Drug Medi-Cal Organized Delivery System

New Provider Orientation
06/20/2018 and 06/21/2018

Welcome and Introductions

- Overview of the day
- Introduction of Staff
- Who is in the Room
- Your way around this building
- Expectations
  - Today is intended to be an overview of the DMC-ODS. It will not be an in-depth training about every element.
  - You will walk out of this orientation with a general sense of what is required and expected of you as a provider AND a clear idea of who to call if you have questions or need help.

Enjoy the show!

Orientation Outline

- Welcome to Managed Care
- Overview of the OC DMC-ODS Network of Care
- Personnel/Staffing requirements
- Quality Improvement/Assurance and Compliance requirements
- Billing and Documentation
- DMC-ODS County plan staff representatives and roles
- Questions and Announcements

Us and Managed Care… it's on

What is Managed Care?

Presented by Authority and Quality Improvement Services (AQIS) and County Program Staff

Welcome to Managed Care

- The County is a Managed Care Organization (MCO)

Managed Care is a health *care* delivery system organized to manage cost, utilization, and quality. ... By contracting with various types of MCOs to deliver Medicaid program health *care* services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. From: www.Medicaid.gov

Medicaid (Medi-Cal) Managed Care

Member Services and Beneficiary Access Lines

The DMC-ODS county plan offers a customer service and access lines, much like we saw demonstrated before.

You may already know the **Member Services** team as your trusty “OC Links” staff. Beginning with the “go live” date, they will also answer calls from beneficiaries wanting to know about the ODS. However, unlike what they do for OC Links, they will NOT be making referrals or linkages to ODS providers.

Linkages/Access will be done only by the **Beneficiary Access Line (BAL)**. You may know them as “the ASO”. However, their role for the ODS will also be a bit different.

We will describe this as we go along.

Welcome to Managed Care

- The County is a Managed Care Organization (MCO)

Managed Care is a health *care* delivery system organized to manage cost, utilization, and quality. ... By contracting with various types of MCOs to deliver Medicaid program health *care* services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. From: www.Medicaid.gov

  - Federal Regulations – 42 CFR Part 2 and 438
  - State Regulations – DHCS bulletins
  - DMC-ODS Waiver – Special Terms and Conditions
  - Intergovernmental Agreement – "State/County contract"

What does this mean for a provider?

As network providers, "**all sub-contracts shall fulfill the requirements of the service or activity delegated under the subcontract in accordance with 42 CFR §438.230".** (From the intergovernmental agreement - IA)

- Policies and Procedures you must have in place
- Access to Persons With Disabilities (PWD)
- Required training for staff/providers
- Items that must be contained in each staff person's personnel file
- Internal Quality Assurance/Improvement function

Let's examine each of these requirements

Policies and Procedures you must have in place

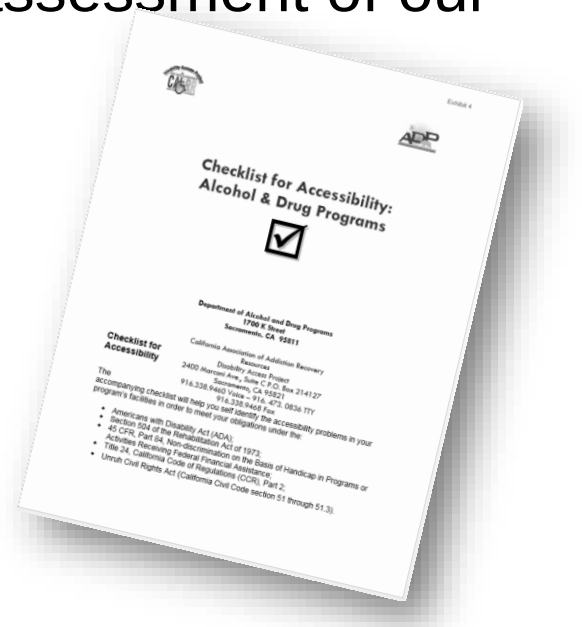
- Admission and re-admission procedures
- Identification of over-payments made to you by the County and re-payments process
- Record retention (beneficiaries and payments/over-payments)
- Requesting authorization for residential services
- Practices consistent with the provision of culturally competent services
- Accountability for audit exceptions as listed on IA (NN2)
- Beneficiaries' rights and protections
- Program integrity
- Use of interns/students
- Coordination/transition of care
- Dedicated staff for routine internal monitoring and audit compliance
- Others as guided by your county monitor/service chief

Access to Persons With Disabilities

As a network, the County is required to provide proper access to SUD services to Persons With Disabilities (PWD).

While not all providers are required to have full accessibility, we must ensure that proper access exists. The way we accomplish this is through an annual assessment of our network and its accessibility to PWD.

These form may look familiar to some of you. For others, you will see it soon, and we need your cooperation.


Checklist for Accessibility:
Alcohol & Drug Programs

Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95811

Checklist for Accessibility

California Association of Addiction Recovery Resources
Disability Action Project
2400 Marconi Ave., Suite C P.O. Box 214127
Sacramento, CA 95821
916.338.9460 Voice • 916.473. 0836 TTY
916.338.9468 Fax

The accompanying checklist will help you self identify the accessibility problems in your program's facilities in order to meet your obligations under the:

- Americans with Disability Act (ADA);
- Section 504 of the Rehabilitation Act of 1973;
- 45 CFR, Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2;
- Unruh Civil Rights Act (California Civil Code section 51 through 51.3).

Training is required

- All staff conducting assessment must complete ASAM A and ASAM B training. The minimum requirements are the e-modules available through “The Change Companies”. The County is also making in person ASAM A training available.
- Documentation training is required. As a bonus, County documentation training presented by the SUD Support team also fulfills the requirement for ASAM B training.
- All LPHA must complete a minimum of 5 Continuing Education Units in Addiction medicine/treatment each year.
- Motivational Interviewing training is required.
- Training on Evidence Based Practices (EBP) in the treatment of addiction is required.

Personnel Files

In the ODS, each individual counselor or clinician is considered a “provider”, not just the agency as a whole. As such, each person must be properly accredited to provide services. Each employee file must contain all the elements listed in the IA, Exhibit A, Attachment I, Section III. PP.6 (pg98):

- License or certification
- Training certificates, all required and optional
- Job application/resume
- Job description
- Performance reviews
- Signed code of conduct, including licensing/certifying body’s code of conduct
- All others contained in the IA and your contract

Quality Assurance/Improvement

Each provider must have a designated qualified staff person to ensure quality of care and to represent the organization as its Quality Improvement (QI) coordinator. The QI coordinator is responsible for,

- Participating in regular (monthly+) QI meetings with AQIS SUD Support team staff
- Engaging in continuous quality improvement within his/her organization/agency
- Providing training to agency staff to ensure proper documentation and billing of services
- Preparing the organization for the County's monitoring visits, responding to audits and implementing corrective action plans
- More…

How is this all going to be monitored

- Your **internal QI staff** is your first line of defense.
  - Your QI coordinator should conduct regular reviews to keep you on track and to correct issues quickly
- **County monitors** will review contract compliance at least 3X/year
  - You will have regular interactions with your monitors and formal monitoring visits throughout the year
  - Your monitor can provide technical assistance (T/A)
- **AQIS SUD support team** (SST) will review charts for documentation compliance
  - This team will make decisions about the appropriateness and “necessity” of services provided and documented
  - Non-compliant services will be recouped
  - SST will provide regular documentation training and can offer T/A to your QI staff to prevent deficiencies

How is this all going to be monitored

- **State Reviews – DHCS**
  - Quality Monitoring Section
  - Post Service Post Payment (PSPP)
  - Financial Branch

- **Federal Reviews – CMS**
  - Centers for Medicaid and Medicare
  - Office of the Inspector General
  - Department of Justice

- The media?

Overview of Orange County DMC-ODS Network of Care

Presented by Program Staff and AQIS

What is the DMC-ODS health plan?

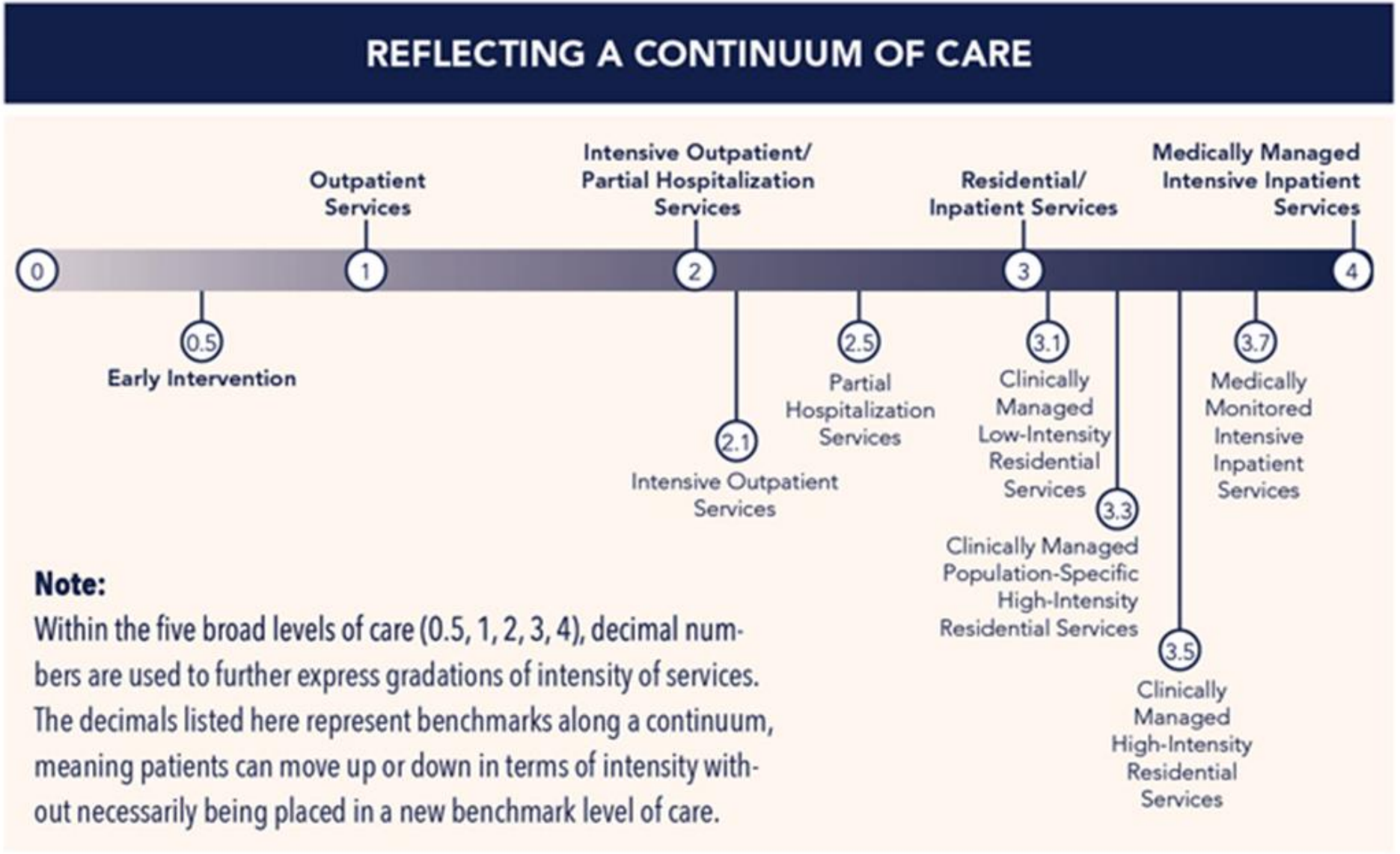
The County Plan provides substance use disorder (SUD) treatment services for all eligible Medi-Cal beneficiaries who reside in Orange County.

- Our mission is *to prevent substance use and mental health disorders; when signs are present, to intervene early and appropriately; and when assessments indicate that treatment is required, to provide the right type of treatment, at the right place, by the right person/program to help individuals to achieve and maintain the highest quality of health and wellness.*

As a beneficiary, your plan offers a full range of SUD treatment services to you when they are medically necessary.

The DMC-ODS Menu

ASAM Model continuum of care



DMC-ODS services are available for Orange County Beneficiaries

- **Outpatient Drug Free**
- **Intensive Outpatient Treatment**
- **Residential Treatment**
- **Withdrawal Management**
- **Opioid (Narcotic) Treatment Program (OTP/NTP)**
- **Medication Assisted Treatment (MAT)**
- **Recovery Services**
- **Case Management**

The Orange County plan **does not offer** Partial Hospitalization

DMC-ODS services are available for Orange County Beneficiaries

Outpatient Drug Free (ODF) counseling services are provided to members up to nine hours a week for adults and less than six hours a week for adolescents when determined to be medically necessary and in accordance with an individualized client plan.

Intensive Outpatient Treatment (IOT) services are provided to members (a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized client plan.

DMC-ODS services are available for Orange County Beneficiaries

Residential Treatment is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to members with a SUD diagnosis when determined as medically necessary and in accordance with an individualized treatment plan.

Residential services require prior authorization by the county plan. **Each authorization for residential services can be for a maximum of 90 days for adults and 30 days for youth.** Only two authorizations for residential services are allowed in a 365 day period. It is possible to have one 30-day extension per year based on medical necessity.

DMC-ODS services are available for Orange County Beneficiaries

Withdrawal Management services are provided when determined as medically necessary and in accordance with an individualized client plan. Each member shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.

Opioid (Narcotic) Treatment Program (OTP/NTP) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized client plan determined by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements.

Required medications: methadone, buprenorphine, naloxone, disulfiram.

DMC-ODS services are available for Orange County Beneficiaries

Medication Assisted Treatment (MAT) Services are available outside of the OTP clinic. MAT is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD.

Recovery Services are important to the member's recovery and wellness. The treatment community becomes a therapeutic agent through which members are empowered and prepared to manage their health and health care.

All levels of care of the plan offer recovery services to county beneficiaries who are no longer actively participating in structured SUD treatment.

DMC-ODS services are available for Orange County Beneficiaries

Your plan offers **Case Management** services by licensed, certified or registered staff at all levels of care. Your case manager can help provide you with advocacy, care coordination to physical health and mental health, assistance with transportation, housing, vocational services, educational and transition services to help get you back on the track you want to be.

The amount and types of case management that beneficiaries receive depend on the person's specific needs, and case management is provided in accordance with the person's individualized treatment plan.

Medical necessity gives you Access

DMC-ODS Access points

The plan **accepts referrals** from various sources, including SUD treatment services from doctors and other primary care providers who think these services may be needed and from the Medi-Cal managed care health plan, for its members.

Other people and organizations may also make referrals to the county, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.

Orange County offers initial screening to determine a beneficiary's appropriate level of care. Beneficiaries are referred to a provider of the level of care identified by the initial screening, and the provider completes a full assessment of the beneficiary's needs, based on the ASAM criteria.

DMC-ODS Access points

Beneficiaries can enter the DMC-ODS system of care through

- The Beneficiary Access Line (BAL)
- The County operated and contracted outpatient clinics
- The County contracted residential programs

Referrals into the County's access points are not the same thing as an access request unless one is made by the beneficiary.

The 24-hour **Beneficiary Access Line (800) 723-8641** is available to respond to after-hours calls regarding access to services and to make referrals, as appropriate.

Medical Necessity

*The term **medical necessity** is important because it will help decide if you are eligible for DMC-ODS services, and what kind of DMC-ODS services are appropriate. Deciding medical necessity is a very important part of the process of getting DMC-ODS services.*

This means a doctor or other licensed professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

You don't need to know if you have a diagnosis to ask for help. Your county DMC-ODS plan will help you get this information and will determine medical necessity with an assessment.

What are Beneficiary Informing Materials

The health plan is required to have systems in place that inform beneficiaries of their rights and responsibilities as members of the plan receiving services. These include,

- Beneficiary Informing Posters
- Informing Brochures and Beneficiary Handbook
- Grievance forms and procedures
- The right to receive translation services
- Notices each time the plan makes an adverse decision about their care
- Internet postings on the county's website

You will receive all the required posting materials from your county monitor or service chief prior to the start of services

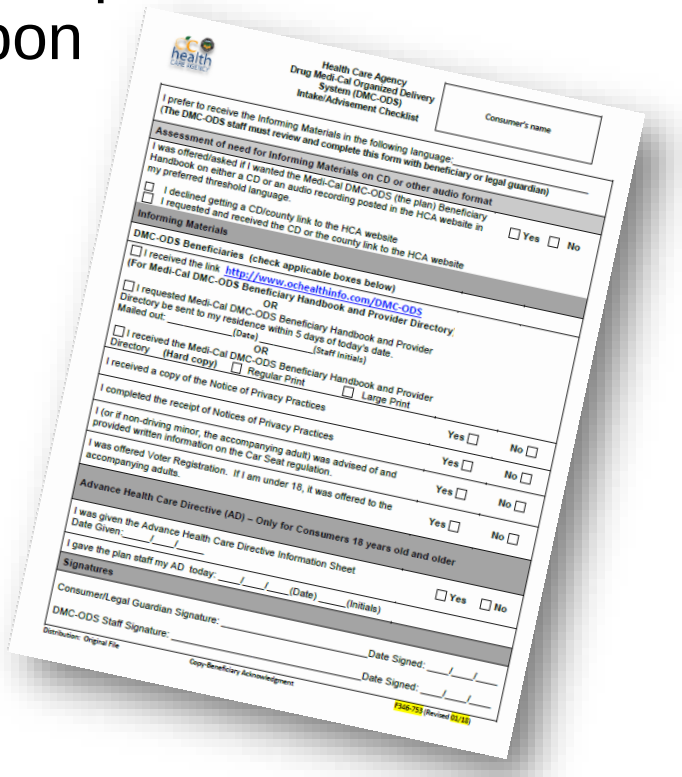
DMC-ODS Beneficiary Handbook

How can I keep track of what all to hand out?

You should bookmark the DMC-ODS County website at www.ochealthinfo.com/dmc-ods

All informing materials will be posted on this page and will be available to the public and to you for quick reference. The handbook can be downloaded upon request.

Here is another quick way to make sure all required informing materials have been issued. Your county monitor or SC will help you as we go live.



Health Care Agency
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Intake/Advisement Checklist

Consumer's name

I prefer to receive the Informing Materials in the following language: _____
(The DMC-ODS staff must review and complete this form with beneficiary or legal guardian)

Assessment of need for Informing Materials on CD or other audio format

I was offered/asked if I wanted the Medi-Cal DMC-ODS (the plan) Beneficiary Handbook on either a CD or an audio recording posted in the HCA website in my preferred threshold language. ☐ Yes ☐ No

☐ I declined getting a CD/county link to the HCA website
☐ I requested and received the CD or the county link to the HCA website

Informing Materials

DMC-ODS Beneficiaries (check applicable boxes below)

☐ I received the link http://www.ochealthinfo.com/DMC-ODS
(For Medi-Cal DMC-ODS Beneficiary Handbook and Provider Directory

OR

☐ I requested Medi-Cal DMC-ODS Beneficiary Handbook and Provider Directory be sent to my residence within 5 days of today's date.
Mailed out: _____(Date) _____(Staff Initials)

OR

☐ I received the Medi-Cal DMC-ODS Beneficiary Handbook and Provider Directory (Hard copy) ☐ Regular Print ☐ Large Print

I received a copy of the Notice of Privacy Practices

I completed the receipt of Notices of Privacy Practices ☐ Yes ☐ No

I (or if non-driving minor, the accompanying adult) was advised of and provided written information on the Car Seat regulation. ☐ Yes ☐ No

I was offered Voter Registration. If I am under 18, it was offered to the accompanying adults. ☐ Yes ☐ No

Advance Health Care Directive (AD) – Only for Consumers 18 years old and older

I was given the Advance Health Care Directive Information Sheet Date Given: ___/___/___ ☐ Yes ☐ No

I gave the plan staff my AD today: ___/___/___ (Date) ____(Initials)

Signatures

Consumer/Legal Guardian Signature: _____ Date Signed: ___/___/___

DMC-ODS Staff Signature: _____ Date Signed: ___/___/___

Distribution: Original File

Copy-Beneficiary Acknowledgment

F366-753 (Revised 01/18)

Personnel requirements and procedures

Presented by Program and IRIS staff

Staff Qualifications

All staff must have the proper qualifications

- LPHA and registered staff
- Certified staff
- All required training completed
- LPHA must also be properly certified by DHCS as DMC-ODS providers
- Medical Director must participate in developing program standards and policies and shall fulfill the responsibilities described in the I/A Exhibit A, Attachment I Section IIIPP5 (pg 98)
- The medical director may perform all duties same as the LPHA

Adding, removing or changing staff in the network

All forms and requests must be sent to your County Monitor or Service Chief for review. Then they will be forwarded to the Integrated Records Information System (IRIS) unit and the SUD Support Team (SST) for processing.

Data Entry Staff (may not be a person providing clinical services)

- Personnel Action Notification (PAN) – completely filled out
- Network Access Request (NAR)
- Token Request

Adding, removing or changing staff in the network

Licensed/Licensed Waivered (Registered with BBS or BOP)

- Personnel Action Notification (PAN) - completely filled out
- Copy of Annual/New Provider Training
- Valid NPI number with name matching license and PAN
- Copy of state DMC certification or copy of 6010 application submitted
- Must also be added to your staffing roster sent to your County Monitor each month (contract) Service Chief (County)

*Please ask for Middle Names or Initials from your staff as we need to have a way to distinguish in IRIS

Adding, removing or changing staff in the network

Certified or Registered Substance Abuse Counselor (CADTP or CCAPP only)

- Personnel Action Notification (PAN) - completely filled out
- Copy of Annual/New Provider Training
- Valid NPI number with name matching license and PAN
- Copy registration or certification
- Must also be added to your staffing roster sent to your County Monitor each month (contract) Service Chief (County)

*Please ask for Middle Names or Initials from your staff as we need to have a way to distinguish in IRIS

Quality Improvement/Assurance and Managed Care regulations compliance

Presented by Authority and Quality Improvement Services

DMC-ODS Health Plan

- As a Managed Care Organization, our “Plan” needs to have all the elements of an MCO/HMO.
  - A network of providers
  - A credentialing system
  - Member Services and Beneficiary Access Line (BAL)
  - Authorization processes
  - Access standards
  - Notice of Adverse Benefits Determination (NOABD)
  - A Grievance and Appeals process
  - Utilization Review
  - Policies and Procedures
  - Beneficiary/Member informing materials
  - Culturally accessible services and access to Persons with Disabilities

Yep. It’s managed care.

Let's start with Access timelines

Federal standards require for services to be made available to beneficiaries within specific time frames

- Outpatient Services 10 days
- NTP/OTP 3 days

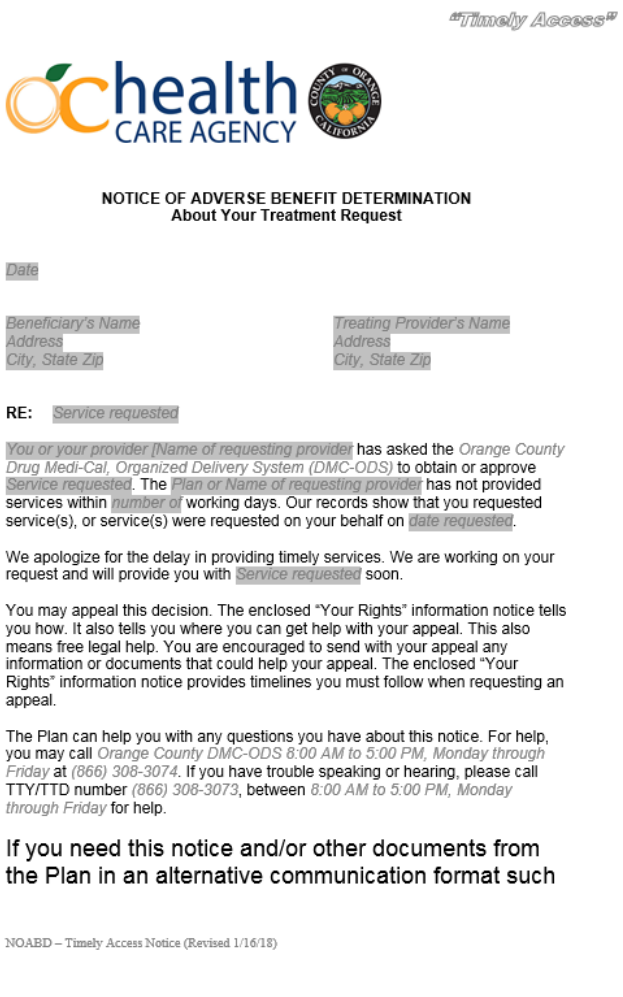
- Residential services 10 days
  (provided this is the correct level of care)

The BAL and all access points are responsible for making every attempt at linking each beneficiary within the required time frame.

All request dates; type of service requested by the beneficiary; type of service indicated by the screening and date of appointment offered must be captured in the Access log.

NOABD related to Access

If the access standards are not met, it triggers the issuance of a Notice of Adverse Benefit Determination (NOABD)- Timely Access



"Timely Access"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider [Name of requesting provider has asked the *Orange County Drug Medi-Cal, Organized Delivery System (DMC-ODS)* to obtain or approve *Service requested*. The *Plan or Name of requesting provider* has not provided services within *number of* working days. Our records show that you requested service(s), or service(s) were requested on your behalf on *date requested*.

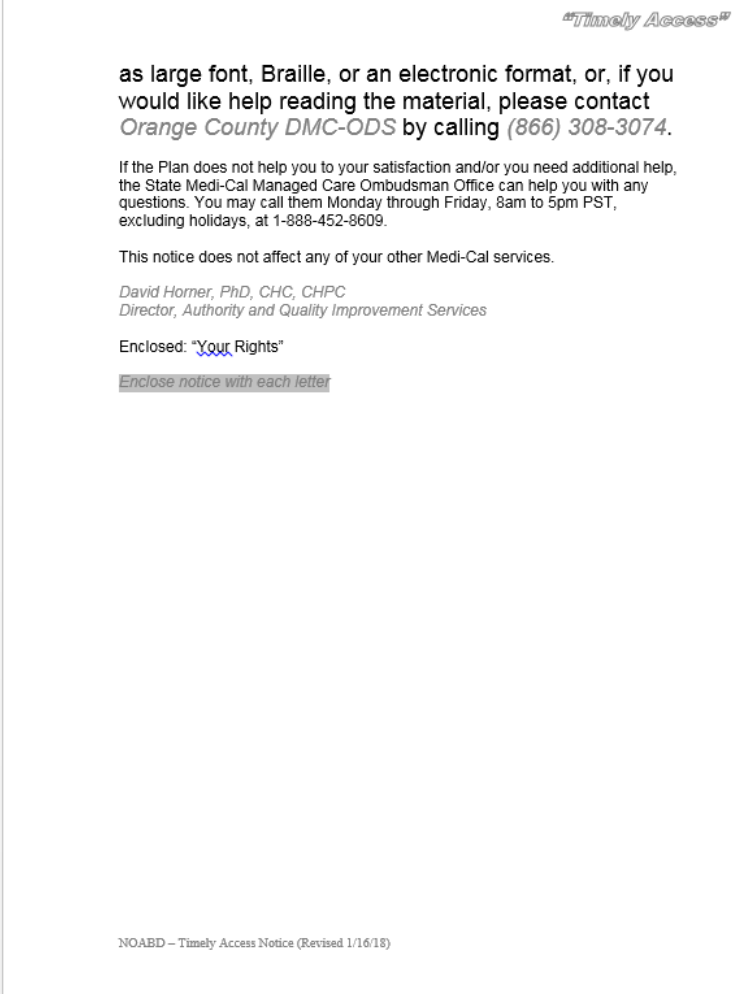
We apologize for the delay in providing timely services. We are working on your request and will provide you with *Service requested* soon.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The Plan can help you with any questions you have about this notice. For help, you may call *Orange County DMC-ODS 8:00 AM to 5:00 PM, Monday through Friday* at *(866) 308-3074*. If you have trouble speaking or hearing, please call TTY/TTD number *(866) 308-3073*, between *8:00 AM to 5:00 PM, Monday through Friday* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such

NOABD – Timely Access Notice (Revised 1/16/18)



"Timely Access"

as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Orange County DMC-ODS* by calling *(866) 308-3074*.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

David Horner, PhD, CHC, CHPC
Director, Authority and Quality Improvement Services

Enclosed: "Your Rights"

Enclose notice with each letter

NOABD – Timely Access Notice (Revised 1/16/18)

What else about NOABD

There are several forms of NOABD, depending on the issue. Every time the plan (County) makes a decision or takes an action contrary to the beneficiary's requests or rights, we must issue a notice. You, as a provider, will not be responsible for every type of notice, but here is the "menu", just for reference.

- Timely Access (Delay)
- Modification
- Denial of Services
- Delay in processing authorization requests
- Authorization termination
- Payment Denial
- Financial Liability
- Grievance and Appeals resolution notices

Credentialing of Providers

The health plan is responsible for credentialing all the providers (human beings) in our network. This is beyond the DMC certification or any licenses staff may already have. Each provider must be properly credentialed before they can bill for services. AQIS is responsible for this activity.

Credentialing involves a process of both primary source and non primary source verification of each staff person's qualifications, including and not limited to:

- Education
- License
- Sanction screening
- Completion of all relevant training
- Completion of 5 units in addiction for LPHA in the DMC-ODS
- Work history
- NPI
- History of sanctions
- Liability claims
- Attestations

Re-credentialing must occur every 3 years

Problem Resolution Process

Problem Resolution Process

The problem resolution process is the County plan's way to work out a problem about any issue related to the SUD treatment services received by the beneficiary, and it could involve the following processes.

- 1. The **Grievance Process** – an expression of unhappiness about anything regarding SUD treatment services.
- 2. The **Appeal Process** – review of a decision (denial or changes to services) that was made about SUD treatment services by the county plan or provider.
- 3. The **State Fair Hearing Process** – review to make sure beneficiaries receive the SUD treatment services which they are entitled to under the Medi-Cal program.

Problem Resolution Process

The county plan has people available to explain these processes to beneficiaries and to help them report a problem either as a grievance, an appeal, or as a request for State Fair Hearing.

You may also authorize another person to act on your behalf, including your SUD treatment provider.

*If you would like help, call **Toll Free:** (866) 308-3074. You may also find information about the grievance and appeal process and download forms at www.ochealthinfo.com/DMC-ODS*

Problem Resolution – and can't find the right help

You can get help from the State if you are having trouble finding the right people at the county to help you find your way through the system.

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

Grievances and Appeals

Grievances

A grievance is an expression of unhappiness about anything regarding your SUD treatment services that are not one of the problems covered by the appeal and State Fair Hearing processes.

You may call your county plan's toll-free phone number to get help with a grievance.

The County will provide self-addressed envelopes at all the providers' sites. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

You may file a grievance at any time.

Grievances

A grievance is **ANY** expression of dissatisfaction about the services the beneficiary is receiving

All grievances must be logged and investigated

If you hear any expression of dissatisfaction, tell the beneficiary about the Grievance process and offer to help them

Even if the person says they don't want to file a grievance, we are obligated to address their issue

What does that mean for me????

Any exceptions?

There is no such thing and an “informal” grievance; however, if the person’s grievance/complaint can be resolved to their satisfaction by the end of the following business day, there will be no need for a formal investigation.

The issue must still be logged, even if resolved within a day.

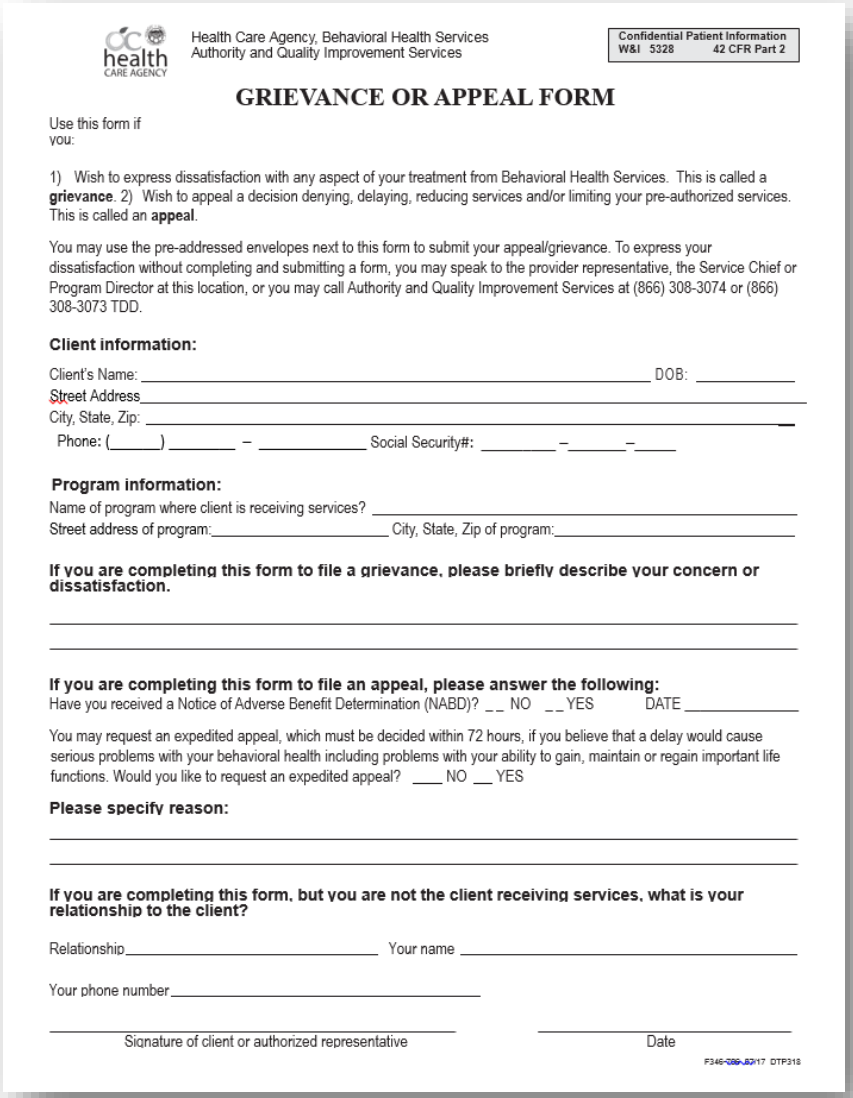
Possible examples: trouble getting in to see their regular counselor, session lengths, access to restrooms, etc.

What other situation could come up that can be resolved within a day to the person’s satisfaction?

Grievances

1. Acknowledge the person's grievance and **between the hours of 8:00 AM and 5:00 PM**, offer to warm transfer them to the 866 number at AQIS to file their grievance.
2. Point the person to the supply of grievance forms and envelopes at your location.
3. If the person insists on not filing a grievance, let them know that you will still have to log their complaint and they will receive a communication from a Grievance investigator.
4. If appropriate, fill out the grievance form and send it to AQIS via secure email or fax

Grievances



Health Care Agency, Behavioral Health Services
Authority and Quality Improvement Services

Confidential Patient Information
W&I 5328 42 CFR Part 2

GRIEVANCE OR APPEAL FORM

Use this form if you:

1) Wish to express dissatisfaction with any aspect of your treatment from Behavioral Health Services. This is called a **grievance**. 2) Wish to appeal a decision denying, delaying, reducing services and/or limiting your pre-authorized services. This is called an **appeal**.

You may use the pre-addressed envelopes next to this form to submit your appeal/grievance. To express your dissatisfaction without completing and submitting a form, you may speak to the provider representative, the Service Chief or Program Director at this location, or you may call Authority and Quality Improvement Services at (866) 308-3074 or (866) 308-3073 TDD.

Client information:

Client's Name: _____ DOB: _____
Street Address _____
City, State, Zip: _____
Phone: (_____) _____ – _____ Social Security#: _____ –_____–_____

Program information:

Name of program where client is receiving services? _____
Street address of program:_____ City, State, Zip of program:_____

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

_____
_____

If you are completing this form to file an appeal, please answer the following:
Have you received a Notice of Adverse Benefit Determination (NABD)? __ NO __ YES DATE _____

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ___ NO __ YES

Please specify reason:

_____
_____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

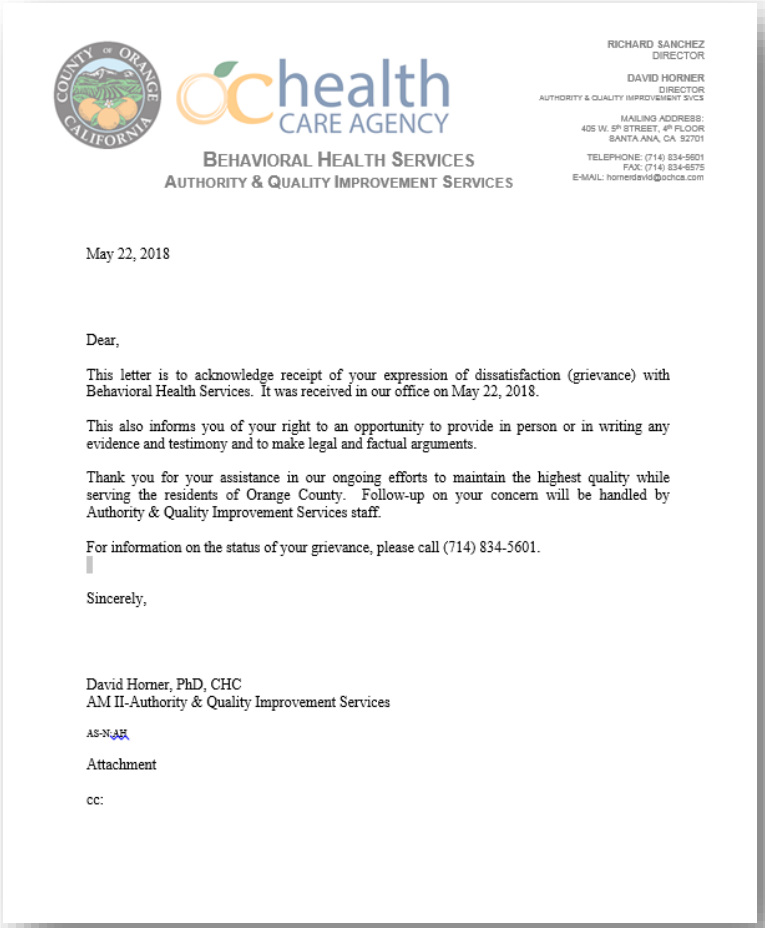
Relationship_____ Your name _____

Your phone number_____

_____ _____
Signature of client or authorized representative Date

F346-285-B2/17 DTP318

AQIS Staff only has 5 calendar days to send out a letter acknowledging receipt of the grievance!



RICHARD SANCHEZ
DIRECTOR

DAVID HORNER
DIRECTOR
AUTHORITY & QUALITY IMPROVEMENT SVCS

MAILING ADDRESS:
405 W. 5th STREET, 4th FLOOR
SANTA ANA, CA 92701

TELEPHONE: (714) 834-5601
FAX: (714) 834-6575
E-MAIL: hornerdavid@ochca.com

BEHAVIORAL HEALTH SERVICES
AUTHORITY & QUALITY IMPROVEMENT SERVICES

May 22, 2018

Dear,

This letter is to acknowledge receipt of your expression of dissatisfaction (grievance) with Behavioral Health Services. It was received in our office on May 22, 2018.

This also informs you of your right to an opportunity to provide in person or in writing any evidence and testimony and to make legal and factual arguments.

Thank you for your assistance in our ongoing efforts to maintain the highest quality while serving the residents of Orange County. Follow-up on your concern will be handled by Authority & Quality Improvement Services staff.

For information on the status of your grievance, please call (714) 834-5601.

Sincerely,

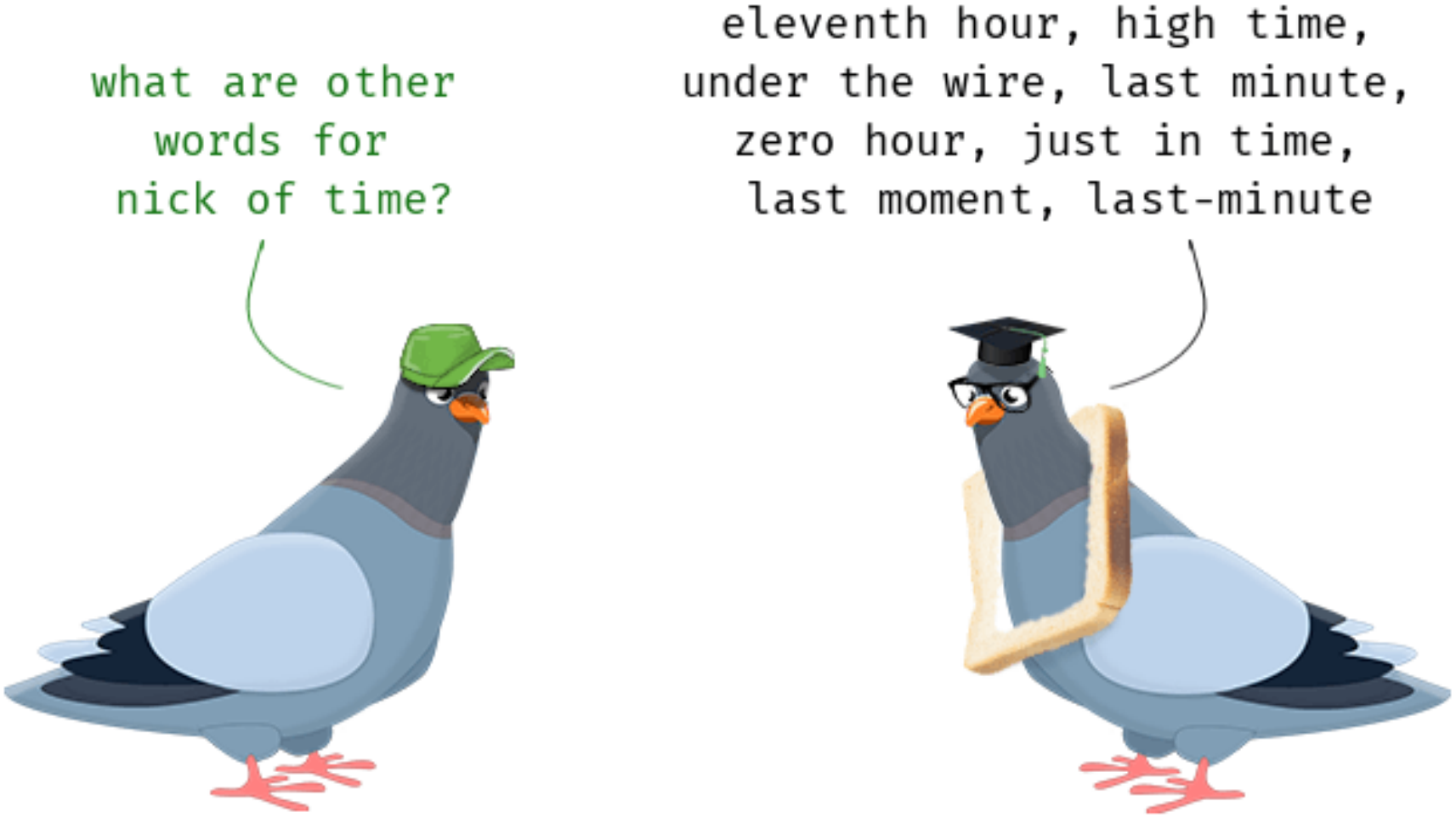
David Horner, PhD, CHC
AM II-Authority & Quality Improvement Services

AS-N:AS

Attachment

cc:

Timelines matter



Appeals

A standard appeal is a request for review of a problem you have with the plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the county plan may take up to 30 days to review it. If you think waiting 30 days will put your health at risk, you should ask for an 'expedited appeal.'

***You may call your county plan's toll-free phone number to get help with filing an appeal**.*

You must file an appeal within 60 days of the date of the action you're appealing when you get a Notice of Adverse Benefit Determination.

State Fair Hearing

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the SUD treatment services to which you are entitled under the Medi-Cal program.

Beneficiaries can request a State Fair Hearing directly from the California Department of Social Services by writing to:

State Hearings Division
California Department of Social Services
744 P Street, Mail Station 9-17-37
Sacramento, California 95814

Beneficiaries can also call 1-800-952-8349 or for TDD 1-800-952-8349.

Performance Metrics

- CalOMS
- DATAR
- External Quality Review Organization (EQRO)
  - 12 Mandatory Measures
- Performance Improvement Projects (PIP)
  - 2 required: 1 clinical; 1 non-clinical
- Satisfaction Surveys
  - UCLA developed, standardized across the State
- Service Verification Surveys
- Onsite Compliance Reviews by County staff
  - Contract Monitoring (Program staff)
  - Documentation Compliance (AQIS SUD Support)

Documentation compliance and Utilization Review

Presented by SUD Support team (AQIS)

Medi-Cal Documentation requirements

The AQIS SUD Support team is responsible for

- Training providers on proper billing requirements
- Conducting site visits to monitor compliance with documentation requirements
- Utilization Review
- Investigating Grievances and Appeals
- Maintaining the provider network directory
- Updating all Beneficiary Informing materials and the DMC-ODS website
- Making recoupment decisions when services are not properly documented or performed

AQIS SUD Support and Medi-Cal Documentation

Here is what they will look for,

- Evidence Based Practices (EBP) clearly demonstrated in the notes
- ASAM based assessment, correctly performed and documented, leading to the correct level of care (LOC) decision
- Documentation of coordination of care between physical health and behavioral health (including mental health)
- Compliant documentation practices as described in the IA and in the required County documentation training and accompanying guide
- Evidence of transitioning beneficiaries along the continuum of care appropriately

Your other DMC-ODS Plan representatives

Meet the Cast

Office of Compliance

Presented by Chief Compliance Officer

What is the role of the Office of Compliance

The Office Of Compliance (OOC) deals with health compliance and privacy issues.

The OOC ensures that HCA abides by all the laws, regulations and statutes that affect business to protect our clients and to comply with funding sources.

The OOC's relationship with contracted providers is mostly around privacy and billing issues.

Contracted providers are required to either have their own compliance program or to agree to adhere to the HCA compliance program and training.

Compliance Agreement Elements

1. Compliance Program
    1. Acknowledge HCA
    2. Internal Program
2. Sanction Screening
    1. Upon Hire
    2. Every six (6) months thereafter - minimum
3. General and Specialized Compliance Training
4. Medical Billing, Coding and Documentation
5. Compliance Audits
6. Business Associate Agreement
    1. Create, Receive, Maintain, Store and Transmit PHI

HCA Compliance Policies and Procedures

HCA Policies Providers Should Receive:

- **Compliance Program**
  - Program Administration
  - Training Requirements
  - Issue Reporting & Investigations
  - Employee Sanction Screening
- **Health Insurance Portability and Accountability Act (HIPAA)**
  - Safeguarding Protected Health Information (PHI)
  - Using and Disclosing PHI
  - Minimum Necessary Standards
  - Breach Response Protocol

Required Staff Sanction Screening

- **Exclusions Lists include:**
  - Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE)
  - General Services Administration (GSA) Excluded Parties List System (EPLS)
  - The California State Medi-Cal Suspended & Ineligible List
  - Social Security Death Master List

- **Exclusions may include individuals who have had:**
  - A health care fraud conviction
  - A conviction related to obstruction of an investigation
  - A conviction for patient abuse
  - Failed to repay Health Education Assistance Loans
  - Their license revoked or suspended

- **Ineligible persons may include individuals who have been:**
  - Excluded, suspended, debarred, or otherwise ineligible to participate in federal health care programs, such as including Medicare and Medicaid programs and/or procurement or non-procurement programs
  - Convicted of a criminal offense that falls under 42 U.S.C. § 1320a-7(a), or similar state statute
  - Excluded on a state exclusion list

Role of a Business Associate

Execute and comply with the terms of the business associate agreement with the County which include:

- Use and Disclosure of PHI
- Safeguarding PHI
  - Administrative, Physical and Technical Controls
- HIPAA Security Rule
  - 45 CFR Part 164 Subpart C
  - Protect E-PHI
- Breach Reporting
  - When to Report
  - Who to Contact
- HCA Access to PHI

Subcontractor Responsibilities

Same Contractual Elements Should Be Applied to Subcontractors:

- Using and Disclosing PHI
  - Create, Receive, Maintain, Store or Transmit
- Safeguarding PHI
  - Administrative, Physical and Technical Controls
- HIPAA Security Rule
  - 45 CFR Part 164 Subpart C
  - Protecting E-PHI
- Breach Reporting
  - When to Report
  - Who to Contact

Breach discovery and notification

If there is a breach of unsecured PHI, contractor is required to:

- Notify OCHCA upon discovery of any suspected or actual breach of security or unauthorized use or disclosure of PHI:
  - Immediate oral notification
  - Written notification within 24 hours of oral notification
  - All specific information regarding breach must be communicated to County no later than 15 calendar days after initial report to County
- Mitigate and investigate breach
- Conduct four factor breach risk assessment
- Notifications:
  - To each affected individual by letter (Must be approved by HCA prior to providing to individual(s))
  - HHS
  - Media, if more than 500 people affected

Provider Compliance Audits

- Compliance Elements
  - Policies and Procedures/Standards of Conduct
  - Compliance Officer/Compliance Committee
  - Training and Education
  - Methods of Communication
  - Responding to Detected Offenses/Implementing CAP
  - Auditing and Monitoring

- HIPAA Elements
  - Administrative, Physical, and Technical Safeguards
  - Breach Mitigation
  - Subcontractor Contracts
  - Background Checks
  - Client Authorizations
  - Accounting of Disclosures
  - Notice of Privacy Practice

What To Report to HCA Compliance

- Compliance Issues
  - Compliance or HCA Policy Violations
  - Billing or Coding Errors
  - Concerns or Issues with HCA Staff
  - Observed Fraud, Waste or Abuse

- HIPAA Issues
  - Suspected or Known Breaches
  - Information Technology Security Issues
  - HIPAA Policy Violations

Additional Information and Contacting Compliance

- Office of Compliance Website
  - http://www.ochealthinfo.com/about/candp/compliance/pr
- Provider Compliance Audit process
  - https://youtu.be/VobjEUKVfqs
- Contact the Office of Compliance
  - Phone: 714-568-5614
  - Fax: 714-834-6595
  - E-mail: officeofcompliance@ochca.com

Workforce Education and Training (WET)

Presented by WET Manager

Wet Services

Purpose is to improve workforce by

- Promoting consumer and family member employment
- Improving the skills of public mental health providers
- Providing training to the community

WET Program Areas

How WET Supports BHS Staff and Contractors

Multi-cultural Development Program and Translation/Interpretation Services

CE/CME Program

Coordination of trainings

- Evidenced based practice trainings
- DMC required and recommended trainings (e.g. Motivational Interviewing, SBIRT, CBT, Co-occurring)
- Mental Health First Aid
- NVCI
- And More….

Consumer/Family Member Career and Employment programs

- Consumer employment support (SSI/SSDI)
- Recovery Education Institute

Neurobehavioral Testing Unit

Wait…

Questions?

Drug Medi-Cal, Organized Delivery System

All clear?

Announcements

But wait! There is more!

There will be more training coming

Today's orientation is intended to be an overview of the DMC-ODS system in Orange County. More detailed training on many of the points presented today will occur throughout the year, including:

- Documentation (ASAM B)
- Access Log
- CalOMS and DATAR
- Evidence Based Practices
- ASAM A and B
- Programmatic Processes
- IRIS
- Billing
- Much more

We are here to help

Random Fun Fact…

Fennec fox

Animal

The fennec fox or fennec is a small nocturnal fox found in the Sahara of North Africa. Its most distinctive feature is its unusually large ears, which also serve to dissipate heat. Wikipedia

Scientific name: Vulpes zerda

Conservation status: Least Concern Encyclopedia of Life

Height: 8 in. (Adult)

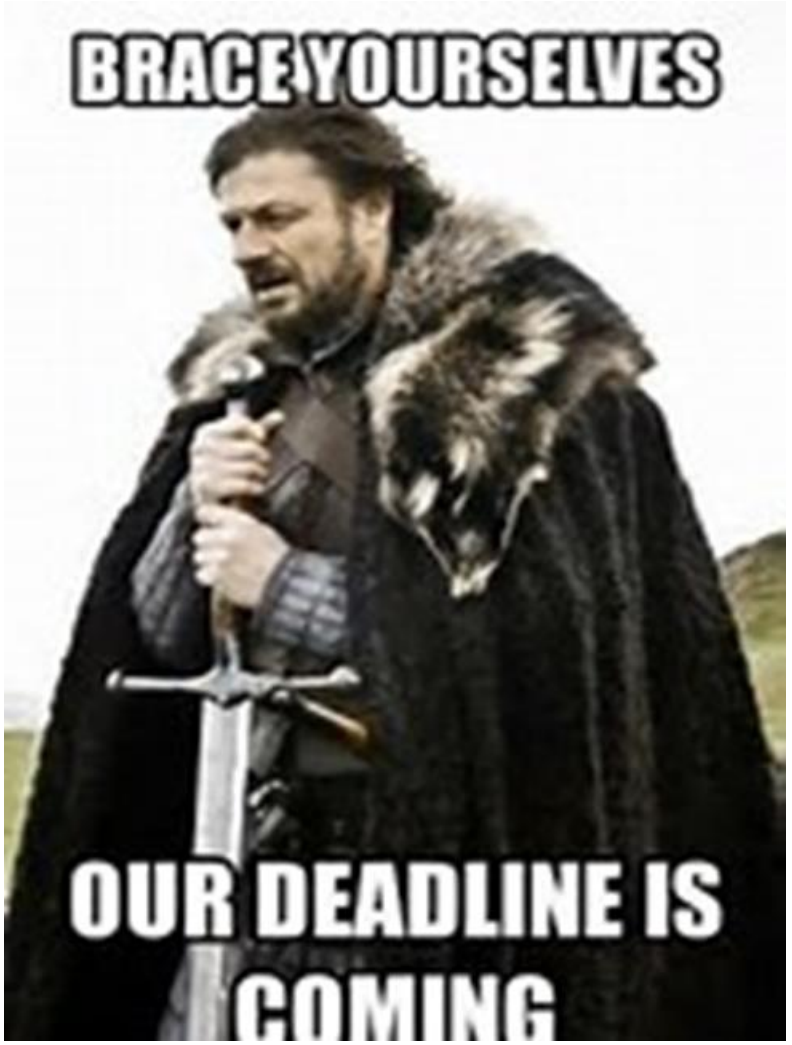
Mass: 1.5 – 3.5 lbs (Adult)

Trophic level: Omnivorous Encyclopedia of Life

Did you know: Fennec foxes are monogamous, and the pair lives with their offspring in a family unit of up to ten individuals. eol.org

It’s Showtime!

July 1st, 2018…



Thank you for participating!

- If you have questions, consult with your service chief or team lead
- Also, the SUD Support Team is here to Support
  (714) 834-5601
- John Crump, LMFT, Service Chief II
- Azahar López, PsyD, Program Manager
- Team email box:
- AQISSUDSUPPORT@ochca.com

Drug Medi-Cal Organized Delivery System

New Provider Orientation
06/20/2018 and 06/21/2018