations	Mandatory	Annually
ASAM Criteria	Mandatory	Annually
Cultural Competency	Mandatory	Semi-Annually
Motivational Interviewing	Optional	As needed
Trauma-Informed Care	Optional	As needed
Cognitive Behavioral Therapy	Optional	As needed
Documentation and EHR	Mandatory	Quarterly
Human Trafficking	Mandatory	Annually

In addition, training in other evidence-based practices such as relapse prevention, psycho-education, and cognitive behavioral therapy, and other specialized areas, as needed, will be provided. A central system to track attendance at all trainings will be maintained. Staffs that are in need of continuing education units will be able to obtain credit through many of the trainings offered. Training and technical assistance on an ongoing basis will also be available for providers who will need additional support in issues related to DMC certification.

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

KCBH has identified several technical assistance needs:

1) Strategies for integrating inter-agency care coordination within SUD treatment programs that includes primary care, mental health, and peer support as part of the beneficiary treatment, recovery and aftercare/ discharge planning process;
2) Strategies for integrating the use of ASAM level of care criteria within professional practice through workforce skills building and accountability;

3) Strategies for fidelity management of evidence-based practices being implemented under the DMC-ODS Pilot;
4) Strategies for developing standardized county treatment protocol and payment mechanisms to ensure that treatment needs of out-of-county beneficiaries are met.
5) A comprehensive list of licensed residential youth treatment facilities that have been DMC certified.

12. **Quality Assurance.** *Describe the County's Quality Management and Quality Improvement programs. 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 a minimum include:*

- *Timeliness of first initial contact to face-to-face appointment*
- *Frequency of follow-up appointments in accordance with individualized treatment plans*
- *Timeliness of services of the first dose of NTP services*
- *Access to after-hours care*
- *Responsiveness of the beneficiary access line*
- *Strategies to reduce avoidable hospitalizations*
- *Coordination of physical and mental health services with 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.*

Review Note: 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 KCBH will complete an annual monitoring site visit for all programs of contracted SUD service providers within Kings County. Providers will be reviewed for compliance with DMC-ODS contract requirements. Provider who are determined to be out of compliance will be given direction to necessary training required to meet the standards of participation in the waiver and may be required to develop a plan of correction to address a deficiency, face possible fiscal sanctions and or up to possible termination or adjustment of their contract. Copies of annual audits will be submitted to DHCS within 2 weeks of issuance.

Quality Assurance activities have primarily been a function of the contracted provider for the Kings County Mental Health Plan. Quality Management for DMC-ODS is planned to

be integrated into the existing structure. Quality Assurance activities are currently undergoing a transfer to KCBH management.

Currently the MHP has developed the Quality Improvement Plan, focused on key outcome areas and which serves as a guideline for annual QI activities. Components of the plan include: monitoring beneficiary satisfaction; improving active participation in QI activities by beneficiaries, family members, staff and other stakeholders; updating policies and procedures to improve clinical practice and reduce audit disallowances; improving training participation, documentation and quality of care; implementing, assessing, and reporting on performance improvement measures.

Kings County has a Quality Improvement Committee (QIC) that is chaired by the Quality Improvement Director/designee. Members of the Quality Improvement (QI) Committee include SUD Administrator, KCBH Deputy Director, Adult Mental Health Program Manager, Children's Mental Health Program Manager, Crisis Services Manager, Finance Administrator, Contracted Providers, consumers, family members, and other interested stakeholder groups including contractors. The QI Steering Committee is made up of KCBH managers and contract managers. Each Committee meets regularly to follow up on existing work, review and provide feedback to other committees, and bring new ideas to improve workflow. The QIC will establish SUD quality assurance and quality improvement functions into existing quality management and improvement processes. SUD management and staff will be included in the membership of the QIC.

QM's main objective will be to monitor the compliance, performance, and quality of all publicly funded SUD treatment services and establish processes for ongoing quality improvement in the SUD system of care. KCBH will have an integrated utilization management and review function for the system of care as a whole, by building on existing processes that serve the MH Plan and, to a lesser extent currently, the SUD System of Care, while developing SUD-specific processes required by the DMC-ODS Waiver. QM's focus will be to establish a quality management infrastructure for an outcome driven and quality focused SUD service continuum. QM will determine quality standards and ensure continuous improvement in the delivery of services.

The Quality Improvement Plan will at a minimum include:

- Timeliness of first initial contact to face-to-face appointment
- 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
- Telephone access line and services in the prevalent non-English languages.
- Frequency of follow-up appointments in accordance with individualized treatment plans

The QIC will review these measures on a quarterly basis using reports provided by the QM

Program Manager. KCBH expects that the QIC, through the various subcommittees, will

identify additional quality measures as DMC-ODS implementation begins. New measures will be integrated into the existing QI process on both an annual and as needed basis.

Assessment of Beneficiary Experiences, Including Grievances and Appeals
Grievance and appeal forms are available to the public in the lobby of all program clinics and facilities. The right to request a grievance or appeal is reviewed with all beneficiaries during the intake process and documentation regarding their right to appeal a grievance is provided. Information about a state fair hearing is provided, should the appeal process render an unsatisfactory resolution. Grievances and appeals are coordinated through the Patients' Rights office in collaboration with the SUD Administrator. The Patients' Rights office shall collect, categorize and assess beneficiary complaint data, and monitor all grievances and appeals.

Beneficiaries may submit a Grievance or Appeal verbally or in writing, by phone or in person to any treatment clinic. The timeframe for grievance resolutions is within 60 calendar days of receipt. Appeals will be resolved within 45 working days, and expedited appeals within 3 working days. These timeframes for resolution may change according to updates in Federal and State regulations. The content of an appeal resolution includes the final disposition of the grievance or appeal, the date the grievance was made, the beneficiary's right to a State Hearing if the problem was a result of an action and was not resolved to the beneficiary's satisfaction, right to request benefits during the appear, and the procedures for requesting the State Fair Hearing.

Records relating to grievances and appeals are maintained by the KCBH Patients' Rights Office. Beneficiary benefits remain in place throughout the grievance and appeal process. Beneficiaries may verbally, or in writing, file for a State Fair hearing, after the exhaustion of an Action Appeal or Expedited Action Appeal process.
Telephone Access Line and Services in the Prevalent Non-English Languages
The Beneficiary Access Line will have the capacity to serve individuals whose preferred language is not English through the use of bilingual staff and the department's interpreter line. Quality Improvement staff will monitor these standards and make recommendations for improvement during annual reviews.

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

DMC-ODS providers will be required to implement at least two of the following evidence based practices (EBPs): Motivational Interviewing; Cognitive Behavioral Therapy; Relapse Prevention; Trauma-Informed Care; and Psycho-Education. KCBH will ensure that all providers are implementing at least two of the identified EBPs through the following:

- Incorporating the requirement to implement at least two of the EBP's listed in all Requests for Proposals for DMC-ODS services
- Including provisions in all contracts for DMC-ODS services requiring providers to implement at least two of the identified EBP's. Providers will need to list the specific

EBP's in the contract, as well as information on how they will be implementing the EBP's with fidelity.

- Similar to all quality and compliance monitoring, KCBH will monitor adherence to implementing at least two of the identified EBP's through review and approval of the contract language; mid-year monitoring, which includes onsite monitoring visit; and review of progress/annual reports.

If a provider is found to be in non-compliance, KCBH will offer technical assistance to adhere to requirements, as well as issue a written report documenting the non-compliance and requiring a Corrective Action Plan be submitted to the County.

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

Although KCBH intends to coordinate with neighboring counties, KCBH is not proposing to implement a regional model at this time.

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

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

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

Kings County has two Medi-Cal managed care health plans (MCP), Anthem Blue Cross and Cal-Viva Health. KCBH has met with MCPs and is developing proposed language for the amended MOUs to incorporate related provisions from the DMC-ODS STCs. The MOUs will also outline mechanisms for sharing information and coordination of service delivery and case management delineation.

All provisions will be in compliance with 42 CFR Section 438. MOUs and associated policies and procedures will be complete prior to the DMC-ODS Waiver implementation date. Kings County has attached a draft of the amended MOU (Attachment B); when approved it will become an addendum to the Implementation Plan.

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

KCBH will consider providing Telehealth SUD services to rural Kings County residents when it is determined that services are medically necessary. The program will follow both ASAM protocols and Medi-Cal procedures for treatment continuation.

Kings County will monitor the utilization of telehealth SUD services for efficacy and feasibility, and will make efforts to expand the service as needed. The standard of care for telehealth will be equivalent to that of in-person treatment. Policies and procedures will be developed to ensure informed consent, confidentiality and privacy protections in accordance with 42 CFR, Part 2, and to ensure that adequate infrastructure to support this service exists. Telehealth treatment will be monitored at least annually.

17. **Contracting.** *Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?*
The power to bind the County lies with the Board of Supervisors, County Administrative Officer and the Purchasing Manager. For contracts that can be executed by the Purchasing Manager, not to exceed $50,000 for services and $100,000 for goods, the contracts should be submitted to the Purchasing Division and County Counsel for review. This should be done at least thirty working days prior to the anticipated starting date of the services. Contracts over $100,000 for goods, or $50,000 for services, require Board of Supervisor approval.

In order to ensure continuity of care during the selective provider contracting process, it is the practice of KCBH not to terminate services without having comparable services available for beneficiaries. It is also a contract requirement that providers give 30-day written notice should they decide to terminate the contract, thereby giving time to ensure beneficiaries are transitioned to another provider for services. Contract term will typically be one year but can be for multiple years, not to exceed three years.

Currently executed contracts will be amended with the updated DMC-ODS services and rates once the Implementation Plan has been approved and DHCS and Kings County have executed the Intergovernmental Agreement.

If an existing provider does not receive a contract of DMC-ODS services, KCBH and the provider will collaboratively develop a transition plan to transfer the care of existing clients to appropriate DMC-ODS providers, taking care to ensure that ongoing services are not interrupted, client confidentiality is maintained, and that clients are respectfully treated, fully informed, and involved in the transition.

Any bidder, proposer, or contractor who is allegedly aggrieved in connection with the solicitation or award of a contract may protest. Bidders are to be advised that protests of the process, terms, conditions or any other aspect of the solicitation, must be made prior to the bid or proposal due date. Bidders and proposers may not protest the contents of the specifications of the bid/RFP nor the award based on the use of the Local Vendor Preference. Protests must be transmitted by facsimile, email or by mail to the attention of the Purchasing Manager.

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

At this time Kings County has one FQHC provider that offers Suboxone. This is the only additional MAT services that Kings anticipates providing in year 1. Kings County will continue to review data collected throughout implementation, and work to expand this level of service if need is indicated through these ongoing reviews.

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

Authorization for placement in any of the three required levels of residential care (3.1, 3.3, and 3.5) will require authorization by KCBH.

Beneficiaries who meet medical necessity and the ASAM criteria for residential treatment will be authorized for enrollment into a residential program for up to 72 hours. This 72 hour (3 day) period will allow the provider to complete a comprehensive assessment incorporating ASAM Placement Criteria and all necessary intake/authorization paperwork to be submitted to KCBH Administration. KCBH Administration will review, approve, pend, or deny within 24 hours of receipt of preauthorization paperwork. This will result in a post authorization without disrupting treatment for the beneficiary. The length of authorization of residential services ranges from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90- day regimens will be authorized in a one-year period. Perinatal and criminal justice clients may receive a longer length of stay based on medical necessity. If longer lengths of stay are needed, other non-Medi-Cal funds can be used.

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KCBH will track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied.

20. **One Year Provisional Period.** *For counties 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 county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.*

This is not applicable as Kings County meets the mandatory requirements upon implementation.

County Authorization

The County Behavioral Health Director for Kings County must review and approved the Implementation Plan. The Signature below verifies this approval.

Lisa D. Lewis, PhD
County Mental Health Director

Kings
County

9/1/17
Date

ATTACHMENT A

Kings County Provider Network					
Provider	Location	Modality	Current Patient Load	DMC-ODS Capacity	Populations Served
Champions Recovery Programs	Hanford	ODF	220	285	Adult
Champions Recovery Programs	Avenal	ODF	40	40	Adult
Champions Recovery Programs	Hanford	IOT	48	60	Adult/Perinatal
Champions Recovery Programs	Hanford	Perinatal Residential	20	20	Perinatal
Champions Recovery Programs	Lemoore	Adult Residential	0	49	Adult Males
Champions Recovery Programs	Hanford	WM	0	12	Perinatal
Champions Recovery Programs	Lemoore	WM	0	48	Adult Males
Kings View Counseling Services	Hanford	ODF	80	80	Adult
WestCare, Inc.	Hanford	ODF	40	40	Youth
WestCare, Inc.	Corcoran	ODF	10	10	Youth
Eminence, Inc.	Avenal	ODF	21	21	Youth
Eminence, Inc.	Corcoran	ODF	12	12	Youth
Eminence, Inc.	Lemoore	ODF	12	12	Youth
Kings View	Tulare	NTP	59	90	NTP/MAT

ADDENDUM TO COORDINATION OF SERVICES MENTAL HEALTH MEMORANDUM OF UNDERSTANDING

This Addendum is an addendum to the signed Memorandum of Understanding (MOU) between County of Kings Department of Behavioral Health (hereinafter referred to as COUNTY) and Blue Cross of California Partnership Plan, Inc. (hereinafter referred to as ANTHEM). The purpose of the Addendum is to describe the responsibilities of the COUNTY and ANTHEM for coordination of Medi-Cal alcohol and other drug services for Plan Members served by both parties under the Department of Health Care Services (DHCS) Medi-Cal Managed Care Program.

This Addendum delineates the specific roles and responsibilities by ANTHEM and COUNTY for screening, referral, coordination and delivery of alcohol and other drug services for Medi-Cal beneficiaries, who meet the medical necessity criteria for Medi-Cal services and identified by DHCS as a Medi-Cal Managed Care Health Plan benefit. MHSUDS Information Notice No: 16-005 has been used as the reference for the required elements in the Addendum. All references in this addendum to "Members" are limited to individuals assigned to or enrolled in the ANTHEM health plan.

BACKGROUND

On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's Health and Human Services Agency request for approval regarding the California section 1115 five-year Medicaid Demonstration, titled "California's Bridge to Reform" (Waiver 11-W-00193/9) under the authority of section 1115(a) of the Social Security Act. On December 30, 2015, CMS approved California's 1115 Waiver Renewal, titled Medi-Cal 2020, to continue to pursuit a positive transformation of the Medi-Cal system.

On August 13, 2015, CMS approved the California Department of Health Care Services proposed amendment of the Special terms and Conditions of Waiver 11-W-00193/9. This amendment to California's Bridge to Reform Waiver authorizes California to implement a new paradigm for Medicaid eligible individuals with substance use disorder (SUD) called the Drug Medi-Cal Organized Delivery System (DMC-ODS). Critical elements include:

- Providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services
- Increased local control and accountability
- Greater administrative oversight
- Creation of utilization controls to improve care and efficient use of resources
- Evidence based practices in substance abuse treatment
- Integrate care with mental health and physical health

TERMS

The MOU, as modified by this Addendum, constitutes the entire understanding and obligation of the parties and supersedes any prior agreement, writings, or understanding of the parties, whether oral or written, in each case with respect to the subject matter of the MOU. This Addendum shall commence on [ENTER DATE HERE], 2017 and shall continue under the terms of the existing MOU.

OVERSIGHT RESPONSIBILITIES OF THE CHWP AND COUNTY

1. ANTHEM has responsibility to work with the COUNTY to insure that oversight is coordinated and comprehensive and that the Member's healthcare is at the center of all oversight. Specific processes and procedures will be developed cooperatively with COUNTY, as well as any actions required to identify and resolve any issues or problems that arise.

2. The COUNTY will serve as the entity that will be responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the addendum to the existing MOU.

3. ANTHEM and COUNTY will formulate a multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. ANTHEM and COUNTY will determine the final composition of the multidisciplinary teams to conduct this oversight function.

4. ANTHEM and the COUNTY will designate as appropriate and when possible the same staff to conduct tasks associated within the oversight and multidisciplinary clinical teams.

SPECIFIC ROLES AND RESPONSIBLITIES

A. Screening, Assessment and Referral

1. Determination of Medical Necessity

a. The COUNTY will follow the medical necessity criteria outlined for the Drug Medi-Cal Organized Delivery System described in the 1115 Waiver Standard Terms and Conditions. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program.

b. ANTHEM will be responsible for determining medical necessity as it relates to covered health care benefits, as outlined in 22 CCR51303(a).

2. Assessment Process

   a. ANTHEM and COUNTY shall develop and agree to written policies and procedures regarding agreed-upon screening, assessment and referral processes.

b. ANTHEM and COUNTY will distribute to the community and to their providers the current version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC Adult & Adolescent) crosswalk that identifies the criteria utilized to assist with determining the appropriate treatment level of care to ensure providers are aware of SUD levels of care for referral purposes.

c. ANTHEM providers will ensure a substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services for Members, is available.

3. Referrals

a. ANTHEM and COUNTY shall develop and agree to written policies and procedures regarding referral processes and tracking of referrals, including the following:

i. The COUNTY will accept referrals from ANTHEM staff, providers and Members' self-referral for determination of medical necessity for alcohol and other drug services.

ii. ANTHEM will accept referrals from COUNTY staff, providers and Members' self-referral for physical health services.

B. Care Coordination

1. ANTHEM and COUNTY will develop and agree to policies and procedures for coordinating health care for Members enrolled in ANTHEM and receiving alcohol and other drug services through COUNTY.

2. An identified point of contact from each party to serve as a liaison and initiate, provide, and maintain the coordination of care as mutually agreed upon in ANTHEM and COUNTY protocols.

3. Coordination of care for alcohol and other drug treatment provided by COUNTY shall occur in accordance with all applicable federal, state and local regulations. A process for shared development of care plans by the beneficiary, caregivers and all providers and collaborative treatment planning activities will be developed to ensure clinical integration between DMC-ODS and managed care providers.

4. ANTHEM and COUNTY will promote availability of clinical consultation for shared clients receiving physical health, mental health and/or SUD services, including consultation on medications when appropriate.

5. The delineation of case management responsibilities will be outlined.

6. Regular meetings to review referral, care coordination, and information exchange protocols and processes will occur with COUNTY and ANTHEM representatives.

C. Information Exchange

ANTHEM and COUNTY will develop and agree to information sharing policies and procedures and agreed upon roles and responsibilities for timely sharing of personal health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3) and other pertinent state and federal laws and regulations, including the Health Insurance Portability and Accountability Act, Title 22 and 42 CFR part 2, governing the confidentiality of mental health, alcohol and drug treatment information.

D. Reporting and Quality Improvement Requirements

ANTHEM and COUNTY will have policies and procedures to address quality improvement requirements and reports.

1. Hold regular meetings, as agreed upon by ANTHEM and COUNTY, to review the referral and care coordination process and monitor Member engagement and utilization.

E. Dispute Resolution Process

At this time, ANTHEM and COUNTY agree to follow the resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Medi-Cal Managed Care Plans and the State Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). A dispute will not delay member access to medically necessary services and the referenced process is outlined in Attachment A – Matrix of Parties' Responsibilities of the signed MOU.

F. Telephone Access

The COUNTY must ensure that Members will be able to access services for urgent or emergency services 24 hours per day, 7 days a week.

The approach will be the "no wrong door" to service access. There will be multiple entry paths for beneficiaries to access alcohol and other drug services. Referrals may come from primary care physicians, providers, ANTHEM staff, County Departments, and self-referral by calling the COUNTY's toll free number that will be available 24 hours per day, 7 days a week for service access, service authorization and referral.

G. Provider and Member Education

ANTHEM and COUNTY shall determine the requirements for coordination of Member and provider information about access to ANTHEM and COUNTY covered services to increase navigation support for beneficiaries and their caregivers.

H. Point of Contact for the MOU Addendum

The Point of Contact for the MOU Addendum will be a designated liaison from both COUNTY and ANTHEM.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the date set forth beneath their respective signatures.

BLUE CROSS OF CALIFORNIA PARTNERSHIP PLAN, INC

Signature:_____

Print Name: _____

Title: _____

Department of Behavioral Health

Signature:_____

Print Name: _____

Title: _____

Date: _____