F. ACCESSING SERVICES

In order to receive SUD services within the County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS), clients must be a resident of San Diego County.

Access
In our commitment to providing excellent customer service, timely access is emphasized. Consistent with the County of San Diego's Health and Human Services Agency's "No Wrong Door" philosophy, Behavioral Health Services members are able to access DMC-ODS services by directly contacting DMS-ODS providers or via the Access and Crisis line. County of San Diego DMC-ODS providers will maintain hours of operation during which services are provided to members in an equal capacity to all members regardless of funding source (e.g., Medi-Cal).

County of San Diego DMC-ODS providers will post the Access and Crisis Line (ACL), 888 724-7240, to assist members with after hour's access. This line includes language translations in the member's preferred language via Language Line which has 150 languages. The ACL uses the California Relay Service (711) for TTY. The ACL maintains policies and procedures to screen for emergency medical and behavioral conditions as well as general screenings to assist with appropriate referrals to access services. Contact information for the Access and Crisis Line is also available on the County of San Diego Behavioral Health Services website and on printed materials as well as Optum San Diego's website.

County of San Diego DMC-ODS providers will ensure an appointment within ten (10) business days of the request for Outpatient, Intensive Outpatient and Residential Services. Opioid Treatment Programs will ensure an appointment within three (3) business days of the request for services. Providers shall ensure an appointment for urgent requests within 48 hours of the request. Requests for withdrawal management services are considered "urgent". Members referred to outpatient due to limited residential capacity shall also be considered "urgent". Residential program will ensure intakes will be conducted 24 hours a day, 7 days a week.

***Reminder: Providers shall issue a Timely Access NOABD when there is a delay in providing timely services as required by the timely access standards.**

All programs will ensure to not have standard wait lists. SUBG funded providers shall follow the standard for priority population members requesting services which includes offering interim services. (See the Priority Population section for more information.) Programs are required to contact other appropriate level programs within the provider network if they do not have capacity, to ensure warm handoffs as needed. Providers shall have policies and procedures in place to screen for emergency medical conditions and immediately refer members to emergency medical care. Time and distance for Outpatient, Intensive Outpatient Services, and Opioid Treatment Programs shall be within thirty (30) minutes from the member's place of residence or up to fifteen (15) miles, unless an alternate access standard has been approved by the Department of Health Care Services (DHCS). There is no "wrong door" in which individuals, and/or organizations, providers, family, or law enforcement, can access specialty SUD services for themselves or on behalf of someone else within San Diego County. Main entry methods are:

- Direct-to-provider self-referrals (member walk-ins, member direct provider calls);
- Member call to the Access and Crisis Line (ACL) toll free number: 1-800-724-7240 (TTY: 711). A 24 hour/7 day a week access number for information/referral and crisis/behavioral health/SUD screening as provided by master level, licensed providers;

- Provider to Provider on behalf of member (referrals from medical partners, SUD Dependency Drug Court or CalWORKs Case Management);

In person or telephonic screenings are often considered first points of entry into the SUD system of care. To ensure the customer experience is viewed as both professional and helpful, Access and Crisis Line screeners are master level, licensed providers with advance clinical and member engagement skills. SUD programs are required by contract to provide trained staff for screening purpose should an individual call or walk in expressing interest in and/or have been referred for services.

Geographical Service Area
Programs shall establish and operate substance use disorder treatment and recovery services for individuals in San Diego County. Service area may be specified to one of six HHSA-identified regions (North Coastal, North Inland, North Central, South, East, and Central). Specific service areas are listed in the contracts, but services shall not be limited to geographic/residential criteria and shall be available to individuals seeking treatment in San Diego County.

Network Adequacy
The State requires County Behavioral Health Plans (which include Mental Health Plans and DMC-ODS Plans) to comply with BHIN 25-013 to ensure covered services are available, accessible, and in accordance with timely access requirements as well as time or distance standards per the Medicaid Managed Care Final Rule (Mega Regs).
In addition, Behavioral Health Plans are required, per BHIN 22-032, to report data on its network providers using the "274" standard which is an Electronic Data Interchange selected by DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. This information is used by DHCS to monitor whether the BHP's provider network is adequate to support the estimated need and demand for behavioral health services. Required provider information, inclusive of identifying information, is sent to DHCS on a **monthly** basis for these purposes.
The SOC Application hosted by Optum (BHS' Administrative Services Organization) is intended to streamline workflows and provider data collection related to Network Adequacy.

Required Actions on the SOC Application:

1. Registration

New hires and program transfers are required to register on the SOC Application promptly, and attest to the accuracy of their information once registration is complete.

2. Information Update
    a. Staff/Providers are expected to update their personal profiles as changes occur.
    b. Program Managers are expected to review their programs' site profiles and update the information as changes occur.
    c. Program Managers can submit an Access Request Form (ARF) to modify information as needed to maintain the provider roster. ARFs can be submitted to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov.
3. Monthly Attestations

Staff/Providers and Program Managers are required to attest to the accuracy of all SOC information on a **monthly** basis.

For tips, FAQs, and other resources on how to complete registration and attestations on the SOC Application, visit the SOC Tips and Resources webpage. If any direct assistance is needed, contact:

Optum Support Desk

1-800-834-3792
sdhelpdesk@optum.com

Out-of-Network (OON) Access
The State Department of Health Care Services (DHCS) requires Behavioral Health Plans (BHPs) to ensure that Members receive medically necessary services within applicable time, distance, and timely access standards.

If the BHP's provider network is unable to meet those standards, the BHP shall allow Members to access out-of-network services and ensure they are adequately and timely covered.

Accordingly, when required access standards cannot be met through in-network providers, the BHP must arrange and authorize services through an Out-of-Network (OON) provider at no greater cost to the Member.

San Diego BHP contracts with Optum, as its Administrative Services Organization (ASO), to administer and execute Out-of-Network (OON) authorizations through Accommodation Agreements.

MHP and DMC-ODS providers shall refer Members to in-network providers when arranging services related to the Member's care. If medically necessary services are not available within required time, distance, or timely access standards, Members may access services from an OON provider through the process described below.

Procedure

1. **Criteria for Executing an Accommodation Agreement.** Accommodation Agreements with OON providers are executed when one or more of the following criteria are met:
    a. There are no San Diego County in-network providers within a reasonable geographic range who meet the cultural, ethnic, and clinical needs of the Member.
    b. Treatment by an OON provider is in the clinical best interest of the Member, as determined by County of San Diego Behavioral Health Services (BHS).
    c. Special requests are made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds.

2. **Referring Provider Responsibilities.** When a provider determines that medically necessary SMHS or SUD services cannot be delivered within required time, distance, or timely access standards:
    a. The provider shall provide case management services.
    b. The provider shall assist the Member in contacting the ASO's Access and Crisis Line at 888-724-7240 (TTY 711) for referral to an appropriate provider.
    c. The provider shall facilitate a warm handoff to ensure continuity of care.
    d. Providers shall initiate and support the established OON process when required access standards cannot be met.

3. ASO (Optum) Responsibilities. Upon receipt of an OON service request:
    a. ASO Review and Processing
        i. Send written acknowledgment to the Member within three (3) working days.
        ii. Determine whether network adequacy or timely access standards cannot be met.

iii. Complete review and authorization within thirty (30) calendar days of receipt of required documentation.
iv. If standards cannot be met:
    1. Identify an appropriate OON provider; or
    2. Offer telehealth when clinically appropriate.
v. If telehealth is declined and no in-network provider can meet standards, coordinate transportation for an in-person visit.
vi. Notify the Member in writing within seven (7) calendar days of approval.

b. Execution of Accommodation Agreement. If OON criteria are met, the ASO shall:
    i. Contact the identified OON provider.
    ii. Execute an Accommodation Agreement requiring the OON provider to:
        1. Follow County standard care procedures;
        2. Accept standard Medi-Cal rates unless otherwise negotiated;
        3. Submit required documentation (license, liability insurance, DEA if applicable).
        4. Verify licensure (Primary Source Verification through the Credentialing Committee does not occur).
        5. Establish the provider in the Designated Database (DDS) to enable authorization and payment.

Accommodation Agreements are time-limited and apply only to authorized service dates.

4. **Member Protections**
    a. The Member may access the OON provider for as long as medically necessary, unless the OON provider agrees to provide services for a shorter timeframe.
    b. If the BHP does not have an in-network provider able to meet applicable access standards, OON authorization shall be maintained as necessary to ensure uninterrupted access to medically necessary services.
    c. The BHP shall ensure that the cost to the Member for authorized OON services is no greater than it would be if services were provided in-network.

Standards for Timely Access and for Time/Distance

1. BHIN 24-020 requires the following Timely Access Standards for services under DMC-ODS:

Modality Type	Standard
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
Non-urgent Follow-up Appointments with a Non-Physician	Offered an appointment within 10 business days of the request for services.**

*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take- home medication, time in treatment requirements is not applicable to buprenorphine patients.)

*Reference: HSC §1357.03 (a)(5)(B), (D), (E) and (F)

Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function. Reference: HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21)). **NOTE:** All Withdrawal Management (WM) is considered urgent.

2. WIC § 14197 determines the standard for **Time or Distance**. For San Diego County, it is 30 minutes or 15 miles from the Medi-Cal member's (or beneficiary's) residence for the following behavioral health services:
    a. Outpatient mental health services and psychiatrist services
    b. Outpatient substance use disorder services
    c. Opioid Treatment Programs

3. Please refer to the document Transportation for Medi-Cal Members:
    a. When providing information to Medi-Cal members or beneficiaries about options for accessing covered non-emergency medical transportation to an in-network provider within time or distance and timely access standards for medically necessary services, when an in-person visit is requested by a member.
    b. When coordinating transportation with local Managed Care Plans (MCPs) for a Medi-Cal member or beneficiary to a network provider and meet timely access standards for medically necessary services when a member is offered a telehealth visit but requests an in-person visit.

DMC-ODS Transition of Care Policy

According to DHCS Information Notice Number 18-051, the County of San Diego as a DMC-ODS county, is required to allow a member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

DMC-ODS treatment services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months.

The County of San Diego DMC-ODS shall provide a member with transition of care with an out-of-network provider when all of the following criteria are met:

1. The County determines through assessment that moving a member to a new provider would result in a serious detriment to the health of the member, or would produce a risk of hospitalization or institutionalization;
2. The County is able to determine that the member has an existing relationship with an out-of-network provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
    a. An existing relationship means the member was receiving treatment from the out-of-network provider prior to the date of his or her transition to the DMC-ODS County.
3. The out-of-network provider is willing to accept the higher of the County of San Diego's DMC-ODS contract rates or DMC rates for the applicable DMC-ODS service(s);
4. The out-of-network provider meets the County of San Diego's DMC-ODS applicable professional standards and has no disqualifying quality of care issues (a quality-of-care issue means the County of San Diego DMC-ODS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other DMC-ODS members);
5. The provider is verified as a current DMC certified provider; and
6. The out-of-network provider supplies the County of San Diego DMC-ODS with all relevant treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations. Additionally, the provider supplies the County of San Diego DMC-ODS with all relevant outcomes data.

Transition of Care Request Process

Members, their authorized representatives, or their current provider, may submit a request to the County of San Diego DMC-ODS to retain their current provider for a period of time by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711). Upon receipt of the request, the County of San Diego DMC-ODS shall send the member written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

Retroactive Transition of Care Request Process

The County of San Diego DMC-ODS shall retroactively approve a transition of care request and reimburse out-of-network providers for services that were provided if the request meets all transition of care requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the County of San Diego DMC-ODS; and
- Have dates of service that are within thirty (30) calendar days of the first service for which the provider requests retroactive continuity of care reimbursement.

Retroactive Transition of Care requests can be initiated by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711) for more information.

Transition of Care Request Denial Process

The County of San Diego DMC-ODS may deny a member's request to retain their current provider under the following circumstance:

- The DMC-ODS county has documented quality of care issues with the DMC provider

If the County of San Diego DMC-ODS denies a member's request to retain their current provider based on the above, then the County shall notify the member of the denial in writing, offer the member at least one in-network alternative provider that offers the same level of services as the out-of-network provider, and inform the member of their right to file a grievance if they disagree with the denial. If a DMC-ODS county offered the member multiple in-network provider alternatives and the member does not make a choice, then the DMC-ODS County shall refer or assign the member to an in-network provider and notify the member of that referral or assignment in writing.

Transition of Care Request Approval Process

On behalf of the County of San Diego DMC-ODS, Optum will manage Transition of Care request approvals. If the County of San Diego DMC-ODS and out-of-network provider are able to enter into a suitable arrangement for transitioning care for a given member, then the County shall allow a member to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the member for a shorter timeframe. In this case, the DMC-ODS County shall allow the member to have access to that provider for the shorter period of time, as established by the out-of-network provider.

Within seven (7) calendar days of approving a transition of care request, the County shall notify the member of the following in writing:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the DMC-ODS County's provider network.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the County shall work with the provider to establish a care plan for the member.

Transition of Care Request Completion Timeline

Each transition of care request shall be completed within thirty (30) calendar days from the date that Optum, on behalf of the County of San Diego DMC-ODS, received the request. Retroactive claims for services from the date of request shall be processed as described above. A transition of care request is considered completed when:

- The County of San Diego DMC-ODS notifies the member, in the manner outlined above, that the request has been approved; or
- The member has either selected or been assigned to an in-network provider after the DMC-ODS county notified the member, in the manner outlined above, that the request was denied.

Termination of Transition of Care Process

The County of San Diego DMC-ODS shall notify the member in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition the member's care to an in-network provider at the end of the transition of care period. This process includes engaging with the member and affected provider(s) before the end of the transition of care period to ensure continuity of services through the transition to an in-network provider.

Referrals

When appropriate, a member shall be referred via consultation with medical staff to a licensed medical professional for physical, psychiatric, labs, and/or other examinations. When a member is referred to a licensed medical professional due to medical concerns, a medical clearance or release will be obtained prior to readmission. The referral and medical clearance shall be documented within the member's file. Refer to AOD Certification Standards Section 7020. Appointments for residential members with medical professionals in the community for examinations or due to medical concerns shall not be delayed arbitrarily based on routine program schedules or program rules, such as acclimation or "black-out" periods, and shall be based on an individualized assessment of the client's medical and clinical risk clearly documented in the client record.

Telehealth

Under the County of San Diego DMC-ODS, telehealth is an option for most services as a means of increasing accessibility to SUD services. BHS is responsible for ensuring that SUD providers who are part of the County of San Diego DMC-ODS Network follow standard telehealth protocols for protecting member confidentiality. Contracted organizational providers in the County of San Diego DMC-ODS shall:

- Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries:
    - The beneficiary has a right to access covered services in person.
    - Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
    - Non-medical transportation benefits are available for in-person visits.
    - Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.
- Use a secure, trusted platform for videoconferencing.
- Verify devices and software use the latest security patches and updates.
- Install the latest antivirus, anti-malware, and firewall software to devices. The underlying network must provide security.
- Verify devices use security features such as passphrases and two-factor authentication. Devices preferably will not store any patient data locally, but if it must, it should be encrypted.
- Verify audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on the program's own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.
- Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) and 42 CFR Part 2 is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so programs must be sure to check any relevant statute for California. Just because software says its HIPAA-compliant isn't enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of the program's practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, "all technologies" perspective.

- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.
- When reviewing software options, many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.
- Effective no sooner than January 1, 2024, all providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve member choice. Also, effective no sooner than January 1, 2024, to preserve a member's right to access covered services in person, a provider furnishing services through telehealth must do one of the following:
    - Offer those same services via in-person, face-to-face contact; or
    - Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange for that care
- Requirements for obtaining consent for telehealth services (and exception for establishing new relationships via telehealth)

Compliance these requirements will be monitored through annual BHS SUD QA site visits (see BHIN 23-018 for more information).

Referral Resource
SUD programs shall serve as a community referral resource, directing individuals in need of other services beyond the scope of the program. The program shall maintain and make available to participants a current list of resources within the community that offer services that are not provided within the program. At a minimum the list of resources shall include medical, dental, mental health, public health, social services and where to apply for the determination of eligibility for State, Federal, or County entitlement programs.

Release of Information to Referrals
In order to facilitate linkage and care coordination, providers shall report all required client information to identified referral source according to specified format and established timelines, providing there is current written consent to release information contained in the client file.

Programs shall have written policy and procedures regarding their role as a community referral resource. Program policy and procedure will identify conditions under which referrals are made, details of the referrals, and additional follow-up services as documented within the client record. Programs will offer individuals either requesting, or in need of services not otherwise offered by the program, resource options/referrals from an updated list of community service resources available within San Diego County.

Missed Scheduled Appointments
All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients (and/or caregivers, if applicable). These policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- For new referrals: When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an **elevated risk**, the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

- For current clients: When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an **elevated risk** the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an **elevated risk** and are unable to be reached on the same day, the program policy needs to document next steps, which may include consultation with a supervisor, contacting the client's emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed scheduled appointment must be documented by the program.

Note: **Elevated risk** is to be defined by the program and/or referral source.

Crisis Intervention Protocol
SUD programs are to have a protocol in place to address client crises and emergency situations. These protocols shall be available to all program staff and staffs are to be trained in crisis intervention procedures. Phone numbers for the Programs' local police, PERT team, fire department, and other emergency services shall be readily available to all staff members.

Access and Crisis Line: 1-888-724-7240 (TTY: 711)
Optum Health operates the Access and Crisis Line (ACL) on behalf of the County of San Diego Behavioral Health Services (COSDBHS). The ACL, which is staffed by licensed and master's level clinicians, provides telephone crisis intervention, suicide prevention services, and behavioral health information and referral 24 hours a day, seven days a week. The ACL may be the client or the family's initial access point into the system of care for routine, urgent or emergency situations.

All ACL clinicians are trained in crisis intervention, with client safety as the primary concern. ACL Counselors evaluate the degree of immediate danger and determine the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation). In an emergency situation, ACL counselors make direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL counselor makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

If the client's mental health condition is serious but does not warrant immediate admission to a facility, the ACL counselor performs a telephone risk screening and contacts an SUD provider directly to ensure that the provider is available to assess the client within 72 hours.

Additionally, the ACL conducts a Brief Level of Care Screening Tool in order to determine a provisional level of care recommendation to guide linkage to an appropriate referral to SUD services. During business hours, the ACL will offer the client the opportunity for a warm handoff to a SUD program best aligned with the client's provisional level of care need.

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an

initial ACL screening. Persons who have hearing impairment may contact the ACL via the California Relay Service 711.

Eligibility Determination
County of San Diego Substance Use Disorder services offer a comprehensive continuum of care to better meet the unique recovery needs of adults, adolescents, and specific subset populations (probation, perinatal), including those struggling with co-occurring disorders.

SUD programs within the County of San Diego system of care are required to develop and maintain written program eligibility, admission, and readmission policy, procedure, and protocols to include non-discriminatory eligibility and admission practices compatible with 42 CFR 438.3, Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The Americans with Disabilities Act, and Title IX of the Education Amendments of 1972 to include:

- Enrollment discrimination is prohibited (42 CFR Title 438.3)
- Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in (42 CFR § 438.50 (c)
- Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the client's health status or need for health care services (42 CFR 438.3)
- The Provider accepts individuals eligible for enrollment in the order in which they apply without restriction (42 CFR Title 438.3)
- The provider will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability (42 CFR 438.3)
- Eligible individuals may not be denied services pending establishment of Medi-Cal

Eligible Populations
Program policies will include a description of "target populations" eligible to receive SUD services within their programs as defined within their contracts. Eligibility may include one or any combination of:

- Adolescents age 12 – 17
- Adults age 18 and over
- Clients self-referred or referred by another person or organization
- Geographical Service Area: Residents of San Diego County (North Coastal, North Inland, North Central, Central, East, South)
- Persons with Medi-Cal or are Medi-Cal eligible (regardless of % FPL and regardless if they have additional insurance), including those served by local Medi-Cal managed care plans and their plan partners. Note: Clients who are at or under 138% of FPL are eligible for Medi-Cal.
- Special populations based on: disabilities, cultural, linguistic, and sexual orientation **(**DHCS AOD Certification Standards, Sec. 7000**)**
- No DMC/Low Income or no insurance:
    - Clients within 138% to 200% FPL without insurance (**and** not Medi-Cal eligible). Please refer to Section O, Provider Contracting, for more information.
    - Clients under 200% FPL with health coverage other than Medi-Cal may be invoiced to the County BHS contract.
    - Clients above the 200% FPL are outside of the BHS target population may not be invoiced to the County BHS contract.
    - Optum will require a denial or Assignment of Benefits (AOB). Check with Optum for requirements.
- Persons meeting DMC-ODS medical necessity criteria

- Justice Overrides
- Individuals under age 21 are eligible to receive Early Periodic Screening, Diagnostic and Treatment (EPSDT) services. They are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) of the Social Security Act.

(See Section A: County of San Diego DMC-ODS for more information.) For more information on the current FPL, see the Poverty Guidelines at US Department of Health & Human Services website.

Sobriety

Request for treatment services shall not be deny based on substance use in during an established period of time (i.e., 24 hours, 72 hours, or 10 days) preceding an admission. Per DHCS, "If a client has been assessed, meets the diagnosis of a substance use disorder (SUD), and is determined to not be under the influence or in need of detoxification or withdrawal management services at the time of admission, the client may be admitted into the residential program for SUD treatment and recovery services. Record of the assessment(s), diagnosis, and determination of the client's level of care must be documented and contained in the client record for review." DHCS does not promote termination of clients from treatment for relapse. Each client should have a relapse plan on file.

Assisting Clients with Medi-Cal

Providers shall make every effort to assist clients with applying for and maintaining eligibility for Medi-Cal and attempt to maintain a minimum of 80% Medi-Cal enrollment of its total program population. Programs will assess the client's insurance status during the initial assessment and throughout treatment. Programs must check clients' Medi-Cal status monthly, including Share of Cost, to verify DMC eligibility. When programs receive information about changes in a client's circumstances that may affect a client's eligibility, programs shall assist the client with reporting changes such as a change in residence, to the MC eligibility office. Changes such as a death of a client shall be reported to the SUD QA team following the SIR procedures. QA will notify DHCS for all client deaths reported.

Medi-Cal Enrollment

For clients who are currently uninsured and eligible for Medi-Cal, programs will offer assistance to obtain Medi-Cal and/or maintain their benefits, by connecting them with a Medi-Cal enrollment entity and/or assisting with the Medi-Cal application process. Medi-Cal applications can be completed throughout the year. For additional Medi-Cal qualifying information, please visit the DHCS website.

There are several ways to assist clients in the Medi-Cal enrollment process:

- Clients may complete or SUD providers may assist clients in completing an online application at:
  - MyBenefits CalWIN
  - Covered California
- Clients may make an appointment or walk-in to a Federally Qualified Health Center (FQHC) where dedicated enrollment staff will assist them with the application process
- Clients may make an appointment or walk-in to a County of San Diego operated Family Resource Center or Live Well Center where dedicated eligibility staff will assist the client with the application process
- The SUD program may partner with local FQHC to host a Medi-Cal enrollment event at the program site
- The SUD program may partner with the County of San Diego Eligibility staff to host a Medi-Cal enrollment event at the program site

- To find a Federally Qualified Health Center or County of San Diego Family Resource Center located near your program, please visit the 2-1-1 San Diego website.

Coordination of Transitions in Care (Step-Up/Down within SUD System and between Health Systems)

Coordinating transitions in client care is foundational to clients benefiting from a full SUD continuum with various levels of care to continuously meet their needs as they progress through treatment and ultimately toward recovery.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. Case management is a billable service that needs to be used to support these care transition responsibilities.

Important Components of Successful Transitions in Care

- Having established policies and procedures for standardizing the care transition process
- Ensuring sufficient training for case managers and staff who are responsible for managing transition in care to ensure understanding of the various levels of care in the DMC-ODS and other service delivery systems
- Clear and thorough treatment and discharge planning so the goals of treatment are clear, such as when transitions may be necessary and the goals of transition
- Client and family preparation and education about transitions in care (i.e. Why they are necessary, what to expect, how to seek help if the need arises, etc.)
- Warm handoffs that involve interpersonal communication and ideally physically accompanying the client during the transition, rather than solely relying on written or electronic communication
- Ensuring that the receiving provider receives necessary information to all of a smooth transition in care
- Interdisciplinary team involvement with assigned accountability for transition-related tasks and outcomes
- Follow up and tracking of referrals to ensure smooth and completed transitions in care
- Positive relationships between the sending and receiving providers
- Medication reconciliation, as needed
- Establishing a quality and process improvement process to identify and ultimately address obstacles (like transportation) to care transitions, both at individual and systemic levels.
- Maintaining client engagement throughout the transition process.

Residential Service Authorization

An Administrative Services Organization (ASO) provides customized administrative services to the County's clients and providers and is responsible for residential placement authorization and coordinating intakes to SUD providers. Optum acts as the ASO for County Behavioral Health Services. While there is no "wrong door" for clients to enter the SUD treatment system, the two most frequently used portals are the Optum Access and Crisis Line (ACL) and direct referrals. Clients seeking residential SUD services in the County may go directly to a SUD residential treatment provider or contact them by telephone to initiate services. Less frequently, clients are referred to SUD services by physical and mental health providers, law enforcement, and County agencies. For assistance with SmartCare during normal business hours (7:00 am to 4:30 pm, M-F), contact the HHSA, BHS_EHRSupport BHS_EHRSupport.HHSA@sdcounty.ca.gov For assistance with SmartCare after normal business hours and on weekends, contact the Optum Support Desk at 800-834-3792.

Residential providers are expected to have established workflow processes in place to meet submission of complete information in authorization requests, and to meet the timelines as described below. The date the authorization request is considered received is the date complete information for the request has been received. Incomplete authorization requests received by Optum that require additional follow-up for information may not meet required timelines.

County shall provide prior authorization for residential and inpatient services--excluding Withdrawal Management (WM) Services--within 24 hours of the prior authorization request being submitted by the provider.

Initial Authorization

The SUD Provider begins the authorization process by 1) Assigning the client to SmartCare Client Programs in Enrolled or Requested status, 2) checking the client's Medi-Cal eligibility, which is not a requirement for services, and communicating client's Medi-Cal eligibility to Optum when calling in initial authorization requests, and 3) completing the required intake/admission documentation (See the SUDURM for further details). If the client meets criteria for admission, the SUD Program will complete the SUD Residential Authorization Request form or the Adolescent Initial Level of Care Assessment form to establish medical necessity and submit it to Optum within 72 hours of the client's admission to the program. The Optum SUD Care Advocates are available for consultation by telephone at 800-798-2254 (select option 3, and then option 2) at any time before or during the authorization process. Residential programs are encouraged to consult should they have questions regarding a client's needs, documentation, or other questions related to authorization.

The SUD Program will notify the Optum SUD Care Advocate of the initial authorization request via telephone and will provide demographic information. The SUD Provider will then fax the Optum fax coversheet with the SUD Residential Authorization Request form or the Adolescent Initial Level of Care Assessment form to Optum at 855-244-9359. Upon receipt of the authorization request, Optum will: verify Medi-Cal eligibility, check SmartCare Client Programs review the clinical documentation, consider Provider's request for ASAM Level of Care 3.1, 3.3, or 3.5, and enter the information into the designated data system. The Optum clinician will make an authorization determination within twenty-four (24 hours) of receipt of a complete initial authorization request and will notify the SUD Provider. See Quick Guide posted on the Optum site.

Approved Request

If the initial authorization request is approved, the SUD Provider will be given an initial authorization for fifteen (15) days. Optum will notify the provider of authorization via a telephone call, and the SUD Provider will begin the continued authorization request process.

Denied Request

If the initial authorization request is denied, then the client receives a Notice of Adverse Benefit Determination (NOABD "denial" letter). The Optum clinician will verbally notify the SUD Provider of the denial and fax the Notice of Adverse Benefit Determination (NOABD) - Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The SUD Provider will provide the client with the NOABD and Client Rights. Clients may appeal the denial through the Grievance and Appeal Process. Providers may also appeal the denial. For more information on the Grievance and Appeal Process, please see Section G: Member Rights.

Continuing Authorization

After the initial authorization request is approved, the SUD Provider will submit via fax within ten (10) days of admission a Continuing Authorization Request. The SUD Provider will fax the Optum fax coversheet with the SUD Residential Authorization form, the ASAM Criteria Assessment, or a new Adolescent Initial Level of Care Assessment form to Optum at 855-244-9359. Prior to faxing authorization request to Optum, the SUD Provider will update SmartCare Client Programs if request is for a different level of care.

The Optum clinician will review the clinical documentation for medical necessity and enter the submitted information in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Approved Continuing Authorization

If continuing authorization request is approved, the Optum clinician will provide a continuing authorization of seventy-five (75) days and will notify the SUD Provider by telephone. For adolescent programs, a continuing authorization of fifteen (15) days will be provided.

Denied Continuation Request

If an authorization request is denied, the Optum clinician will verbally notify the SUD Provider of the denial and fax to the program the Notice of Adverse Benefit Determination (NOABD) – Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The program will provide the notice and other documents to the client. Clients may appeal the denial through the Grievance and Appeal Process (for more information on the Grievance and Appeal Process, please see Section I: Quality Assurance).

Extension Authorization Request

If the SUD Provider determines that a client needs additional residential treatment services, the SUD Provider will submit an extension request for continuing authorization for thirty (30) more days, no later than 10 days before their current authorization expires. Perinatal SUD programs may submit extension authorization requests in thirty (30) day increments,and shall also defer to any postpartum timelines outlined in their contract with the County of San Diego. Adolescent SUD Provider may request an extension request for thirty (30) more days and must be submitted to Optum by day thirty (30). Prior to faxing authorization request to Optum, the SUD Provider will update SmartCare Client Programs if request is for a different level of care.

The Extension Authorization Request may include any documentation that indicates ASAM Medical Necessity. The extension authorization request documentation will be faxed and include at a minimum:

- Optum RSUD Auth Request Fax Cover Sheet **AND**
- SUD Residential Authorization Request Form **OR**
- A new Adolescent Initial Level of Care Assessment

The Optum clinician will review all submitted clinical documentation for medical necessity and document in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the extension authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or

functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Residential Level of Care Changes

If the client's assessed level of care changes and the client needs to be moved to another residential level of care (e.g., 3.1 to 3.5), the SUD Provider will update SmartCare Client Programs level of care and submit a request to change the level of care via fax that will include:

- Optum RSUD Auth Request Fax Cover Sheet **AND**
- SUD Residential Authorization Request Form **OR**
- A new Adolescent Initial Level of Care Assessment

The Optum clinician will review all submitted clinical documentation for medical necessity and document in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Discharge

When medical necessity is no longer met for residential treatment during an authorized stay, the SUD Provider shall recommend a change in level of care and transfer or discharge the client. The SUD Provider will submit to Optum via fax the discharge summary within thirty (30) days of the last face-to-face with the client (please see "Timelines" under "Discharge Summary" further in this section for more information).

Retrospective Authorization Request Requirements

Residential providers are expected to submit all authorization requests within prescribed timelines. There are limited circumstances in which retrospective authorizations may be conducted, including:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for members with other health care coverage pending evidence of billing, including dual-eligible members;
- Circumstances beyond the program's control (such as natural disaster. This does not include negligence, misunderstanding of requirements, illness or absences of staff), and/or,
- Member's failure to identify payer/concealed Medi-Cal eligibility at the time of admission.

The residential program shall be required to send copies of the entire client chart and documentation as to why an authorization request is being sent retrospectively.

All Retrospective Authorization Requests must be submitted within four (4) months from the date of the client's retrospective eligibility or within four (4) months of Provider being notified of denial from other primary health insurance coverage. Retrospective Authorization Requests which are not submitted timely will be administratively denied.

In cases where the review is retrospective, the ASO, on behalf of the DMC-ODS, will communicate the decision to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall communicate to the provider in a manner that is consistent with state requirements.

Charitable Choice Regulations

Charitable Choice regulations require that religious organizations provide notice to all clients regarding their right to referral to another provider to which they have no religious objection. Charitable Choice referrals shall be reported to the County. This is applicable to religious organizations only. Please refer to 68 FR 56429 9/30/2003 (model notice on page 56438).

Nondiscrimination against religious organizations

- A religious organization is a nonprofit organization which is eligible on the same basis as any other organization to participate in applicable programs consistent with the First Amendment to the U.S. Constitution. These applicable programs include those under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, 42 U.S.C. 300x to 300x-66 and the Projects for Assistance in Transition from Homelessness (PATH) Formula Grants, 42 U.S.C. 290cc-21 to 290cc-35 as these programs fund substance abuse and/or treatment services.
- Nothing in these regulations except the provisions provided herein and the SAMHSA Charitable Choices provisions which are the provisions of 42 U.S.C. 300x-65 and 42 U.S.C. 290kk, et seq. shall limit the ability of a governmental entity to have the same eligibility conditions apply to religious organizations and any other nonprofit private organization.
- No governmental entity receiving funds under these programs shall discriminate against an organization on the basis of religion or religious affiliation.

Religious activities, character, and independence

- Programs which receive funds from SAMHSA, or a governmental entity will not use these funds for religious activities. The organization's religious activities must be offered in a separate time or location and participation is voluntary for an individual who receives substance use disorders services.
- A religious organization maintains its independence from governmental entities to practice and express its religious beliefs.
- Faith-based organizations which provide services need not remove religious materials from their facilities. A SAMHSA-funded religious organization may keep its structure of governance and include religious terms in its printed material and governing documents.

Non-discrimination requirement

- A religious organization which provides substance use services will not discriminate against a program member or a participant who receives substance use services based on religious beliefs or a refusal to participate in a religious practice.

Rights to services from an alternative provider

- An individual who receives or is interested in services and disagrees with the religious nature of the program has a right to obtain a notice, a referral, and alternative services within a reasonable time period.
- A program that provides a referral to an individual or interested individual will provide the participant with a notice of a right to receive services from an alternative provider who will meet the requirements of needed services such as accessibility and timeliness of treatment.
- Programs will maintain a system that ensures that appropriate referrals are made which meets the needs of the individual such as in the geographic area. A SAMHSA treatment locator may be used.
- Referrals will maintain the laws of confidentiality and specifically confidentiality regarding alcohol and drug abuse records (42 CFR Part 2). The program will contact the State regarding the referral and make sure the individual contacts the alternative provider.

Priority Population Clients Requests for Services
SUBG funded programs must follow the priority population list for treatment admission preferences:

- Pregnant person using IV substances
- Pregnant person using other non-IV substances
- Person using IV substances
- All other eligible individuals

When priority population clients are not able to be admitted to a SUBG funded program due to capacity limitations, interim services shall be provided within 48 hours if no other facility has capacity to admit the client. Examples of interim services include referrals/education for prenatal care, HIV/TB services/education, referrals for housing, self-sufficiency services, medical care, etc.

All DHCS funded programs shall report capacity and waitlist management information to DHCS monthly via DATAR. QA monitors priority population waitlists reported to confirm accuracy of the data and confirm if interim services provided for priority population clients. Programs shall keep records of interim services for each priority population client not admitted, which includes documenting efforts for each client, and provide upon request to QA.

Persons with Disabilities (PWD) Access to Services
Any enterprise licensed or certified by the DHCS or any entity (counties and providers) receiving state or federal funding that has been allocated by DHCS must comply with statutory and regulatory requirements such as:

- Americans with Disability Act (ADA) Exhibit 1
- Section 504 and 508 of the Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (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, Activities Receiving Federal Financial Assistance and;
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD).

These statutory and regulatory requirements assist in ensuring Persons with Disabilities (PWD) are provided access to Substance Use Disorder (SUD) prevention, treatment and recovery services. The legislation and regulations require all providers make reasonable accommodations and provide accessible services for PWD, and this also includes providers making electronic and information technology accessible to people with disabilities. These are per program standards within the Legal Entity, so each program site needs to comply with the above statutory and regulatory requirements.

Providers applying for initial licensure or certification must plan to be fully accessible at the time of application. Applicants for renewal of a licensure or certification must have conducted an assessment to identify barriers to service and develop an Access to Service Plan (i.e., corrective action plan) for removing or mitigating any identified barriers. Applicants failing to address these requirements can anticipate denial of their initial application or the withholding of renewals for existing licensed or certified programs until these requirements are adequately addressed.

The county is responsible for ensuring that SUD services and the SUD contracted providers are accessible and do not discriminate against or deny equal opportunity to a PWD to participate in and benefit from the provided service. Language Requirement
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. Programs shall access professional certified interpreter services as needed for deaf, hard of hearing and late deafened participants to facilitate complete communication and to ensure provision of appropriate confidential treatment and recovery services. The offer of interpreter services and the client's response must be documented, as should the use of an interpreter, and include documentation when services are provided in a language other than English.

DMC-ODS County of Responsibility
As outlined in MHSUDS 18-051, the DMC-ODS county must allow the member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

If a member moves to a new county and initiates an inter-county transfer, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation. (BHIN 21-032)

The DMC-ODS County shall ensure that members receiving NTP services and working in or traveling to another county (including a county that does not opt in to the DMC-ODS program) do not experience a disruption of NTP services.

In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the member.