SAPC All Provider Meeting

Operationalizing New Clinical Standards and Practices*

*Note: This presentation pertains to *AFTER* launch of the DMC-ODS Waiver in July 2017, NOT current requirements.

Outline

- **SAPC Provider Network Flow**
- **Overview of Quality Improvement & Utilization Management Programs**
  - Establishing Medical Necessity
  - ASAM Assessments
  - Documentation of Services
  - Residential Preauthorization Process
  - Other Authorized Services
  - Complaints/Grievance and Appeals Procedures
- **Maximizing Use of LPHA's and Medical Directors**
- **Recovery Bridge Housing**
- **Physician Consultation Service**
- **Governing Regulation – Updates**
  - Confidentiality – 42 CFR Part 2
  - Managed Care – 42 CFR Part 438
- **Trainings**
- **Discussion / Q&A**

Note: This presentation pertains to _AFTER_ launch of the DMC-ODS Waiver in July 2017, NOT current requirements.
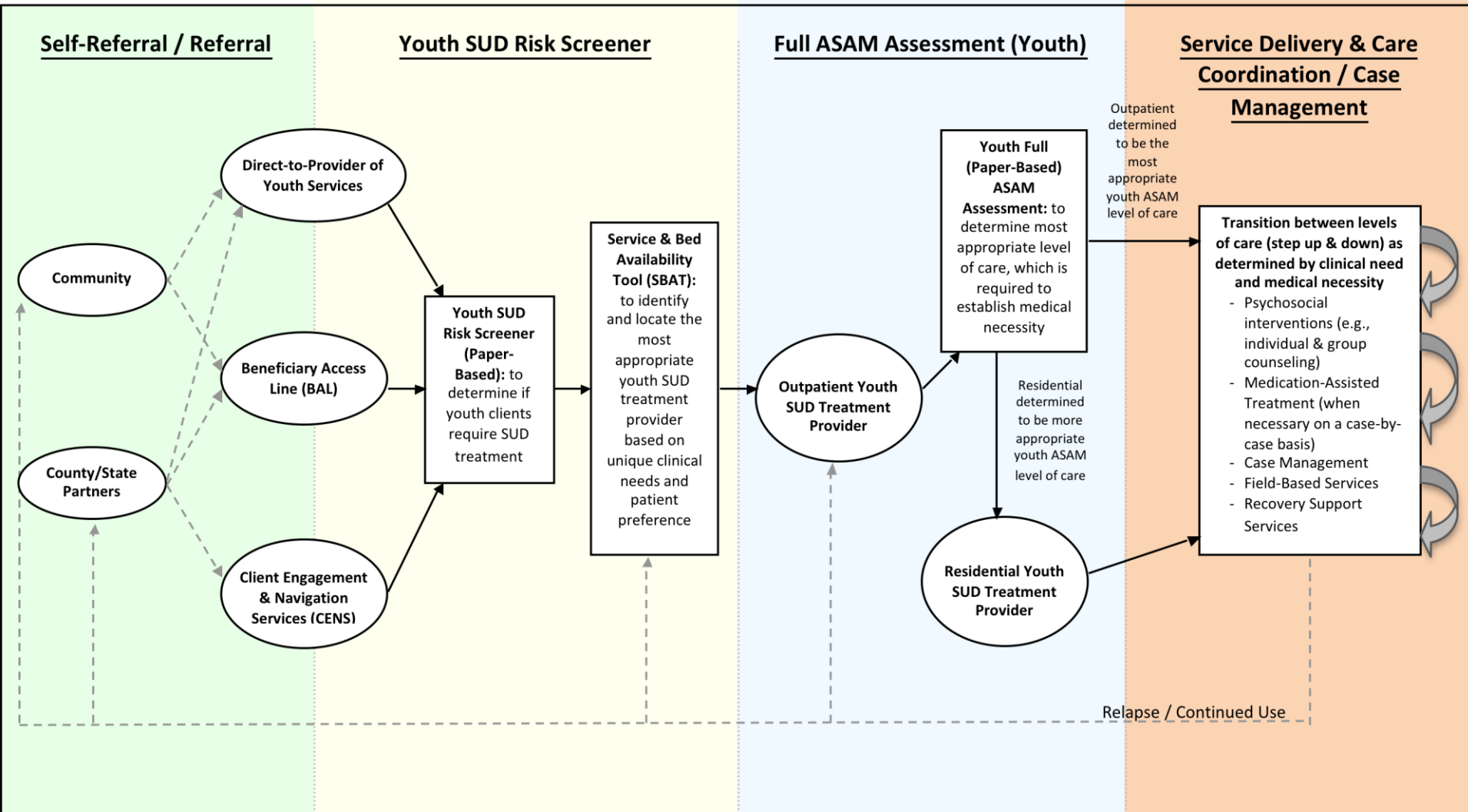
SAPC Provider Network Flow – ADULTS
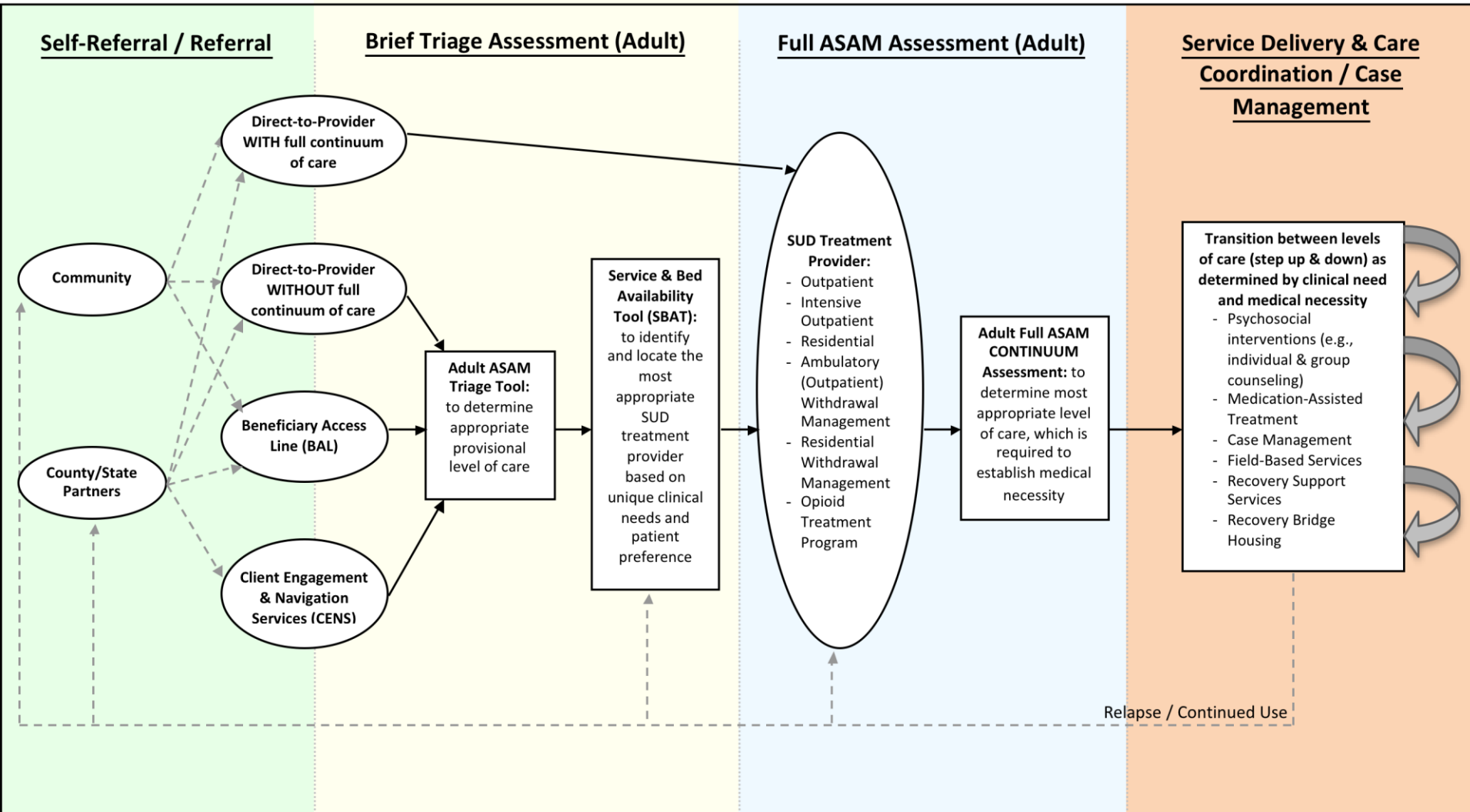
*See handout for details of flow

SAPC Provider Network Flow – YOUTH

*See handout for details of flow

Overview of QI & UM Programs

- **Establishing Medical Necessity**
  - **Two Instances of Establishing Medical Necessity**
    - To be eligible for Drug Medi-Cal services (e.g., to qualify for insurance)
    - To be eligible with a specific service (e.g., to qualify for a specific service)

    1. **Medical Necessity for <u>Drug Medi-Cal (DMC) Eligibility</u>**
       - Medi-Cal status* + DSM-5 diagnosis + appropriate ASAM level of care assessment
         *Providers must determine Medi-Cal status, SAPC UM staff will confirm medical necessity
       - Must be renewed:
         - <u>Every 6 months</u> for all <u>non-OTP services</u>
         - <u>Every 12 months</u> for all <u>OTP services</u>
    2. **Medical Necessity for <u>Specific Services</u>**
       - DSM-5 diagnosis + appropriate ASAM level of care assessment
       - Renewal periods vary depending on the service (refer to QI & UM Manual for full details)

Overview of QI & UM Programs (cont'd)

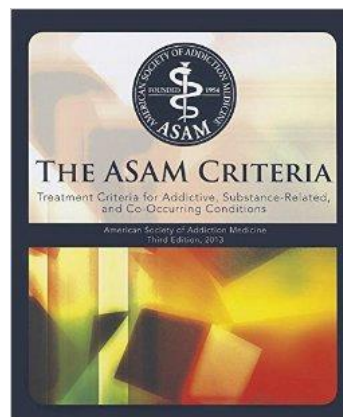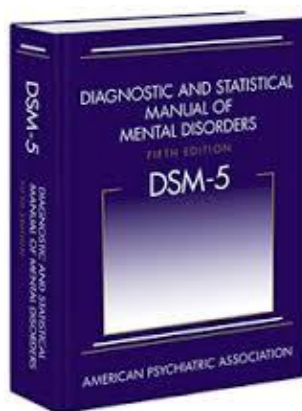- **Establishing Medical Necessity (cont'd)**
  - **<u>Medical necessity criteria</u>:**
    1. **DSM-5 diagnosis** for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders;

       OR

       Be assessed to be at-risk for developing substance use disorder (for youth under age 21)

    2. **ASAM treatment criteria** to ensure that services are appropriate and provided in the appropriate level of care

Medical Necessity

Overview of QI & UM Programs (cont'd)

- **Establishing Medical Necessity (cont'd)**
  - <u>**Staffing – Determination of medical necessity for services**</u>
    - **LPHA's must sign-off and confirm medical necessity for services, but counselors can perform the ASAM assessment necessary to arrive at a medical necessity determination**

  - **Non-DMC services will also need to meet medical necessity**
    - SAPC will be providing the same service benefits to all patients, regardless of Medi-Cal or funding status (e.g., My Health LA)

Overview of QI & UM Programs (cont'd)

- **ASAM Assessments – ADULTS**
  - SAPC is piloting two <u>electronic ASAM assessment tools</u>:
    - **ASAM CONTINUUM → electronic full ASAM assessment** that will help to confirm, <u>in conjunction with the counselor/LPHA's clinical opinion</u>, what ASAM level of care (LOC) is most appropriate
    - **ASAM CONTINUUM Triage Tool → electronic ASAM brief triage assessment** that will help to determine an appropriate provisional ASAM LOC, <u>in conjunction with the counselor/LPHA's clinical opinion</u>

Overview of QI & UM Programs (cont'd)

- **ASAM Assessments – ADULTS (cont'd)**
  - **Potential benefits of electronic ASAM assessments:**
    - **Utilization Management** – Simplify review process for both providers and SAPC
    - **Help to facilitate a comprehensive health assessment** – including SUDs – to determine the most appropriate ASAM LOC
      - Service delivery benefits
      - Training benefits

  - **These electronic assessment tools will be made available to all SAPC SUD providers serving adults**

  - **Important Note:** Assessment tools are only tools. They do NOT replace sound clinical judgment by counselors and clinicians

Overview of QI & UM Programs (cont'd)

- **Assessments – YOUTH**
  - Youth SUD providers will use <u>paper-based assessments</u> that are being developed and piloted:
    - **Youth SUD screener**
    - **Youth ASAM full assessment**

Overview of QI & UM Programs (cont'd)

- **Documentation of Services**
  - <u>Purposeful and thorough documentation</u> will be critical in order to justify the provision of specialty SUD services in a managed care environment

Overview of QI & UM Programs (cont'd)

- **Documentation of Services (cont'd)**
  - **What is <u>managed care</u>?**
    - "Managed Care is a **health care delivery system organized to manage cost, utilization, and quality**…
    - **Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care**…
    - Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care."
    https://www.medicaid.gov/medicaid/managed-care/index.html

  - **The DMC-ODS Waiver transforms SAPC into a managed care plan and SAPC's providers into a Medicaid managed care network that provides specialty SUD services to LA County residents.**

Overview of QI & UM Programs (cont'd)

- **Documentation of Services (cont'd)**
  - What is "purposeful and thorough" documentation?
    - **SUMMARY of the unique biopsychosocial details of a case**
    - **WHAT services are being provided**
    - **WHY are the services being provided**
      - Provide care rationale and mindset of the counselor or LPHA providing the service
      - Describe why, after when considering the unique biopsychosocial circumstances of a case, a particular service is being provided

  - **"If it's not written down, it didn't happen"**
    - SAPC Utilization Management staff will make service authorization decisions, which will ultimately impact reimbursement, based on what is and is not included in clinical documentation by counselors and clinicians

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Overview of QI & UM Programs (cont'd)

- **Documentation of Services (cont'd)**
  - **Electronic Documentation**
    - For providers who do NOT already have a certified EHR, format of documentation will be standardized on the Electronic Health Record (EHR) that SAPC will be implementing for those who are interested
    - For providers who already have their own certified EHR and want to continue using their system, SAPC will need to approve documentation formats to ensure consistency

  - **Progress notes will be required to follow one of four formats**:
    - 1) SOAP   3) BIRP
    - 2) GIRP   4) SIRP

    - See sample progress note provided in packet of information

Overview of QI & UM Programs (cont'd)

- **Residential Preauthorization Process**
  - **All residential services (NOT including residential withdrawal management [WM-3.2]) will require preauthorization by SAPC prior to the service being approved and paid for*** → <u>SAPC is required to preauthorize these residential cases within 24 hrs</u>
    - ***<u>Exception</u>: Providers are able to admit patients prior to SAPC preauthorization if they accept financial risk for the admission**
      - If SAPC ultimately approves the residential service, reimbursement will be retroactively paid to the date of service delivery; but if SAPC ultimately denies approval for the residential service, provider will not be reimbursed for the delivery of that residential service
    - **Examples:**
      - Cases where relapse risk is deemed to be significant without immediate placement in residential care
      - Admissions on weekends and/or holidays

Overview of QI & UM Programs (cont'd)

- **Residential Preauthorization Process (cont'd)**
  - Residential preauthorizations will only be required when:
    - Initiating residential care
    - Transitioning from non-residential to residential levels of care
  - A notification to SAPC, rather than a residential reauthorization, is required for transitions between residential levels of care (e.g., either transitions up or down between residential levels)

Residential Preauthorizations – Youth, Young Adults, & Adults
(see Table 14 in QI & UM Manual for more details)

Age Group	Initial Residential Preauthorization	Residential Reauthorizations	Drug Medi-Cal Service Limits	7-Day Grace Period
Youth under age 18	Thirty (30) calendar days at the outset of residential services	Every thirty (30) calendar days, based on medical necessity	N/A	N/A
Young Adult age 18 – 21	Sixty (60) calendar days at the outset of residential services	Every thirty (30) calendar days, based on medical necessity	N/A	N/A
Adult over age 21	Sixty (60) calendar days at the outset of residential services	Every thirty (30) calendar days, based on medical necessity	Maximum DMC reimbursable residential length of stay is ninety (90) calendar days, with one thirty (30) calendar day extension in a one-year period, based on medical necessity	Yes

Residential Preauthorizations – Perinatal & Criminal Justice Adults
(see Table 14 in QI & UM Manual for more details)

Age Group	Initial Residential Preauthorization	Residential Reauthorizations	Drug Medi-Cal Service Limits	7-Day Grace Period
Perinatal Adults	Sixty (60) calendar days at the outset of residential services	Every thirty (30) calendar days, based on medical necessity	Maximum DMC reimbursable residential length of stay is up to sixty (60) calendar days after the postpartum period, based on medical necessity	Yes
Criminal Justice Adults	Sixty (60) calendar days at the outset of residential services	Every thirty (30) calendar days, based on medical necessity	Maximum DMC reimbursable residential length of stay is ninety (90) calendar days, with one thirty (30) calendar day extension in a one-year period, based on medical necessity, and the ability to fund additional lengths of residential stay with non-DMC funding	Yes

Overview of QI & UM Programs (cont'd)

- **Residential Preauthorization Process (cont'd)**
  - **Residential Grace Period – Adults who are DMC eligible and age 21 and over only (N/A to Youth)**
    - **While DMC will only reimburse two non-continuous residential admissions per year, SAPC will implement a 7 calendar day grace period by which the residential stay for adults age 21 and over who leave (e.g., drop out) or are administratively discharged (e.g., kicked out for reason) from residential treatment within 7 calendar days will be reimbursed with non-DMC funds → This will help preserve the two allowable DMC reimbursable residential admissions per year.**
      - The first residential admission for adults age 21 and over will always be paid for via DMC, even if less than 7 calendar days. However, the residential grace period will apply for subsequent residential admissions with no cap (e.g., the residential grace period applies for all residential admissions beyond the first admission).
      - <u>Grace period is not necessary for youth</u> given that their residential services are provided via EPSDT based on medical necessity.
    - **Bottom-line, patients who need residential treatment services will receive necessary services and providers will be reimbursed for the delivery of those services, assuming medical necessity is established.**

Overview of QI & UM Programs (cont'd)

- **Managed care environments are complicated to navigate**
  - Successful providers in this new managed care environment must be intimately familiar with managed care rules and the various required utilization management (UM) processes (e.g., preauthorized and authorized services) → See QI & UM Manual for full details of these UM processes.

Overview of QI & UM Programs (cont'd)

- **Other Authorized Services**
  - **MAT for Youth (case-by-case basis)**
    - Re-authorization required every 30 calendar days up until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
  - **Withdrawal Management for Youth (case-by-case basis)**
    - Withdrawal management (WM) for _adults_ does not require preauthorization or authorization in any setting.
    - For youth, WM is not an ASAM level of care and is therefore not included in the DMC-ODS youth benefit package. However, WM may be approved for youth on a case-by-case basis via an authorization process if determined to be medically necessary, and may be integrated with services in other settings.
    - Youth WM is authorized for the full duration of the WM episode → As a result, reauthorizations and requests for continuation of youth WM services are N/A.
    - Youth WM is an authorized and NOT a preauthorized service, meaning that providers can deliver the service prior to SAPC authorization, but will only be reimbursed once SAPC grants authorization.
    - When WM for youth involves medication-assisted treatment (MAT), MAT for youth under age 18 requires authorization.
  - **Recovery Bridge Housing**
    - See details in subsequent slides and in QI & UM Manual.

Overview of QI & UM Programs (cont'd)

- **Service Preauthorizations & Authorizations**
  – All service preauthorizations & authorizations will occur via the electronic Authorization and Utilization Management module within the EHR that SAPC will be implementing for those who are interested.
  – For providers who already have their own certified EHR and want to continue using their system, a portal for the electronic Authorization and Utilization Management module will be made available connecting the providers' certified EHR with SAPC's.

  – Refer to QI & UM Manual for specific details for procedures and notification/submission timelines for various service authorizations.

Overview of QI & UM Programs (cont'd)

- **Complaints/Grievance and Appeals Procedures**
  - A complaint/grievance and/or appeals process is available for "involved parties" including patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent

  - **Appeal**: Refers to a request for review of an "action" or SAPC decision, which may include:
    - Denial or limited authorization of a requested service such as the type or level of service
    - Denial, suspension, or termination of a previously authorized service.
    - Denial, in whole or in part, of payment for a service
    - Failure to provide services in a timely manner

Overview of QI & UM Programs (cont'd)

- **Complaints/Grievance and Appeals Procedures (cont'd)**
  - **Complaint/Grievance**: Refers to an expression of dissatisfaction about any matter other than an "action," as defined previously
    - Possible subjects for complaints/grievances include, but are not limited to:
      - Quality of care of services provided
      - Timeliness of service provision
      - Aspects of the interpersonal relationships such as rudeness of a provider or employee
      - Failure to respect patient rights

  - **Complaints/grievances will be called into SAPC** and calls will be routed to the appropriate SAPC unit based on the nature of the dissatisfaction (e.g., Contracts, Clinical Services & Research)
  - **Appeals will be submitted electronically** either via the EHR that SAPC will be implementing or a portal to the EHR (for providers who are using their own certified EHR)

Overview of QI & UM Programs (cont'd)

- **Complaints/Grievance and Appeals Procedures (cont'd)**
  - **<u>2 layers of potential appeals</u>:**
    - **County level**
    - **State Fair Hearing**
      - Must exhaust the County level appeal before proceeding to a State Fair Hearing

  - Refer to QI & UM Manual for full details of timeframes for notices, resolution, etc.

Maximizing Use of LPHA's and Medical Directors

- **Points of clarification**
  - **All physicians are LPHAs, but not all LPHAs are physicians** → LPHA's *INCLUDE* physicians, among other health professionals (except for SUD counselors)
  - **Physicians are the only type of LPHA that can serve as a DMC Medical Director** → Physicians are still required for provider agencies because LPHAs cannot replace DMC Medical Directors
  - **Things that were previously reserved for DMC Medical Directors that LPHAs will be able to do once the DMC-ODS Waiver is launched July 2017:**
    - Sign treatment plans without physician signature
    - Determine medical necessity
    - Other SUD services (see DHCS DMC-ODS staffing grid)

- **Goal – Utilize staff at the highest level they are capable as a result of their education and training.** Whenever possible, it is recommended that Medical Directors at provider agencies perform functions that others (non-physician LPHAs) within the agency are unable to optimally perform.

Maximizing Use of LPHA's and Medical Directors (cont'd)

- **Recommended responsibilities of Medical Directors to maximize their benefit and role within the SUD system of care include:**
  - Provide Medication-Assisted Treatment, when clinically necessary
  - Provide withdrawal management, when clinically necessary
  - Provide clinical supervision for staff
  - Provide physical exams, when necessary
  - Refer/treat co-occurring physical and mental health conditions
  - Assist other professional staff with challenging cases (e.g., refractory SUD, co-occurring conditions, certain special populations)
  - Lead Quality Improvement functions/projects (e.g., Quality Improvement Projects, leading clinical team meetings, etc)
  - Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM-5, MAT, co-occurring mental health conditions)

Physician Consultation Service

- **Who**
  - Physician Consultation Services will be provided through the **University of California, San Francisco (UCSF) Substance Use Warmline** to support DMC physicians within its provider network.
  - **Intended for physicians only** and should not be initiated by non-physicians or patients.

- **What**
  - Physician consultations will be an **opportunity for DMC physicians to consult with an addiction specialist for advice, opinion, or recommendations**.
  - The content of the consultation will be **limited to addiction expertise**, and may involve, but will not be limited to, **management of complex cases, and questions involving medication-assisted treatments (MAT)**.
  - The referring **DMC physician will ultimately be responsible** for using his/her professional judgment to consider all relevant information (e.g., patient preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide high quality patient care.

Physician Consultation Service (cont'd)

- **How**
  - Physician Consultation Services will be **initiated by calling the UCSF Substance Use Warmline at (855) 300-3595** http://nccc.ucsf.edu/clinical-resources/substance-use-resources/

- **When**
  - Physician Consultation Services will be available **Monday through Friday (excluding holidays) between 7 am and 3 pm PST**
  - Voicemail will be available 24-hrs per day.

Recovery Bridge Housing

Need for Recovery Bridge Housing for SUD patients

- Safe and stable living environments are essential to individuals recovering from substance use disorders (SUDs).

- **Homeless or unstably housed individuals with SUDs are at greater risk of relapsing and not completing treatment.**

- Patients with SUDs currently have very limited access to housing while in outpatient treatment settings.
  - Subsidies for recovery housing through SAPC are currently available only for perinatal and a small number of drug court patients.

- Historically, homeless and low-income patients with SUD have had limited access to recovery residences, which have been mostly self-pay.

Recovery Bridge Housing (cont'd)

What is Recovery Bridge Housing?

- **RBH pairs a subsidy for recovery residences with concurrent enrollment in outpatient (OP), intensive outpatient (IOP), Opioid Treatment Program (OTP), and outpatient withdrawal management (OP-WM) settings.**

- **RBH is abstinence-based* and peer supported.**
  – Abstinence is NOT defined as abstinence from Medication-Assisted Treatment (MAT). As such, patients receiving MAT can and should be eligible for RBH.

- **Treatment services cannot be provided in RBH.**

- **RBH is appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical and mental health conditions.**

+ **TREATMENT & CARE** **=** **RBH**

Recovery Bridge Housing (cont'd)

SAPC RBH Pilot Project

- RBH is NOT a Drug Medi-Cal (DMC) reimbursable service.

- SAPC RBH Pilot project will offer RBH as a benefit within START-ODS that will be funded with non-DMC funding.

- Results of pilot will inform future decisions about this benefit.

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Recovery Bridge Housing (cont'd)

RBH Benefit Description

- **Patients who receive RBH subsidies must be abstinent from substances of abuse (NOT including MAT) and concurrently receiving OP/IOP/OTP/OP-WM treatment.**
    - Patients receiving MAT should be eligible for RBH.

- **SAPC may authorize up to 90 calendar day stay in RBH per calendar year for eligible adults.**
    - Perinatal patients are eligible for extended lengths of stay up to sixty (60) calendar days after the postpartum period, based on medical necessity.
    - Patients who do not utilize the entirety of the 90 days during the year may use the remainder of the unused days later during the calendar year, as necessary.

- **RBH aligns with the spirit of the American Society of Addiction Medicine (ASAM) criteria for patients to be placed in the least restrictive environment necessary to meet their biopsychosocial needs.**

Recovery Bridge Housing (cont'd)

Who is Eligible for RBH?

SAPC may authorize RBH for *adults* who meet <u>all</u> of the following criteria:

- In need of stable, safe living environment in order to best support their recovery from SUDs.

- Belongs to a special population (see next slide).

- Concurrently enrolled in treatment in OP/IOP/OTP/OP-WM settings.

Recovery Bridge Housing (cont'd)

***Homeless adult* patients receive priority for RBH subsidy, including:**

- Chronically homeless
- High utilizer patients (SAPC high tier care management definition)
- Perinatal patients
- HIV/AIDS patients
- Intravenous Drug Users
- Certain non-AB 109 criminal justice patients without housing funded through criminal justice system
- Transition Age Youth (18-25)
- Homeless patients stepping down from residential treatment
- Lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations

Note: Undocumented homeless adult patients who meet the criteria listed above are eligible for placement in RBH

Recovery Bridge Housing (cont'd)

Foundational Principles of RBH – Key Concepts

- Patient chooses abstinence-focused housing.

- Program should emphasize personal recovery goals of participants and long-term housing stability.

- Program design should establish minimal necessary barriers for entry.

- Program must meet or exceed National Association of Recovery Residences (NARR) standards of care.

- "Lapse" is not treated as an automatic cause for eviction.

- SUD case managers are required to help patients transition into permanent housing options.

Recovery Bridge Housing (cont'd)

RBH Provider Expectations

- Initially RBH will be limited to current SAPC contracted treatment providers.

- RBH providers must meet or exceed SAPC RBH standards of care (based on NARR standards of care).

- Planning for housing placement at discharge begins as soon as patient enters program, either in RBH or other housing options available through Coordinated Entry System (CES).

Recovery Bridge Housing (RBH)

SAPC Authorization and Oversight Role for RBH

- Patient eligibility for RBH must be authorized by SAPC Utilization Management (UM) Unit.
  - Patient meets medical necessity for and is currently enrolled in OP/IOP/OTP/OP-WM treatment
  - Patient needs stable living environment

- SAPC Contracts will provide monitoring and oversight of subsidized RBH to ensure quality and adherence to requirements.
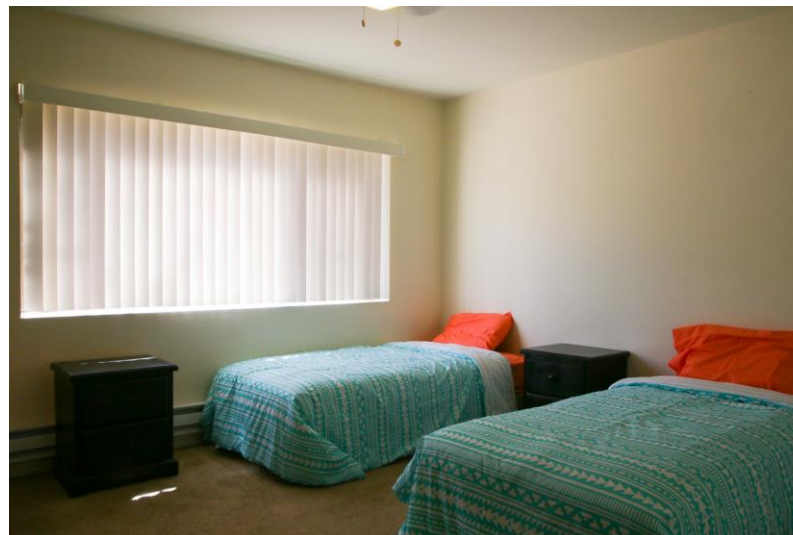
Recovery Bridge Housing (cont'd)

Linkages to Permanent Supportive Housing

- SUD treatment case managers must assist patient to get linked to permanent housing options for which they may be eligible through Coordinated Entry System (CES).

- SAPC will host training by Los Angeles Homeless Services Authority (LAHSA) for SUD providers on:
  - Overview of CES
  - Using Vulnerability Index Service Prioritization and Decision Tool (VI-SPDAT) to help match patients to appropriate housing options for which they are eligible

Governing Regulation - Updates

- **42 CFR Part 2 – Final Rule Summary**
  - **Effective date** – 3/21/17

  - **What has NOT changed?**
    - **Who must follow Part 2** → Still applies only to federally-assisted programs
    - **What information is protected** → Still protects info that would identify a patient, either directly or indirectly, as having or having had a SUD
    - **How info protected by Part 2 can be disclosed** → May not be disclosed without written patient consent, unless another exception applies
    - **Prohibition on re-disclosures** → Still prohibits re-disclosure without written consent

Governing Regulation - Updates

- **42 CFR Part 2 – Final Rule Summary**
  - **What HAS changed?**
    - **Consent options**
      - **To Whom → Both specific AND general designation options**
        - » A patient will be able to list any of the following in the "to whom" section:
          - Name of an individual provider
          - Name of an entity with a "treating provider relationship" Name of a third-party payer
          - Name of entity with neither a "treating provider relationship" nor that is a third party payer, PLUS:
            - Name of specific individual provider
            - Name of entity with which patient has a "treating provider relationship"
            - General designation of providers with a "treating provider relationship" (e.g., "all my treating providers")

Governing Regulation - Updates

- **42 CFR Part 2 – Final Rule Summary**
  - **What HAS changed?**
    - **Consent options (cont'd)**
      - **Amount and Kind of Information → More specific info is now required**
        » Release forms must now explicitly describe the SUD info to be disclosed with sufficient specificity to allow the disclosing program or other entity to comply with the request
          - For example, it would be permissible to state, "all of my SUD records" so long as more detailed options of those records is also included. However, it would NOT be permissible to state "all of my records" because that lacks the required specificity.

Governing Regulation - Updates

- **42 CFR Part 2 – Final Rule Summary**
  - **What HAS changed?**
    - **<u>Security of Records</u>**
      - Part 2 now requires that both Part 2 programs and lawful holders of patient identifying Part 2 info have established policies and procedures for the security of both paper AND electronic records
    - **<u>List of Disclosures Requirement</u>**
      - To balance the increased flexibility of general designations, Part 2 now requires patients who have included a general designation to be provided, upon request in writing (either paper or electronic), a list of entities to which their info has been disclosed pursuant to that general designation

Governing Regulation – Updates (cont'd)

- **42 CFR Part 438 – Managed Care Requirements**
  - Overview
    - **Network adequacy and access to care standards**
      - Access, timeliness of services, and distances standards

Description	Access Standard
Appointment scheduled	Immediately, but no later than 3 business days after brief triage assessment
Intake date with SUD provider *(starting July 2017)*	- Within five (5) business days from date of brief triage assessment in outpatient settings - Within ten (10) business days from date of brief triage assessment in residential settings
Intake date with SUD provider *(starting July 2018)*	Within five (5) business days from date of brief triage assessment in all treatment levels of care
Distance	Every effort must be made to refer patients to a treatment program within: - Thirty (30) minutes of travel time by personal or public transportation; OR - Ten (10) miles from the patients' location of choice

Governing Regulation – Updates (cont'd)

- ## 42 CFR Part 438 – Managed Care Requirements
  - Overview (cont'd)
    - **Patient/consumer protections (cont'd)**
      - Written policies on <u>patient rights</u>
      - <u>Receive information on available treatment options and alternatives</u> (e.g., discussion of MAT as a treatment option for those with opioid and alcohol use disorders)
      - <u>Participate in decisions</u> regarding his/her care, including the right to refuse treatment
      - <u>Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation</u>
      - <u>Request and receive copy of health records</u>, and request they be amended or corrected (if appropriate)
      - Up-to-date provider directories
      - Must adhere to <u>National Standards for Culturally and Linguistically Appropriate Services </u>(CLAS)

Governing Regulation – Updates (cont'd)

- **42 CFR Part 438 – Managed Care Requirements**
  - Overview (cont'd)
    - **Quality of care requirements**
      - Written quality strategy/plan, including:
        - » Utilization management controls (e.g., preauthorization of residential services)
        - » Performance measures
        - » Quality improvement projects
    - **Promote delivery system and payment reform toward value-based payment models**

Trainings

- **Training Framework for DMC-ODS Preparation**
  – Clinical Trainings – UCLA & CIBHS
  – Other Provider Readiness Trainings – CIBHS

- **Clinical Trainings**

  – Core Training Topics

    - ASAM & Documentation / Motivational Interviewing / Cognitive Behavioral Therapy / MAT

  – Training Prerequisites

    - ASAM e-Trainings – Modules 1 (pre-requisite for ASAM trainings AND state requirement)/ Module 2 (state requirement only)

    - A Tour of Motivational Interviewing (http://tinyurl.com/hbenh3g) (pre-requisite for MI)

Panel Discussion / Q&A

Thank you!

- **Next Mandatory All Provider Meeting Date:**
  - **Thursday, April 6, 2017 from 1pm – 3:30pm**